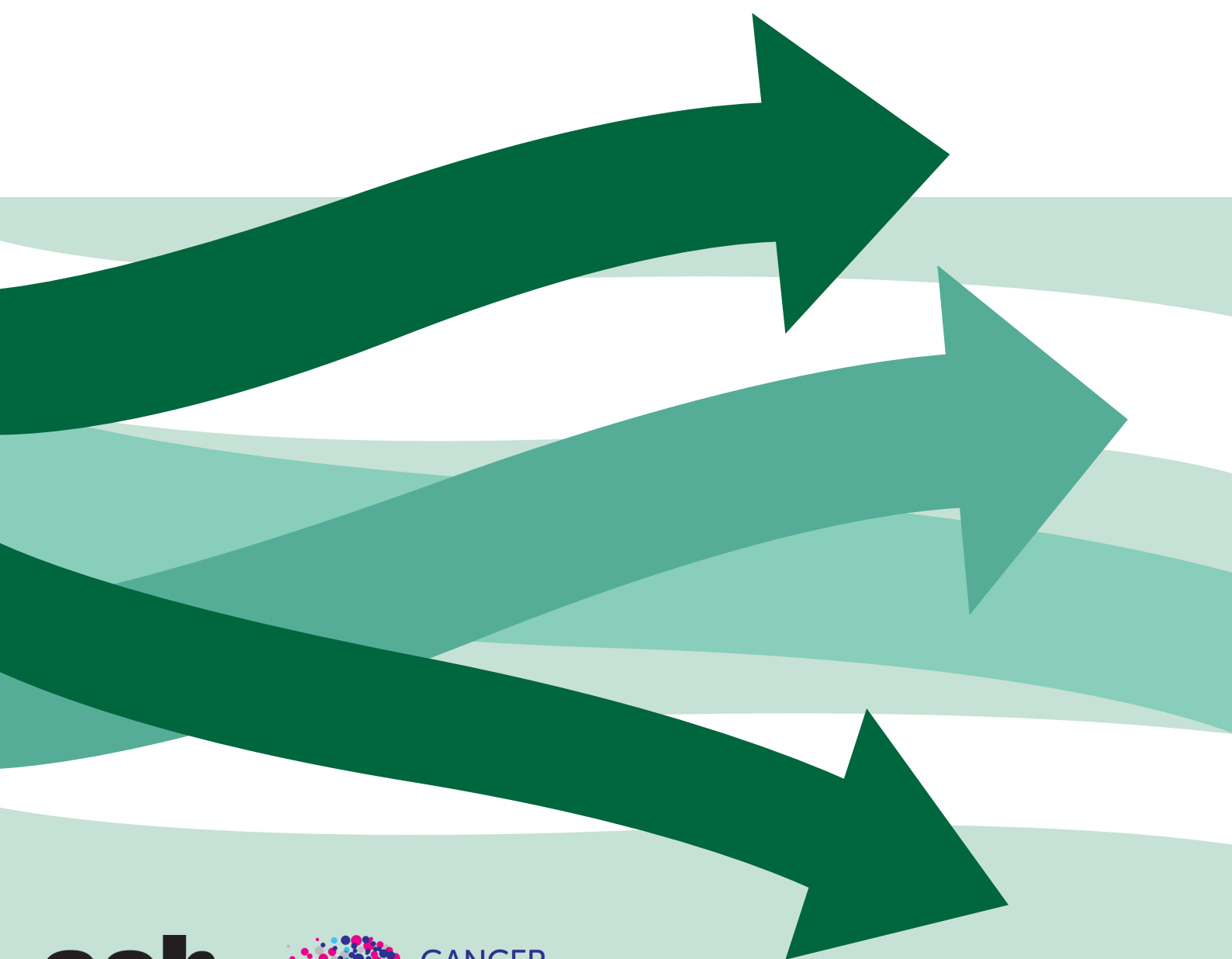


# Many ways forward

Stop smoking services and tobacco control  
work in English local authorities, 2019



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# Summary

Many opportunities exist for local authority commissioners of tobacco control and stop smoking services to build on their past successes and improve their local offer. These include joint working with colleagues in other local authority services, partnering with the NHS (now newly engaged in smoking cessation thanks to the Long Term Plan), and pursuing population approaches within Sustainability and Transformation Partnerships and Integrated Care Systems.

Every effort is needed to seize these opportunities if the Government is to achieve its 2030 smokefree ambition for England, yet the threat of further budget cuts remains prominent for most local authority tobacco control leads.

## Key findings

- » In 2019, 69% of surveyed local authorities in England offered a specialist stop smoking service to local smokers and 59% offered a service to all smokers, compared to 56% of local authorities offering a universal specialist stop smoking service in 2018.
- » Among the local authorities that still had a budget for stop smoking services, 35% had cut this budget between 2018/19 and 2019/20. This was the fifth successive year in which more than a third of local authorities had cut their stop smoking service budgets.
- » Pressure on budgets remains by far the biggest threat to stop smoking services and wider tobacco control work in local authorities in England. Almost three quarters (74%) of respondents said pressure on budgets was a threat to local tobacco control, including ongoing cuts to local authority budgets, further cuts to the public health grant and uncertainty about the future of the grant after March 2021.
- » In the four years from 2014/15 to 2018/19, total local authority spending on stop smoking services and tobacco control in England fell by 36% from £135.9m to £87.3m.
- » Respondents highlighted the opportunities offered by partnerships and alliances locally, with the NHS and with other local authority services, and at wider strategic level. Most (92%) Sustainability and Transformation Partnerships or Integrated Care Systems had identified smoking as a priority.
- » Despite the cuts, 98% of surveyed local authorities still offered some or all local smokers face-to-face support to quit and 97% were engaged in some form of wider tobacco control activity.
- » Smokers in disadvantaged groups were less likely to receive targeted support in areas where specialist support had been replaced by integrated lifestyle or primary care-based services.
- » Specialist stop smoking advisers received more training in smoking cessation on average (3.2 days) than health trainers (2.2 days) and intermediate advisers (1.6 days), but in a fifth (21%) of local authorities with specialist stop smoking advisers, these advisers received 1.5 days training or less.
- » Only 65% of local authority stop smoking services offered smokers a full 12-week course of dual Nicotine Replacement Therapy (NRT).

## Recommendations

- » Government must reverse cuts to public health funding and deliver new investment in local tobacco control by imposing a 'polluter pays' charge on the tobacco industry. This charge would raise £300m - £500m per year and could fund stop smoking services, enforcement against the illicit tobacco trade, and mass media public health campaigns to help reduce smoking.
- » The NHS and local authorities should work together to ensure that new NHS services developed in response to the Long Term Plan are integrated with wider community stop smoking support, including targeted lung health checks.

- » Local authorities should ensure that all smokers have access to behavioural support to help them quit smoking alongside a choice of a full 12-week course of dual NRT or a full course of Champix (varenicline).
- » Directors of Public Health, NHS senior leaders and their colleagues in tobacco control should ensure that the priority given to smoking in Sustainability and Transformation Partnerships and Integrated Care Systems is followed through in comprehensive strategic planning involving all local and regional partners.
- » Local authorities that have decommissioned specialist stop smoking services in favour of integrated lifestyle services or primary care-based support should ensure that these approaches are effective in reaching smokers in high prevalence groups.
- » Commissioners should ensure that advisers employed to deliver behavioural support are trained to National Centre for Smoking Cessation and Training (NCSCT) standards and undertake refresher training at least annually to stay up to date with the latest developments in smoking cessation.
- » Local authorities which do not currently provide e-cigarette starter packs as part of their cessation offer should consider doing so to give local smokers the best possible chance to quit.

## Summary of findings

Findings are from an online survey of tobacco control leads in local authorities in England. Responses were received for 127 local authorities, 84% of the 151 local authorities in England with responsibility for public health.

### Meeting the needs of smokers

There is stark inequity in the local authority offer to smokers across England. In some areas, stop smoking services have been scaled down or decommissioned altogether. Elsewhere, local authorities have sustained or developed their services.

In 2019, 69% of surveyed local authorities in England offered a specialist stop smoking service to local smokers, up from 65% in 2018, though only 59% offered a service to all smokers. A fifth of local authorities (20%) offered an integrated lifestyle service with no specialist service, 9% only offered support in primary care and 2% only offered telephone support.

Almost all local authorities (97%) offered behavioural support for smoking cessation, in some cases in addition to integrated advice on multiple behavioural health issues. Behavioural support for smoking cessation was provided by a range of different advisers: 83% of local authorities providing behavioural support used specialist stop smoking advisers; 63% used intermediate advisers, such as GPs and pharmacists; and 33% used health trainers or coaches who support clients in addressing all their behavioural health issues.

On average, specialist stop smoking advisers received more training in smoking cessation (mean 3.2 days) than health trainers (2.2 days) and intermediate advisers (1.6 days). However, in 21% of local authorities where specialist advisers were employed, these advisers received less than two days training.

Two thirds of local authority stop smoking services (65%) offered smokers a full 12-week course of dual NRT. Six percent did not offer any NRT to smokers.

Eleven per cent of local authorities offered smokers e-cigarettes through their stop smoking service.

### Targeting high prevalence groups

Among surveyed local authorities, 87% targeted pregnant women, 70% targeted people with mental health conditions, 67% targeted people in routine and manual occupations or who have low incomes, and 60% targeted people with acute or long-term conditions.

Specialist services were more likely to target high prevalence groups than integrated lifestyle services, which in turn were more likely to target high prevalence groups than services provided through primary care only.

The challenge of targeting high prevalence groups while also providing a universal service was resolved in different ways in different local authorities: by providing both a universal and a targeted specialist service; by providing a specialist service to target groups alongside a wider offer of support through lifestyle or primary care services; or by providing a service to target groups only.

In 66% of local authorities, GPs offered smokers full 12-week courses of dual NRT. In 23% of local authorities GPs did not prescribe any NRT.

## **Partnerships and tobacco control**

In 92% of local authorities, survey respondents reported that smoking was a priority for their Sustainability and Transformation Partnerships (STPs) or Integrated Care Systems (ICSs).

