A CHANGING LANDSCAPE

STOP SMOKING SERVICES AND TOBACCO CONTROL IN ENGLAND

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Executive summary

Key messages for policy-makers

In the past four years, government cuts to the public health grant and to wider local authority spending have had a serious impact on local authority budgets for stop smoking services and wider tobacco control. In 2018, 38% of local authorities in England that still had a budget for stop smoking services cut this budget, following similar cuts in 50% of local authorities in 2017 and in 59% of local authorities in 2016.

Between 2014/15 and 2017/18 local authority spending on tobacco control and stop smoking services in England fell by £41.3million (30%). Spending per resident smoker fell from £17.87 to £14.86.

The principal outcome of these budget cuts has been the loss of the universal offer of specialist stop smoking support. If you are a smoker, where you live now makes a big difference to the support you can receive, if any, to help you quit. In 2018, 65% of local authorities commissioned a specialist stop smoking service (down from 74% in 2017) and only 56% commissioned a universal specialist service open to all local smokers. Other local authorities have switched to the 'integrated lifestyle' service model (22%), have reduced their service to support from GPs and pharmacists (9%), or have decommissioned altogether (3%).

Specialist stop smoking services, as described in NICE guideline NG92[1], still deliver the best outcomes for smokers: more smokers quit through specialist services than through any of the other models of delivery. Focused, specialist smoking cessation advice is evidence-based and highly cost-effective. Services must retain this approach at the heart of their services, however they are configured, if they are to deliver change for smokers. The shift away from specialist services may save money in the short term but risks a failure to deliver results if specialist smoking cessation support is lost in the process.

Despite intense cost pressure, most local authorities have done well to sustain a service. Innovative ideas, such as the integration of e-cigarettes into the smoking cessation offer, are being explored. And the great majority of local authorities still undertake wider tobacco control work, which is crucial not only to tackling immediate harms but also to reducing prevalence and health inequalities in the long term.

Principal findings

Methods

The principal method was an online survey of local authority tobacco control leads, supplemented by telephone interviews with survey non-respondents. Official statistics on local authority spending and stop smoking service outcomes were also used in the analysis.

Budgets and spending

Four fifths (79%) of local authorities surveyed had a specific budget for stop smoking services in 2018; 18% no longer had a specific budget as they had moved to an integrated lifestyle model of service delivery; and 3% had decommissioned services altogether.

Budget cuts were not as common in 2018 as in the two previous years. Nonetheless, among surveyed local authorities that still had a budget for stop smoking services, 36% reduced these budgets in 2018. This followed cuts in stop smoking service budgets in 50% of local authorities in 2017 and in 59% of local authorities in 2016. Budgets were cut principally due to reductions in the public health grant and wider government pressure on local authority spending.

Between 2014/15 and 2017/18, total local authority spending in England on stop smoking services and wider tobacco control fell by £41.3million (30%). Spending per resident smoker fell from £17.87 to £14.86.

Average local authority spending on stop smoking services and tobacco control fell from £900,000 to £629,000 between 2014/15 and 2017/18. However, 16% of local authorities increased their budgets over this period.

1 National Institute for Health and Care Excellence: Stop smoking services and interventions, Guideline NG92, NICE 2018.

Local spending has fallen by £41m from 2014/15 to 2017/18 (down 30%)

Government cuts to the public health grant are the main reason for the reduction in spending

Only 56% of local authorities now offer a specialist stop smoking service to all smokers

Support for smokers to quit

In 2018, 65% of all local authorities commissioned a specialist stop smoking service, including 56% that commissioned a universal specialist stop smoking service; 22% commissioned an integrated lifestyle service instead of a specialist service; 9% commissioned stop smoking support from professionals in primary care only; and 3% did not commission any services.

Some integrated lifestyle services still employed specialist stop smoking advisers. Overall, smokers could see a specialist stop smoking adviser in three quarters (75%) of the services commissioned by local authorities, though access was restricted to target groups in 10%.

The level of smoking cessation training received by advisers was similar regardless of whether they were specialist stop smoking advisers, lifestyle advisers or primary care professionals.

The support and medications offered to smokers were similar regardless of whether the services were specialist or lifestyle services, but they were less extensive in surveyed local authorities where services were restricted to primary care.

A full 12-week combined course of Champix and dual nicotine replacement therapy (NRT) was available to smokers through 74% of specialist services and 73% of lifestyle services. In surveyed local authorities where the only service offer was in primary care, only 50% of GPs prescribed this combined course of medications. GPs were more likely to prescribe these medications if the local authority also commissioned a specialist or lifestyle service.

Commissioning costs

On average, local authorities that commissioned a specialist stop smoking service spent 25% more (per resident adult smoker) on *all* their services for smokers, including any support delivered beyond the specialist service, than local authorities that commissioned a lifestyle service as their principal service for smokers; and more than twice as much as those local authorities that limited their service to primary care.

Quit rates

The highest quit rates were in local authorities which still had specialist stop smoking services.

E-cigarettes

All surveyed stop smoking services supported smokers who choose to use e-cigarettes. However, attitudes and practice vary. Most services only provide advice about the use of e-cigarettes but some include them in their offer to smokers, for example through free starter kits.