In 2019, 60% of surveyed local authorities were part of a local tobacco control alliance or partnership, down from 74% in 2015.

Almost all surveyed local authorities (97%) were pursuing some wider tobacco control activity, including tackling illegal tobacco (91%), communications and campaigns (88%), enforcing legislation (87%) and promoting smokefree public spaces (62%). Ten local authorities were not tackling illegal tobacco despite a statutory obligation to do so.

## **Opportunities and threats**

Joint working, partnerships and alliances were most often identified as opportunities by survey respondents, including new alliances with the NHS and partnerships across wider footprints. Opportunities were also identified for integrating tobacco control into the wider work of the local authority, potentially enabling greater reach into local communities, and aligning the work of tobacco control to other council priorities.

By far the most common threat to tobacco control identified by survey respondents was the ongoing pressure on budgets, cited in some form by 74% of respondents who answered the question. These pressures included the year-on-year cuts in the public health grant, the uncertainty about the future of the grant, the consequences for public health of the wider cuts to local authority budgets, and internal pressure to review public health spending and make substantial changes.

## **Budgets and spending**

Among the local authorities that still had a budget for stop smoking services, 35% had cut this budget between 2018/19 and 2019/20. This was the fifth successive year in which more than a third of local authorities had cut their stop smoking service budgets.

Less than two thirds of surveyed local authorities (64%) still had a budget for wider tobacco control. Among these local authorities, 23% had cut this budget and 14% had increased their budget between 2018/19 and 2019/20.

According to the data published by the Ministry of Housing, Communities and Local Government (MHCLG), local authority spending on stop smoking services and wider tobacco control fell by 8% between 2017/18 and 2018/19. However, spending on wider tobacco control rose slightly over this period, by 3%, while spending on stop smoking services fell by 9.2%. Over the four years from 2014/15 to 2018/19 there was a 36% decline in total local authority spending on stop smoking services and tobacco control.

# 1. Introduction

This report presents findings of the sixth annual survey of tobacco control leads in England, conducted by Action on Smoking and Health (ASH) and funded by Cancer Research UK (CRUK). The report explores some of the issues that have shaped the development and diversification of local stop smoking services and tobacco control work in English local authorities.

ASH has surveyed tobacco control leads every year since the transfer of public health from the NHS to local government in 2013. Over this period, the survey has described the influence of local authority priorities and values on tobacco control and the impact of the cuts to budgets for stop smoking services and wider tobacco control.

The importance of the political priority given to tobacco control within the local authority setting was clear from the outset. In 2014, 51% of local authorities gave tobacco control a high or above average priority but for 15% the priority was low or below average,<sup>1</sup> rising to 18% in 2015<sup>2</sup> and 19% in 2016.<sup>3</sup> These local authorities experienced the deepest cuts to their smoking cessation and tobacco control budgets. But even in the majority of local authorities where tobacco control remained a priority, this political commitment mitigated but did not necessarily prevent cuts being made to smoking cessation and tobacco control budgets.<sup>4</sup> The principal drivers of cuts to smoking cessation services and tobacco control work were external: the government cuts to the public health grant and to local authority budgets as a whole.<sup>3</sup>

Over time, budget cuts inevitably had an impact on services. Some stop smoking services were decommissioned altogether; others were scaled down or restricted to target populations.<sup>5</sup> By 2018 only 59% of local authorities still had a budget for wider tobacco control work.<sup>6</sup> But the changes to these services have been shaped by much more than financial pressures. The emergence of new approaches, especially 'integrated lifestyle services' which address multiple health needs rather than just smoking, also reflect a local government view of how individual needs should be met. The contribution of the local government world-view to the ongoing development of stop smoking services and tobacco control work is explored in this report.

This report includes an account of the opportunities and threats that currently face stop smoking services and wider tobacco control work in local authorities in England. Although cost pressures remain the predominant threat, there are many opportunities including new partnerships with the NHS and across local health economies. The NHS Long Term Plan, published in January 2019, has opened the door to new services and resources for smoking cessation within the NHS.<sup>7</sup> As the leaders of local tobacco control partnerships, local authorities are well-placed to ensure that new clinical services fit into a broader, comprehensive approach to reducing tobacco harm locally. In doing so, they will be continuing to play a key role in delivering the government's ambition to make England smokefree by 2030.<sup>8</sup>

## 2. Methods

This report presents the findings of an online survey of tobacco control leads in local authorities in England. The survey was the sixth annual survey of local authority tobacco control leads conducted by ASH since 2013. The survey was open for completion online between July and September 2019. Local tobacco control leads were emailed by ASH and invited to complete the survey. Non-respondents were initially followed up by email, then telephone, and encouraged to participate.

Completed responses were received from 120 individuals who provided data on 127 local authorities, 84% of the 151 local authorities in England with responsibility for public health (excluding the Isles of Scilly). Four fifths (81%) of respondents identified their role as a tobacco control lead, or a commissioner of tobacco control/smoking cessation services, or both (n=103). Of the remaining 24 respondents, two were directors of public health, four were consultants in public health, eight had other public health roles, seven were stop smoking service managers, two of whom also managed integrated lifestyle services, and three had other clinical roles.

All quantitative data was analysed using SPSS Version 23. Data from open questions was subject to content analysis.

# 3. Meeting the needs of smokers

## 3.1 Directions of travel

In addition to the closed questions that formed the bulk of the survey, respondents were asked to describe their local authority's services for smokers in their own words. Their free-text responses are used throughout this report to illustrate the range and complexity of local activity and to qualify the necessarily simplified quantitative results.

We begin with a broad view: an illustration of the diversity of local authorities' ambitions for their stop smoking services (Table 1). Four characteristic trajectories of the development of stop smoking services are described in Table 1: decommissioning, scaling down, sustaining the inherited model and taking new approaches. These trajectories can be seen in all types of local authorities from county councils to London boroughs.

Table 1 illustrates the inequity of provision for smokers across England. In some local authorities, smokers still have access to high quality services and support. Elsewhere, there may be little or nothing on offer.

**Table 1: Examples of stop smoking services in 2019**

Trajectory	County council/unitary authority	Metropolitan borough/London borough
Decommissioned	Since July 2019 our stop smoking service has been decommissioned and so now we deliver only to pregnant women. This is specialist support from a full-time experienced advisor, providing behavioural support face-to-face in the home or on the phone as well as combination NRT.	We have ceased our stop smoking services from April 2019.
Scaled down	We currently have a universal offer of NRT and behavioural support from some pharmacies across the city, with hopefully more available soon once the training has been completed. There is specific behavioural support and NRT for pregnant women from trained midwives as part of the maternity services. Historically we had an integrated service, however, this service has now ended and we are currently reviewing our provision.	Delivered by community pharmacies. The service is intermediate level but all forms of pharmacotherapy are offered at full treatment courses. Pregnant women can also utilise dual NRT therapy but universal service does not offer this. Behavioural support is offered alongside pharmacotherapy but not at the duration and intensity that a specialised stop smoking service would offer.
Established/sustained	Universal evidence-based service with specialist behavioural support and pharmacotherapy over (at least) a six-week period, available for all smokers to access. The service aims to deliver 2000 four-week successful quits each year.	A team of specialist advisors who provide stop smoking support from 56 separate geographical locations across the city (however density of clinics is targeted to reduce health inequalities). The service provides pharmacotherapy advice to clients and vouchers to obtain free pharmacotherapy to clients who are eligible to receive it.



New directions	Smoking remains a key priority across the county and city and as joined up authorities commission lifestyle services to offer specialist stop smoking support as part of an integrated lifestyle service across the county. As part of this contract, specialist stop smoking support is offered in a wide range of settings and to targeted populations with high smoking rates. Our advisors are all NCSCT trained and also provide an integrated lifestyle service that supports the 'whole' person to improve their health outcomes. As a complex, diverse population we provide stop smoking support in a wide range of settings but also through Smoking Cessation Advisors who are bilingual. Our services access points and delivery are flexible to ensure we are open to everyone.	New tobacco treatment model developed for 2019. Service commissioned to operate in primary care targeting key groups of smokers. Specialist team based in public health support complex smokers in maternity, long term conditions, outpatients and staff in acute settings. Workplace tobacco treatment. In addition outreach is commissioned to deliver awareness raising about tobacco and treatment and signposting. Live Well signpost. The borough is also part of London wide helpline and digital support offer as part of universal service. Local Making Every Opportunity Count programme (MEOC) includes tobacco increasing referrals into support.
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### 3.2 Taking a holistic view

Respondents to the survey were asked to specify several key characteristics of their local authority's services for smokers including:

- » The service model adopted (specialist services, integrated lifestyle services and primary-care-based services)
- » The support offered (behavioural support for smoking cessation, integrated advice on multiple health issues including smoking, brief advice, and self-support)
- » The types of adviser employed (specialist stop smoking advisers, intermediate advisers, and health trainers/coaches)

Local commissioning decisions cut across these variables. Although cost has clearly been a crucial factor in shaping these decisions, many local authorities have also been keen to explore new approaches to delivering support for their population of smokers. In particular, some local authorities have sought to look beyond the focus on tobacco dependence of specialist stop smoking services, seeking to understand and respond to the needs of smokers more holistically. This view has informed the commissioning of 'integrated lifestyle services' which offer advice on a range of behavioural health issues, not just smoking. But it has also shaped the direction of some specialist stop smoking services:

*The specialist stop smoking service forms one part of the of the whole system approach to tobacco control across the borough, incorporating work with various different partners. The service aims to provide advice and guidance through personalised face to face support, or the use of technology to build resilience. The team works holistically to support other services across the borough and signpost people to a range of universal and specialist services to address wider lifestyle issues including debt, welfare and housing.*

This example makes explicit the link between a holistic view of individual need and a systems view of local services and support. This 'big picture' approach has always been a core strength of local authorities and was central to the rationale for the transfer of public health to local authorities in 2013. Although specialist stop smoking services also have a history of engaging at a systems level to meet needs, for example by training intermediate advisers and engaging community organisations, such engagement aims to reach more smokers in order to help them quit rather than to address their wider needs.

Taking a holistic view of smokers' needs has its risks, given the evidence that an adviser who talks to a smoker about all their personal health concerns at once may not be effective in tackling the one behaviour – smoking – that does the most damage.<sup>9</sup> Public Health England has drawn a distinction between lifestyle services that triage smokers to specialist support (effective) and lifestyle services that offer 'multi-behaviour change interventions' (not effective, at least for smoking).<sup>10</sup>

But what, in fact, is being offered? Are advisers in integrated lifestyle services and elsewhere assessing and responding to needs holistically but still keeping a clear focus on tobacco dependence? Or are they conducting 'multi-behaviour change interventions' and failing to tackle the smoking behaviour? The answer to this question is not easy to gain through a survey and may vary even in any one local authority, depending on the skills of the advisers employed. The following examples illustrate the range of possibilities and the difficulty of making an assessment based purely on a service description:

*The stop smoking service forms part of a wider integrated lifestyle service but is delivered by trained smoking cessation specialists as opposed to generic lifestyle advisors. Smoking cessation provision is normally via face-to-face, one-to-one support in various clinic and community settings but is targeted proportionally to high prevalence areas.*

*The Wellbeing Service provides integrated support for smoking, healthy weight and alcohol. About 60% of clients receive an intervention for smoking.*

*A 12-week NRT licenced behaviour change service to smokers. The service is integrated into the mainstream Healthy Lifestyle Service offering all health behaviour support so clients can access any part of the service during their stop smoking sessions. The service also links with Social Prescribing programmes to help and support quitters in their local areas.*

Every one of these services offered local smokers 'behavioural support for smoking cessation' as well as 'integrated advice on multiple behavioural health issues including smoking'.

The findings in the remainder of this chapter describe both the diversity of service models currently being commissioned by local authorities and the character of the support offered.

### 3.3 Service types

Respondents to the survey were asked which of the following their local authority commissioned or provided:

- » Specialist stop smoking service
- » Integrated lifestyle service
- » Smoking cessation support in primary care

Overall, 69% of surveyed local authorities commissioned a specialist stop smoking service in 2019 (Table 2). Around a third of these local authorities also commissioned an integrated lifestyle service (22% of all local authorities). A fifth of local authorities (20%) commissioned an integrated lifestyle service with no specialist service. Overall, 57% of local authorities commissioned stop smoking support in primary care including 9% that only commissioned support in primary care. Three local authorities (2%) reported that the only local support was a telephone service, two of which were London boroughs that did not commission any stop smoking services but referred smokers to the London website and helpline.

Not all specialist services were available to all smokers. Of the 87 local authorities that had retained a specialist service, 12 did not offer a universal service including three where the service was only available for pregnant women. The remaining 75 had a universal offer for local smokers (59% of all surveyed local authorities). In some cases, however, this offer combined a specialist service that was only available to specific target populations and a service for all smokers delivered via a lifestyle service, primary care, telephone or online (see section 4.1). Among the 54 local authorities that provided an integrated lifestyle service, all but two (96%) offered this to all smokers. There were no restrictions on access to commissioned services for smokers in primary care.

A higher proportion of local authorities reported commissioning a specialist stop smoking service in 2019 (69%) than in 2018 (65%) and there was a slight decline in the proportion commissioning a lifestyle service with no specialist service (20% vs. 22%).

The typology used in Table 2 simplifies a complex range of services and service combinations. Table 3 uses this typology to present examples of respondents' own descriptions of their services. These shed some light on this complexity including the relationships between the different components of local services, the range of providers commissioned, the types of adviser employed, the targeting of services and the restrictions on access to parts of the service. In practice, the difference between a specialist service commissioned as part of an integrated service and an integrated service that offers specialist support may be semantic in some cases.

**Table 2: Types of service for smokers commissioned or provided by local authorities**

Type of service	Local authorities	
	2019	2018
Specialist service	87 (69%)	65%
Lifestyle service with no specialist service	26 (20%)	22%
Support in primary care only	11 (9%)	9%
Telephone support only	3 (2%)	3%

**Table 3: Examples of service, by combination of service type**

Service combination (n=127)	Examples of local services
specialist service only (n=29, 23%)	Universal service for all smokers providing behavioural support and pharmacotherapy, plus support for smokers using e-cigarettes to quit, with targeted activity for priority groups.
Specialist service + lifestyle service (n=9, 7%)	We commission our integrated lifestyle service, part of which is our specialist stop smoking support. This is a universal service but we specifically target residents with long-term conditions and routine and manual workers. We also commission an acute trust and a midwifery service. Our stop smoking service provides brief intervention training for wider partners, including school nurses and other frontline staff.
Specialist service + primary care (n=30, 24%)	The Council commissions stop smoking services from GP practices and community pharmacies. The specialist stop smoking service is an internal public health service which aims to support the most addicted smokers and provide more intensive support to groups such as pregnant women, mental health service users, people who have previously failed to quit using a GP or pharmacy service.
Specialist service + lifestyle service + primary care (n=19, 15%)	Integrated lifestyle service including specialist smoking services aimed at pregnant women and people with mental health conditions and a community-based smoking cessation services accessible from pharmacies.
Lifestyle service only (n=13, 10%)	We deliver a 12 week stop smoking service via our Integrated Lifestyle Service. Clients can choose between face to face or telephone support, with a choice of Pharmacotherapy. The service is e-cigarette friendly.
Lifestyle service + primary care (n=13, 10%)	We commission specialist stop smoking support as part of an integrated lifestyle service. In addition we commission GPs and pharmacies to provide stop smoking services through a local Public Health Local Service Agreement.
Primary care only (n=11, 9%)	Intermediate advisors based mostly in nearly all GP practices and community pharmacies. Other providers include children/young people and adult substance misuse services, 0-19 children's public health services, small number of Community and Voluntary Sector providers.
Telephone service only (n=3, 2%)	Currently, a telephone-based behaviour change support service for smoking cessation. Service will be commissioned out in 2020/21.

### 3.4 The support and treatment offered

Respondents to the survey were asked which of the following types of advice/support they provided for smokers:

- » Behavioural support for smoking cessation
- » Integrated advice on multiple behavioural health issues including smoking
- » Very brief advice/brief advice
- » Self-support (e.g. website apps)

Table 4 describes the results. Almost all of the surveyed local authorities (97%) offered behavioural support for smoking cessation. Of the four who did not, two respondents said their service offered 'integrated advice on multiple behavioural health issues including smoking' and two only offered self-support.

Table 5 describes the types of support offered by service type. Behavioural support for smoking cessation was consistently offered by all local authorities with specialist services and by all local authorities providing support in primary care only, and by 92% (all but 2) of the local authorities with a lifestyle service but no specialist service.

In the 123 local authorities where behavioural support was offered, three quarters (75%) offered 12 weeks of behavioural support to all smokers. A further 7% offered 12 weeks of support to smokers in priority groups. The remainder all offered between 4 and 8 weeks of support. In all but three of these local authorities (97%), behavioural support was provided individually face-to-face. Of the three that did not, two provided a group-based service and one provided a telephone service only.

Significant numbers of respondents did not know if NRT and Champix (varenicline) were offered to smokers through local stop smoking services (7% did not know for NRT, 11% for Champix). Excluding these 'don't know' responses:

- » Two thirds of local authority stop smoking services (65%) offered smokers a full 12-week course of dual NRT either directly or indirectly, such as via a voucher or letter to their GP. A further 21% offered a part course of dual NRT. The remainder offered either single NRT only (8%) or no NRT (6%).
- » A full 12-week course of Champix was offered by 87% of local authority stop smoking services, with 8% offering a part course and 5% not offering the medication.

Eleven percent of local authorities offered e-cigarettes to some or all smokers through their stop smoking service.

**Table 4: Types of advice/support for smokers commissioned or provided by local authorities**

Type of advice/support	Local authorities
Behavioural support for smoking cessation	123 (97%)
Integrated advice on multiple behavioural health issues including smoking	61 (48%)
Very brief advice/brief advice	98 (77%)
Self-support (e.g. websites, apps)	77 (61%)

**Table 5: Types of advice/support for smokers commissioned or provided by local authorities by service type**

	<i>n</i>	Behavioural support	Integrated advice	Brief/very brief advice	Self-support
Specialist service	87	87 (100%)	36 (41%)	69 (79%)	55 (63%)
Lifestyle service with no specialist service	26	24 (92%)	23 (88%)	20 (77%)	12 (46%)
Support in primary care only	11	11 (100%)	2 (18%)	8 (73%)	7 (64%)
Telephone support only	3	1 (33%)	0 (0%)	1 (33%)	3 (100%)

### 3.5 Types of adviser

Respondents who indicated that their local service provided behavioural support for smoking cessation were asked to identify the types of adviser who were employed to provide this behavioural support. Three types of adviser were distinguished:

- » Specialist stop smoking advisers
- » Health trainers/coaches, whose professional role is to support clients in addressing all their behavioural health issues
- » Intermediate stop smoking advisers, who provide stop smoking advice as part of a wider professional role
- » The following examples of services illustrate these roles and some of the characteristic differences between them.

### Specialist stop smoking advisers:

*Tier 3 Specialist support: A clinical service for smokers who are highly dependent and who are likely to have had multiple failed quit attempts and/or multiple/complex needs, want help with stopping and are willing and able to put in the time and effort needed to be successful. Smokers need to commit to a minimum of 6 weekly sessions, with further sessions over a longer period of time offered if required. The intervention is delivered by highly trained stop smoking specialist advisers and includes behavioural support and medication; outcomes are recorded at 4 and 12 weeks.*

### Health trainers:

*The city's Health Trainer service offers a universal service to individuals aged 16 and over requiring support to address health issues. There are a number of ways in which a Health Trainer may engage with individuals. For example it could initially be through an individual being invited to attend for a health check, it could be through referral from another health professional, or could be direct access from an individual for a specific purpose such as support to stop smoking or help with their weight. The Health Trainer uses techniques based on psychological evidence and theories to help people change behaviours that are known to cause ill-health. The Health Trainer service is responsible for providing support to residents that wish to stop smoking. This is provided in accordance with NICE Guidance and staff remain competent to deliver the service as set out by the National Centre for Smoking Cessation and Training.*

### Intermediate stop smoking advisers:

*A universal stop smoking service delivered by staff within general practice and community pharmacy by trained staff who do this as part of their role rather than a dedicated role.*

Overall, 83% of the local authorities that provided behavioural support for smoking cessation used specialist stop smoking advisers to provide this support (Table 6). However, intermediate advisers and health trainers were also widely used to provide behavioural support: 63% of the local authorities that provided behavioural support used intermediate advisers to do so and 33% used health trainers/coaches.

Table 7 describes the types of adviser employed to deliver behavioural support by the combination of services commissioned. All combinations may include support in primary care. All but one of the local authorities with a specialist service employed specialist stop smoking advisers. Local authorities with lifestyle services but no specialist service were as likely to employ specialist advisers as they were to employ health trainers/coaches. Intermediate advisers had a role in each approach in a majority of cases. Using examples of respondents' service descriptions, Table 8 illustrates the interactions of specialist and integrated services with specialist and generic advisers.

Respondents to the survey were asked to identify the number of advisers offering behavioural support to smokers in their area: whole-time equivalent numbers for specialist advisers and health trainers/coaches and overall numbers for intermediate advisers. Figure 4 to 6 illustrate the results for each type of adviser for all local authorities that provided behavioural support (inconsistencies with Table 7 are due to missing data). Local authorities with specialist services employed the most specialist advisers and half (51%) of local authorities with lifestyle services and no specialist service employed two or more specialist advisers (Figure 4). Where local authorities with lifestyle services employed health trainers, they were likely to employ many (Figure 5). The primary-care-based model clearly shifts delivery of support to intermediate stop smoking advisers, ranging in these local authorities from 17 to 160 advisers (Figure 6).

**Table 6: Types of adviser delivering behavioural support for smoking cessation (percentages are of all local authorities providing behavioural support)**

	Local authorities
Specialist stop smoking advisers	101 (83%)
Health trainers/coaches	40 (33%)
Intermediate stop smoking advisers	76 (63%)

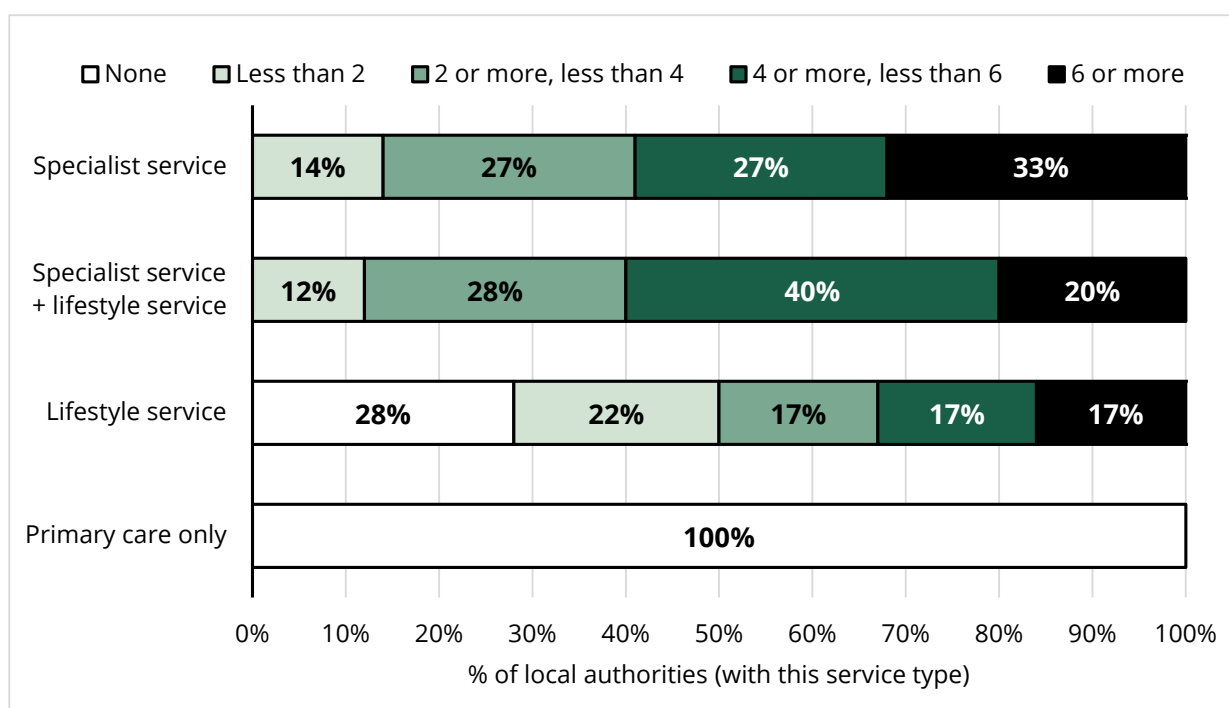
**Table 7: Types of adviser providing behavioural support by service combination (all combinations may include support in primary care)**

	<i>n</i>	Specialist stop smoking advisers	Health trainers/coaches	Intermediate stop smoking advisers
Specialist service	87	87 (100%)	36 (41%)	69 (79%)
Specialist service + lifestyle service	26	24 (92%)	23 (88%)	20 (77%)
Lifestyle service	11	11 (100%)	2 (18%)	8 (73%)
Support in primary care only	3	1 (33%)	0 (0%)	1 (33%)

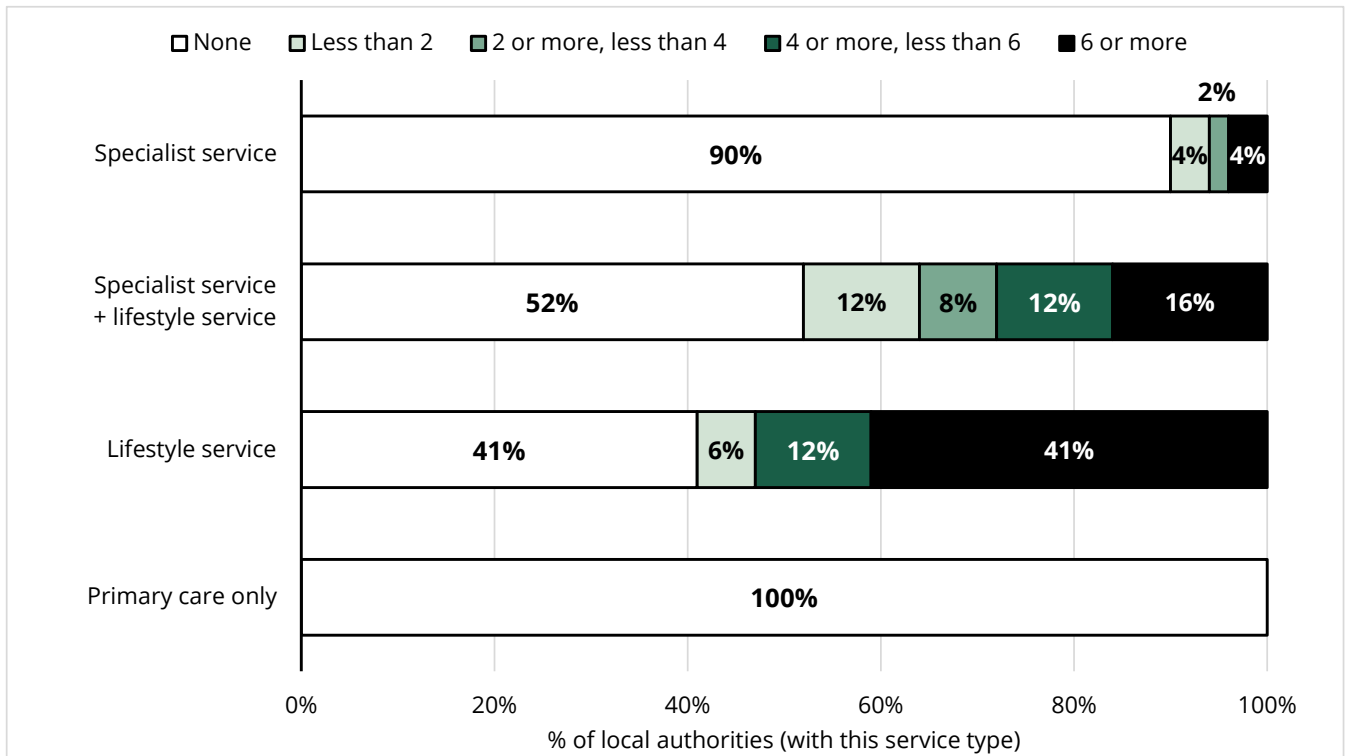
**Table 8: Examples of different adviser types employed by principal commissioned service**

Principal commissioned service	Specialist stop smoking advisers	Health trainers/coaches
Specialist service	We provide specialised support to quit smoking at our stop smoking clinics based at various locations across the borough. We offer tools and support whether you prefer to quit by yourself or with the help of our friendly Stop Smoking Specialists.	New Lifestyle Advisors in post using behavioural support for wider lifestyle improvement - linked to Primary Care Networks and working with social prescribers.
Lifestyle service	Experienced smoking cessation advisers are employed by our integrated lifestyle service provider. They offer support in community settings which lasts up to 12 weeks and can provide behavioural support and a range of NRT products and a vape directly to residents. In addition, they work directly on wards with two local Acute Trusts and provide weekly visits to the maternity departments.	Stop smoking support is provided within an integrated healthy lifestyles service. It is a universal service and coaches see people in a community setting as well as in their HQ. All coaches are trained in the same way as specialist advisers are trained. We have two coaches that work predominantly in the maternity system and out of antenatal clinics. We also contract with GP practices and pharmacies.

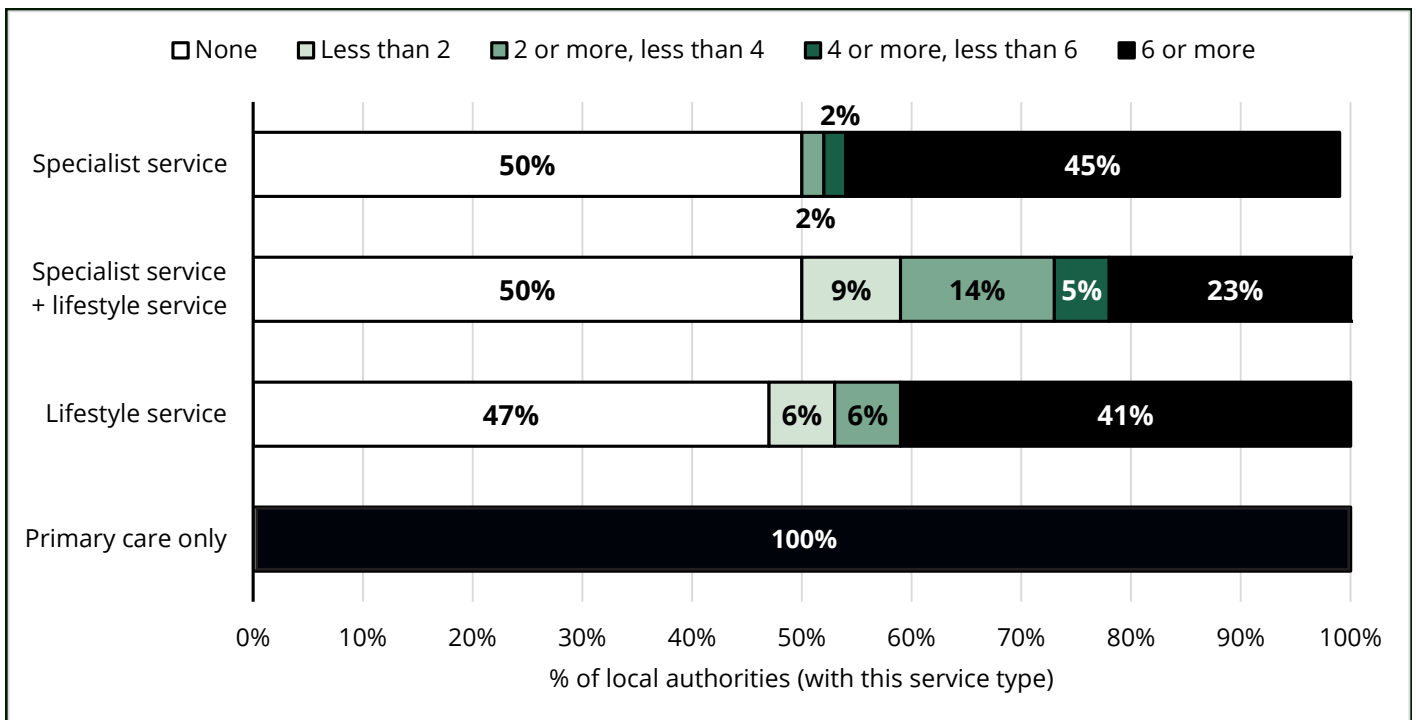
**Figure 4: Number of whole-time-equivalent specialist stop smoking advisers employed, by service combination (all combinations may include support in primary care)**



**Figure 5: Number of whole-time-equivalent health trainers/coaches employed, by service combination (all combinations may include support in primary care)**



**Figure 6: Number of intermediate stop smoking advisers employed, by service combination (all combinations may include support in primary care)**



### 3.6 The training of advisers

Where local authorities provided behavioural support for smoking cessation, respondents to the survey were asked how many days training in smoking cessation their advisers received (Table 9). On average, specialist stop smoking advisers received a day more training in smoking cessation than health trainers/coaches and twice as much as intermediate stop smoking advisers. However, in one fifth (21%) of local authorities with specialist stop smoking advisers, these advisers received only 0.5 to 1.5 days training. There were no significant differences in the number of days training advisers received across service types (Table 10).

**Table 9: Number of days training in smoking cessation by adviser type.** (Percentages are of local authorities offering behavioural support for smoking cessation and providing data on this adviser type)

	<i>n</i>	Mean	0.5-1.5 days	2 days	3 days	4 days or more
Specialist stop smoking advisers	57	3.2 days	12 (21%)	21 (37%)	9 (16%)	15 (26%)
Health trainers/coaches	19	2.2 days	5 (27%)	10 (53%)	1 (5%)	3 (16%)
Intermediate stop smoking advisers	55	1.6 days	30 (55%)	21 (38%)	3 (6%)	1 (2%)

**Table 10: Mean number of days training in smoking cessation by adviser type and principal commissioned service**

	<i>n</i>	Mean number of days training in smoking cessation		
		Specialist service	Lifestyle service (no specialist service)	Service in primary care only
Specialist stop smoking advisers	57	3.2	3.0	-
Health trainers/coaches	18	2.4	2.0	-
Intermediate stop smoking advisers	55	1.7	1.5	1.4



# 4. Reaching the population of smokers

## 4.1 Universal vs. targeted services

As both smoking prevalence and the public health grant have declined, local authorities have had to consider how best to use their resources for stop smoking services. This has led to a movement in two directions. On the one hand, most local authorities targeted their stop smoking offer towards population groups where prevalence remains high. On the other hand, many local authorities had sought to integrate their stop smoking offer in community-based services in order to reach out to as many smokers as possible. In the following examples, the emphasis shifts from the former approach (the first example has no universal component) to the latter:

*Targeted integrated lifestyle service for people 50 years and over living in identified areas (Lower Layer Super Output Areas). Universal stop smoking in pregnancy service.*

*The specialist service will focus on specified population groups where smoking prevalence is higher or the impact of smoking to the individual is significant. The specialist service is a hub and spoke model and will support the Universal Stop Smoking Services which is the GPs, Pharmacies, Community providers including public health contracted service who deliver the Level 2 service.*

*The service offer is based upon universal proportionalism. All smokers can access support to quit smoking via pharmacies and some GPs, and all licensed stop smoking medication is available first line. However, due to a reduction in funding, the availability of specialist support is limited to the high-risk groups.*

*We maintain a generic smoking cessation offer for all smokers in our communities. We also work to integrate the offer of smoking cessation as part of wider service development (acute trusts, mental health services, substance treatment services, maternity)*

The second and third examples illustrate a common approach: restricting the specialist service to target populations and offering a universal service through primary care and community providers. However, some local authorities used a lifestyle service to provide their universal offer while others had reduced their universal offer to online or telephone support. Table 11 illustrates this range of approaches.

**Table 11: Examples of universal, targeted services, differentiated in how the universal component of the service is delivered**

Universal component	Service description
Specialist service	We run group support clinics and one-to-one, individual behavioural support. We have three targeted groups in our service which are Pregnant women, their partners who smoke or anyone living in the pregnant woman's household. We support people with mental health conditions who have been referred by one of our mental health referrers only, who want to stop smoking. We also support people who want to stop chewing tobacco/using shisha.
Lifestyle service	We currently have an integrated lifestyle service which offers a universal stop smoking offer. We also have a midwife-led tobacco addiction service and locally commissioned service agreements with GPs and pharmacies. We are in the process of commissioning a nurse-led tobacco addiction service at the hospital.
Primary care	We commission GPs and pharmacies to provide smoking cessation support as a universal offer. We also have an in-house stop smoking advisor who provides support to targeted vulnerable groups. We also commission a specialist smoking in pregnancy service.

Telephone	Provides a comprehensive stop smoking service to anyone living, working or have a registered GP in the county. It is primarily a telephone service for general population however provides face-to-face support to specialist groups which include pregnant women and their partners, people with mental ill health and vulnerable populations.
Online/post	The service provides a targeted specialist service with pharmacotherapy support to those identified as benefiting the most from a successful quit. All smokers can access a range of online support including apps and information or be sent a postal support pack to help with any quit attempt.

## 4.2 Target populations

Respondents to the survey were asked to identify which high prevalence populations they targeted. Table 12 presents the results for all local authorities and by the principal commissioned service. Some respondents also volunteered other target groups: alcohol and drug misusers, prisoners, young people, carers and the long-term unemployed.

The less specialist the local authority's principal commissioned service was, the less likely the service was to target specific high prevalence populations.

**Table 12: Populations targeted by local authority services for smokers by service type**

Target population	All local authorities	Specialist service	Lifestyle service (no specialist service)	Support in primary care only
Pregnant women	110 (87%)	94%	85%	60%
People with mental health conditions	88 (70%)	76%	65%	45%
People in routine and manual occupations or who have low incomes	85 (67%)	73%	62%	45%
People with acute or long-term conditions	75 (60%)	69%	46%	27%
People of Black or Minority Ethnicity	43 (34%)	41%	23%	9%
Post-partum women	37 (29%)	32%	27%	9%
Lesbian, Gay, Bisexual or Transgender people	19 (15%)	17%	12%	0%

## 4.3 Primary care prescribing

GPs have a role in prescribing stop smoking medications regardless of whether or not they are commissioned by local authorities to provide stop smoking support. The recommended pharmacology for smokers, alongside behavioural support, is the offer of full 12-week courses of either dual NRT or varenicline, which requires that prescribers offer both.

All respondents to the survey were asked whether local GPs prescribed NRT and Champix (varenicline). Around a fifth of respondents did not know. Table 13 describes the results for those local authorities where respondents were able to provide data. In nearly a quarter of local authorities (23%), NRT was not prescribed at all by GPs. A full 12-week course of dual NRT was available from GPs in two thirds (66%) of local authorities. Varenicline was more widely available but was not prescribed by GPs in 13% of local authorities.

Excluding 'don't know' responses, the choice of both dual NRT and varenicline was prescribed by GPs in 66% of local authorities.

GPs were least likely to prescribe full courses of dual NRT and varenicline in areas where the only service was a primary-care-based service: this combination of medications was prescribed by GPs in 60% of local authorities with a service in

primary care only, in 68% of local authorities that had retained a specialist service and in 62% of local authorities with a lifestyle service only.

**Table 13: GP prescribing of NRT and Champix (varenicline) by local authority. 'Don't know' responses excluded**

Number of local authorities responding	Medication					
	NRT	Dual		Single only		
	Any prescribed	Full course	Part course	Full course	Part course	Not prescribed
101	78 (77%)	67 (66%)	7 (7%)	3 (3%)	1 (1%)	23 (23%)
	Champix					
	Any prescribed	Full course	Part course			Not prescribed
110	94 (85%)	87 (79%)	7 (6%)			16 (13%)

# 5. Partnerships and tobacco control

## 5.1 Strategic leadership and local partnerships

Sustainability and Transformation Partnerships and Integrated Care Systems (STPs/ICSs) offer a focus for strategic leadership of population health, though in some areas they are still at an early stage of development. Respondents to the survey were asked if smoking was a priority in their local STP or ICS. Although around a fifth did not know, among the local authorities that did provide data (n=99), a large majority (92%) reported that smoking was a priority for their STP or ICS.

Partnerships were frequently identified by survey respondents as one of their local opportunities for smoking cessation and tobacco control (see Section 6.1). The following additional comments describe the value of partnerships in delivering both strategy and long-term outcomes in tobacco control:

*We're pleased with the direction of tobacco control in the county, with a range of new partners engaging to see how they can contribute. The new five year strategy and action plan will move this agenda forward.*

*The city is making a concerted effort to address smoking and over the next year will build partnerships so smoking is on all key partners' agenda with a clear action plan. The 2018 Annual Population Survey shows that our prevalence has reduced and we anticipate more stronger joined up working will add to this.*

Despite the importance of partnerships to many local authorities, only 60% were part of a local tobacco control alliance or partnership at the time of the survey, a decline over four years from 74% in 2015.

## 5.2 Tobacco control activity

Respondents to the survey were asked to identify the range of wider tobacco control work their local authority undertook against a pre-defined list of options. Table 14 describes the results. In addition, five local authorities were doing work in education or with young people.

The number of activities in Table 14 pursued by any single local authority ranged from zero, reported by four local authorities (3%) to all seven, reported by 14 (12%). Half (50%) of the surveyed local authorities were pursuing five or more of these wider tobacco control activities. Most local authorities were still engaged in tackling illicit tobacco (91%), communications and campaigns about smoking and tobacco (88%) and enforcing smoking-related legislation (87%). Overall, 92 local authorities (72%) were engaged in all three of these activities.

The mean number of tobacco control activities pursued by local authorities was 4.4. There was no difference in the number pursued by local authorities with specialist stop smoking services and those with lifestyle services only (4.7 activities) but local authorities with stop smoking support in primary care only pursued on average fewer tobacco control activities (3.4 activities).

**Table 14: Wider tobacco control work undertaken by local authorities (n=117)**

	Local authorities
Tackling illegal tobacco	107 (91%)
Communications and campaigns	103 (88%)
Enforcing legislation (e.g. age of sale, point of sale, smokefree legislation)	102 (87%)
Smokefree public spaces	72 (62%)
Regional support/action	56 (48%)
Smokefree homes	51 (44%)
Research	25 (21%)
None of the above	4 (3%)

# 6. Opportunities and threats

## 6.1 Opportunities

Respondents were asked to describe, in their own words, the current opportunities they saw for their local authority's stop smoking services and tobacco control work. Their responses illuminate the shared potential for partnership and renewal across local and regional health economies.

A total of 103 respondents described current opportunities for their stop smoking services and wider tobacco control work. Although their responses were diverse, there were a number of linked themes:

- » The pursuit of a whole-system approach
- » New and renewed partnerships and joint working
- » The growing role of the NHS in smoking cessation
- » The integration of smoking cessation and tobacco control in the work of the organisation
- » Reaching into communities and targeting the most in need
- » Making connections to other local authority agendas
- » The development of integrated lifestyle services

**Joint working, partnerships and alliances** were together the most frequently identified opportunity for stop smoking services and tobacco control, cited by half of the respondents who answered this question (n=52, 50%). These partnerships included joint working with other local authority services, working across the local health economy, especially with the NHS, and partnerships over larger areas such as regionally or at STP/ICS level.

*To build better, stronger partnerships with a range of colleagues including children's services, drugs and alcohol services, integrated community teams and primary care.*

*More effective partnerships with mental health and acute services, including across the Sustainability Transformation Partnership. Public Health also has a greater stake in housing, so we can begin to hold the smoke free homes agenda up against existing policy.*

*Given current budget cuts on local authorities, there is an increase appetite and need for joint tobacco control work across local authorities especially when issues are not locally fixed e.g. tackling illegal tobacco. Furthermore, often tobacco control issues do not stop at local authority boundaries therefore its makes sense from a financial and geographical perspective to co-commission work with other local authorities.*

Seventeen respondents identified an existing or new local tobacco control alliance as an opportunity and 11 cited the STP (Sustainability and Transformation Partnership) or ICS (Integrated Care System). Regional or cross-borough opportunities were mentioned by ten respondents.

Many of the examples given of joint working and partnerships were indicative of a **system-wide approach** to tobacco control and smoking cessation, though not always described as such. Nine respondents specifically identified a 'whole-system' or 'system-wide' approach in their account of current opportunities. This was expressed as a general principle and described in some detail:

*Working together across the whole system including NHS.*

*Joint system-wide work i.e. with hospital and local authority licencing and control teams, trading standards and local service providers i.e. substance misuse, and smoking cessation promotion in community settings.*

The **role of the NHS** in local partnerships is growing, in part because of the NHS Long Term Plan, which was identified as an opportunity by 17 respondents. Nearly a third of respondents (n=32) identified existing, planned or potential smoking cessation services within the NHS as an opportunity.

*CQUIN has provided an opportunity to work closer with acute trusts improving engagement with the provider as part of the community offer.*

*We are also looking for stop smoking services to collaborate on an in-house secondary care project and working with all the hospitals in the city and county.*

*The NHS Long Term plan is an opportunity to embed systematic identification and advice in NHS settings.*

The **integration of smoking cessation and tobacco control in the work of the local authority** and the wider workforce was identified by a fifth of respondents (n=21) and opportunities to **reach further into local communities** and target high-prevalence groups were identified by 16 respondents.

*There are opportunities to build capacity in the community and wider workforce through a programme of training in brief advice and very brief advice.*

*Remodelling of service to engage the wider health and social care workforce in promoting annual quit attempts.*

*New model being developed based on a population approach making stop smoking support everyone's business.*

*Targeted work in conjunction with other council teams to access harder to reach communities.*

The Ottawa model, which integrates smoking cessation into clinical care pathways, was specifically cited by four respondents. A whole-system approach also helps to connect tobacco control to other local council priorities. Seven respondents identified the opportunities of such connections, including connections to inequalities, the wider determinants of health, child poverty, climate change and environmental littering.

The integration of stop smoking and tobacco control functions into the wider work of the local authority is not predicated on taking an 'integrated lifestyle' approach to service delivery. Nonetheless, where integrated lifestyle services do exist or are planned, this broader ethos of integration may be part of the rationale for the approach:

*The further integration of our integrated service with the local authority's other community functions presents opportunities for improving service efficiency in the following ways: more staff can assist by making referrals into the service, more locations will be available for service delivery at no cost, greater efficiency in administrative and management functions will lead to reduced costs - which will become available for service delivery.*

*Potential integration into wider wellbeing approach could increase reach and potential for more very brief advice and referrals into the specialist stop smoking service.*

*As part of a wider lifestyle service there is the opportunity to access smokers who have presented for support with other lifestyle issues who may not otherwise have sought smoking cessation advice.*

Other opportunities identified by respondents were:

- » Maternity and neonatal work (17 respondents)
- » Innovative use of e-cigarettes (16 respondents)
- » New local strategies and action plans (12 respondents)
- » Leadership and senior-level buy-in (9 respondents)
- » Tackling illicit tobacco (6 respondents)
- » Promoting smokefree environments (5 respondents)
- » Digital services and apps (3 respondents)

## 6.2 Threats

Respondents to the survey were also asked to identify, in their own words, any current threats to their stop smoking services and tobacco control work.

A total of 104 respondents identified one or more threats to their stop smoking services and/or tobacco control work. By far the most common threat identified was the ongoing pressure on budgets, cited in some form by 71 respondents (74% of those answering the question). Respondents mentioned:

- » The year-on-year cuts in the public health grant
- » The uncertainty about the future of the public health grant
- » The consequences for public health of the wider cuts to local authority budgets
- » Pressure to review public health spending and make substantial changes

The following examples illustrate the ways in which these problems affect both current and future service provision:

*Potential removal of the Public Health ring-fenced grant could mean tobacco funding is severely decreased beyond 2020. Even if this is not the case local authority budgets are under extreme pressure and this could impact public health budgets in the near future where difficult decisions will have to be made.*

*Identified gaps in service provision are being addressed by the procurement of a specialist Smoking Cessation Service supported by a Tobacco Control service. Any cuts to Public Health Ring Fenced Grant could impact the design and reach of the service delivery model.*

Similarly, 16 respondents identified a lack of capacity as a current threat. There are clear links between budgets, capacity and the curtailment of present and future opportunities:

*Requirement to make further savings impacting on scale. Risk of GPs disengaging with the provision of stop smoking advice/support as they are no longer directly commissioned. Trading standards team has been eroded, very little work happening around tobacco.*

*Continued Local Authority cuts and competition with other services. Being able to provide and maintain a good quality service with significantly diminished resources & staff. Having to say no to requests to provide additional support for areas we have traditionally supported e.g. secondary care, schools.*

Competition with other services or priorities, or simply a lack of priority, was identified as a threat by 14 respondents overall. A lack of political priority – e.g. Not seen as a priority by the Health and Wellbeing Board – was identified by 5 respondents. More often the problem was articulated as competition with other priorities, potentially exacerbated by the lack of statutory status of stop smoking services.

*Keeping smoking as a priority within the system when obesity is a high priority for many.*

*With the public health funding shrinking, non-mandatory work including tobacco control services are always under threat of scrapping to utilise funds to other priority areas.*

Ten respondents mentioned the declining number of people accessing stop smoking services as a threat, some of whom linked this phenomenon to wider issues of the changing population of smokers.

*Reducing numbers accessing the service, though prevalence has reduced and harder to reach are becoming the focus.*

*Our current prevalence is low, therefore the local challenge is to engage with the hard core smokers. The service was not able to meet the targets last year and therefore the threat is the same this year.*

Overall, eight respondents mentioned either the changing demographic of the smoking population or declining prevalence as being a threat. However, contrary to this concern over declining footfall, two respondents noted the potential threat of an increase in demand due to new NHS investment at a time of loss of capacity within local authority services:

*If these CCG and NHS work streams succeed in increasing numbers initiating quit attempts, there will be nowhere for them to receive community support as my service is too stretched. If they were seen in surgeries or pharmacies then we may not be able to afford the additional numbers. GP surgeries are already overstretched and are seeing smokers monthly rather than weekly or fortnightly.*

Six other respondents also cited poor links with the NHS or a lack of engagement by the NHS as current threats.

Other threats, each identified by 2-3 respondents, were a lack of national strategic leadership, lack of stakeholder engagement in tobacco control work, the potential integration of a specialist service into a wellbeing service, withdrawal of resources for regional action, and proliferation of illicit sales. Six respondents said there were no current threats to their services and work.



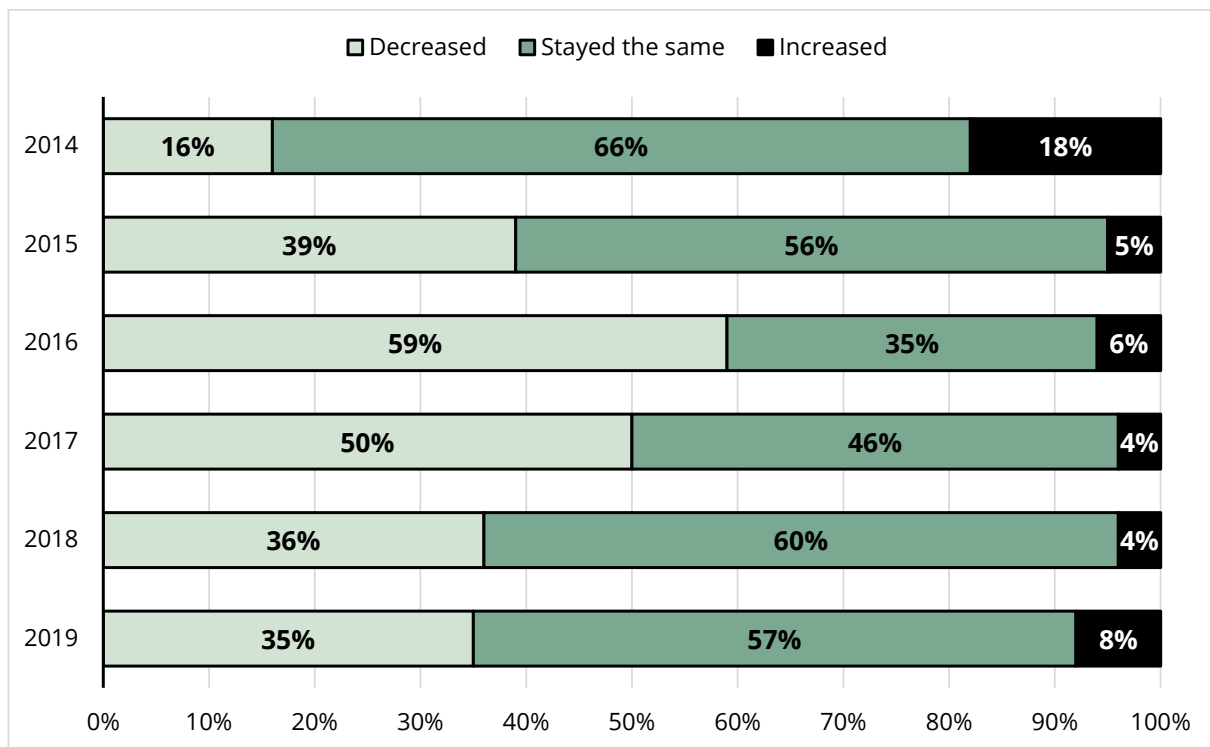
# 7. Budgets and spending

## 7.1 Changes to budgets for stop smoking services 2018/19 – 2019/20

In 2019, 82% of the surveyed local authorities still had a budget for stop smoking services (n=100). Of the 22 local authorities (18%) that did not have a budget, 19 had integrated this budget with a wider lifestyle budget and three did not commission stop smoking services.

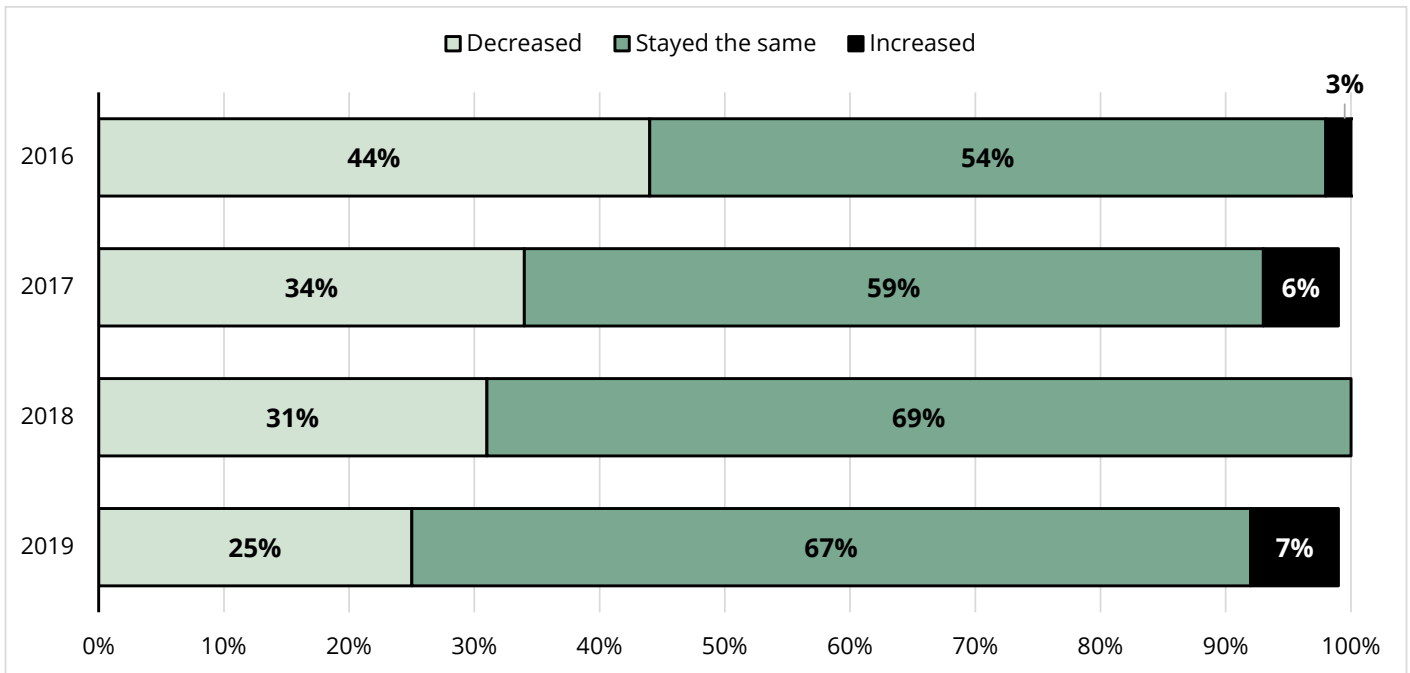
Among the local authorities that still had a budget for stop smoking services, 35% had cut this budget between 2018/19 and 2019/20, including 28% that had made cuts of more than 5%. Eight percent of budgets had increased and 57% had stayed the same. Although the extent of cuts in 2019 was similar to the previous year, this was the fifth successive year in which more than a third of local authorities had cut their stop smoking service budgets (Figure 1).

**Figure 1: Changes to local authority stop smoking service budgets 2014 – 2019 (excludes local authorities that do not have a budget for stop smoking services)**



Overall, 78% of surveyed local authorities had a budget for stop smoking medications in 2019 (n=94). A quarter (25%) of these budgets had been cut between 2018/19 and 2019/20 including 16% that had been cut by more than 5%. Five percent of medications budgets had increased and 67% had stayed the same. Figure 2 illustrates the changes to budgets for stop smoking medications since 2016.

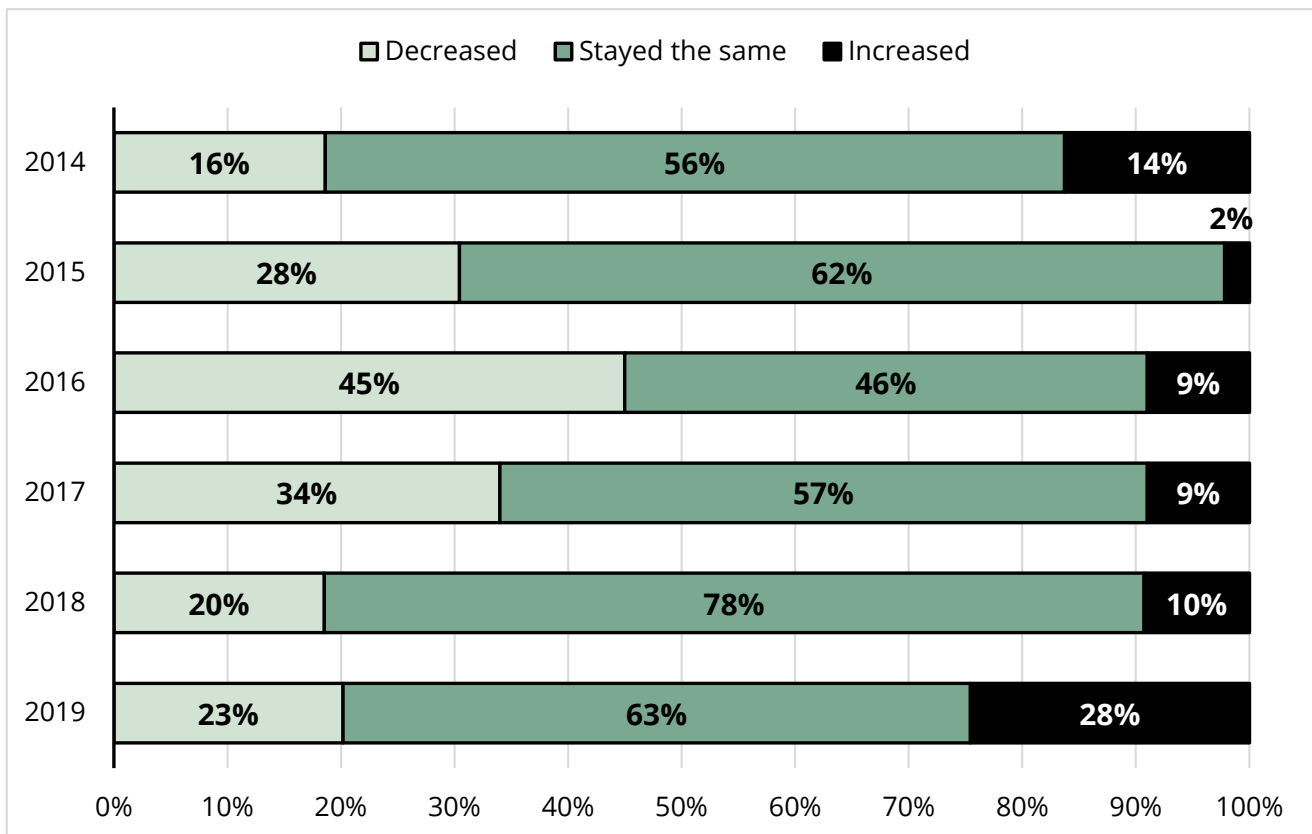
**Figure 2: Changes to local authority stop smoking medication budgets 2014 - 2019 (excludes local authorities that do not have a budget for stop smoking medications)**



## 7.2 Changes to budgets for wider tobacco control 2018/19 – 2019/20

Excluding the 9% of local authorities where the respondents did not know if there was a budget for wider tobacco control, 64% of local authorities (n=70) reported having such a budget. Among the local authorities that had a budget, 23% had cut this budget between 2018/19 and 2019/20 including 19% that had been cut by more than 5%. Wider tobacco control budgets had been kept the same in 63% of local authorities and increased in 14% (Figure 3).

**Figure 3: Changes to local authority tobacco control budgets 2014 - 2019 (excludes local authorities that do not have a budget for tobacco control)**



## 7.3 Spending on stop smoking services and tobacco control 2017/18 – 2018/19

According to the data published by the Ministry of Housing, Communities and Local Government (MHCLG), total local authority spending on stop smoking services and tobacco control fell by 8% between 2017/18 and 2018/19 (Table 15). Spending on wider tobacco control rose slightly over this period, by 3%, while spending on stop smoking services fell by 9.2%. The largest falls in spending were in the South East and West Midlands, whereas in the South West and the East Midlands overall spending rose slightly.

In the four years from 2014/15 to 2018/19, total local authority spending on stop smoking services and tobacco control in England fell by 36% from £135.9m to £87.3m.

**Table 15: Changes in spending on stop smoking services and wider tobacco control, 2017/18 – 2018/19 (MCLG)**

	Stop smoking services			Wider tobacco control			Total		
	2017/18	2018/19	Change	2017/18	2018/19	Change	2017/18	2018/19	Change
England	£85.2m	£77.3m	-£7.9m (-9.2%)	£9.7m	£10.0m	+£0.3m (+3%)	£94.9m	£87.3m	-£7.6m (-8.0%)
North East	£7.09m	£6.54m	-£0.56m (-7.9%)	£1.10m	£0.77m	-£0.33 (-30%)	£8.19m	£7.30m	-£0.89m (-10.9%)
North West	£11.41m	£10.68m	-£0.72m (-6.4%)	£1.75m	£1.94m	+£0.19m (+11%)	£13.16m	£12.62m	-£0.54m (-4.1%)
Yorkshire & The Humber	£9.54m	£8.79m	-£0.75m (-9.4%)	£1.21m	£1.15m	-£0.06m (-5%)	£10.74m	£9.94m	-£0.8m (-7.5%)
East Midlands	£6.37m	£6.21m	-£0.17m (-2.6%)	£0.53m	£0.91m	+£0.39m (74%)	£6.9m	£7.12m	+£0.22m (+3.2%)
West Midlands	£7.33m	£6.04m	-£1.29m (-17.6%)	£0.65m	£0.63m	-£0.3m (-4%)	£7.98m	£6.66m	-£1.31m (-16.5%)
East of England	£10.12m	£9.04m	-£1.08m (-10.7%)	£1.18m	£1.13m	-£0.04m (-4%)	£11.3m	£10.17m	-£1.12m (-9.9%)
South West	£6.11m	£6.1m	-£0.01 (-0.2%)	£0.53m	£0.66m	+£0.12m (+23%)	£6.64m	£6.76m	+£0.11m (+1.7%)
South East	£14.8m	£11.55m	-£3.25m (-22%)	£1.21m	£1.19m	-£0.02m (-2%)	£16.01m	£12.74m	-£3.27m (-20.4%)
London	£12.5m	£12.3m	-£0.2m (-1.6%)	£1.56m	£1.61m	+£0.05m (+3%)	£14.06m	£13.91m	-£0.16m (-1.1%)

## 8. Discussion

This report draws attention to the increasing diversity of local authority stop smoking services and tobacco control work. The contraction of budgets for public health has been a major driver of change<sup>11</sup> resulting in the decline of many services especially in areas where political support for tobacco control has been weak.<sup>12</sup> Financial pressures remain by far the most common threat identified by survey respondents this year yet, despite years of cuts, most local authorities still commissioned or provided a substantial offer to smokers and engaged in tobacco control activity.

Within the context of financial constraint, the trajectories that local authorities have taken reflect choices informed by local values and priorities. These include:

- » How the needs of the individual are characterised
- » The value given to specialist intervention
- » How the tension between the needs of the population and the needs of target groups is resolved
- » The level of commitment to partnership and a 'whole-system' approach

The assessment of individual needs is an everyday task for local authority social care, housing and welfare services. Local authorities that have introduced 'integrated lifestyle services' are in this tradition: seeking to describe needs holistically and engage clients about wider health and welfare needs. However, in the development of stop smoking services, this interest in smokers' wider needs has usually gone hand-in-hand with an understanding of the value of specialist intervention. The tension between a holistic approach to assessing needs and the importance of specialist advice to address tobacco dependence resolves in many different ways including lifestyle services that triage smokers into specialist services, lifestyle services that employ specialist stop smoking advisers, generic health trainers with NCSCT training, and specialist stop smoking advisers who support clients in addressing their wider needs. Of all the local authorities that offered face-to-face support to local smokers, only two did not offer 'behavioural support for smoking cessation'.

The risk remains that some advisers may be ineffective if smokers can avoid addressing their smoking behaviour by choosing to discuss other issues. All smoking cessation advisers ought to be able to address this risk but the limited training in smoking cessation received by many advisers, including specialist advisers in some areas, raises the question of whether they consistently have the skills to do this. The evidence of the importance of a specialist focus on smoking needs to be reiterated<sup>13</sup> even though many of those commissioning lifestyle approaches are clearly well aware of it.

How stop smoking services are targeted has become a prominent issue in commissioning both because resources have tightened and because tackling the high rates of smoking prevalence in disadvantaged groups is crucial to ending the tobacco epidemic and its associated health inequalities.<sup>14 15</sup> The question for commissioners of stop smoking services is how to balance the needs of smokers in disadvantaged groups with the needs of the whole population of smokers. This is a tension between vertical and horizontal equity: in order to address the needs of the whole population of smokers fairly, resources should be targeted where the need is greatest, but fairness also demands that the needs of every smoker should be addressed. In practice, this tension plays out in different ways, with some local authorities giving greater emphasis to the vertical (targeted) component and others to the horizontal (universal) component.

An increasingly common approach, described in some detail in Chapter 4, is to combine targeted specialist support with a less intensive offer to all smokers, such as support from a lifestyle service, telephone helpline or online. Local authorities that take this approach typically still describe their services as being universal, though in practice the universal offer may be much less effective than the core offer to target groups. However, local authorities that take the alternative approach and focus on the universal offer risk failing to adequately meet the needs of smokers in disadvantaged groups. The local authorities that only offered a service through primary care were the least likely to have identified target groups for their offer of behavioural support, yet such targeting is central to the task of reducing inequalities in smoking.<sup>16</sup>

Given the complexity of these issues, the diversity of services described in this report should not be seen as a problem in itself. Problems arise where smokers cannot get access to effective support because they are not eligible for a service, or the universal component of the service is inadequate, or the adviser is not trained to support them through a quit attempt, or they cannot access stop smoking medications. These issues define the inequity in support for smokers in England.

Partnership and 'joined-up thinking' have always been important to tobacco control. Tobacco control alliances brought together the NHS, local government and the voluntary and community sector long before public health moved from the NHS to local government. Six years after that move, partnerships and whole-system approaches were described by survey respondents as the primary opportunities for their current work. The role of the NHS is central to many of these opportunities, principally because of the commitments in the NHS Long Term Plan to provide tobacco treatment services in hospitals, mental health services, learning disability services and for pregnant women . The opportunities for strategic leadership on population health offered by Sustainability and Transformation Partnerships and Integrated Care Systems are also clear. Local authorities, with their broad view of both population and individual needs, are well placed to help integrate established and emerging services into a comprehensive local approach to tobacco control and smoking cessation.

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**Action on Smoking and Health**

6th Floor, Suites 59-63  
New House  
67-68 Hatton Garden  
London, EC1N 8JY

tel: 020 7404 0242

fax: 020 7404 0850

e-mail: [enquiries@ash.org.uk](mailto:enquiries@ash.org.uk)

Visit our website [www.ash.org.uk](http://www.ash.org.uk) for more information.

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