Wider tobacco control

Wider tobacco control activity was reported in 85% of local authorities surveyed. In 28% of local authorities, respondents described tobacco control work undertaken locally while also reporting that the local authority had no budget for wider tobacco control.

The most commonly reported tobacco control activities within surveyed local authorities were trading standards work, especially tackling illicit tobacco; promoting smokefree environments, including in local hospitals and acute mental health units; media and campaigns; and work with young people.

The stakeholders most often identified by surveyed tobacco control leads as being helpful in tackling smoking were NHS trusts, trading standards, primary care professionals, clinical commissioning groups (CCGs), and maternity and midwifery services.

Recommendations

The government's commitment to more NHS action on prevention and health inequalities[2] should extend to supporting local government. In England, local authorities play a vital role in delivering interventions for the population of smokers through specialist stop smoking services and wider tobacco control work.

Rather than cutting the public health grant further, the government should be reversing the decline in the public health grant and seeking a sustainable long-term funding solution so that local authorities can provide the public health services required to meet the needs of the population.

Local authorities should explore every possible means of sustaining evidence-based specialist stop smoking support at the heart of their offer to smokers (regardless of how the service as a whole is configured).

Local authorities should invest in wider tobacco control activity in addition to quit smoking support. This includes maximising the value of their partnerships, community relationships and profile to shape a smokefree future: working with local stakeholders and to reach out to smokers and shaping environments that discourage the uptake of smoking.

Local authorities should work together to tackle regional tobacco control problems (such as the supply of illicit tobacco), deliver media campaigns across a larger footprint, and develop innovative approaches to the delivery of specialist stop smoking services.

Local authorities should consider how best to integrate e-cigarettes as a quitting tool into their offer to smokers, especially in reaching high prevalence disadvantaged groups. Innovative approaches should be evaluated in order that a fully evidenced-based approach to the utilisation by services of e-cigarettes can be developed.

2 *NHS Long-term Plan*, NHS England 2019

1. Introduction

This report presents the findings of the fifth annual survey of tobacco control leads in local authorities in England. The survey was first conducted in 2014, the year after public health teams moved to upper tier and unitary local authorities from primary care trusts, and has subsequently monitored the changes in the finance and delivery of stop smoking services and wider tobacco control work within these authorities.

The 2018 survey was the first to gain data from all local authorities in England with public health responsibilities. This was achieved by pursuing survey non-respondents by telephone and asking them a brief set of core questions. As a result, this report offers a comprehensive picture of the commissioning landscape for stop smoking services.

This complete dataset also enabled integration with official statistics on local authority spending and stop smoking service outcomes. For the first time, this report includes analysis of local authority spending data, as reported to the Ministry of Housing, Communities and Local Government, and stop smoking service returns.

The survey of tobacco control leads was conducted before the cut to the public health grant announced by the government in December 2018. This change will doubtless help to perpetuate the pattern of year-on-year cuts to local authority budgets for stop smoking services and wider tobacco control reported here.

The majority of local authorities have done well to sustain their services for smokers and wider tobacco control work despite the severity of the cost pressures upon them. Nonetheless, the direction of travel continues to be away from the evidence-based specialist services that local authorities inherited from the NHS. At a time when one part of government is making a strong case for investing in smoking prevention within the NHS[3], this report offers a reminder of the central role that local authorities continue to play in helping smokers quit, reducing inequalities and creating the conditions for a smokefree future.

2. Methods

The findings in this report are principally drawn from an online survey of tobacco control leads in local authorities in England, boosted by additional telephone and web research. In addition, some findings draw on an analysis of official statistics: local authority spending data as reported to the Ministry of Housing, Communities and Local Government (MHCLG)[4] and stop smoking service returns, as reported to NHS Digital[5].

Survey of tobacco control leads

This survey was the fifth annual survey of local authority tobacco control leads commissioned by Cancer Research UK and conducted by ASH since the transfer of public health to local government in April 2013. Each survey has asked a set of core questions while also exploring new areas of interest using a mix of closed and open (free-text) questions. The survey was open online during August and September 2018. Local tobacco

3 *NHS Long-term Plan*, NHS England 2019

4 Ministry of Housing, Communities and Local Government: Local authority revenue expenditure and financing Collection, GOV.UK 2018 https://www.gov.uk/government/collections/local-authority-revenue-expenditure-and-financing

5 NHS Digital: Stop Smoking Services Collection, 2018 https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/stop-smoking-services-collection

control leads were emailed by ASH and invited to complete the survey. Non-respondents were initially followed up by telephone and encouraged to participate. Specially-tailored surveys were created for tobacco control leads in areas where local authorities collaborate in commissioning services for smokers.

Completed responses were received from 102 individuals, providing data on 107 local authorities, 71% of the 151 local authorities in England with responsibility for public health (Cornwall and the Isles of Scilly were treated as one authority). Eighty-five respondents identified their role as a tobacco control lead, or a commissioner of tobacco control/smoking cessation services, or both. Of the remaining 17 respondents, two were directors of public health, five were consultants in public health and ten were stop smoking service managers.

In order to obtain a fully comprehensive picture of current services, all survey non-respondents were followed up again and asked a few basic questions over the telephone or by email. The core findings on services reported here are for all local authorities in England with responsibility for public health.

Web information on local service provision was also interrogated when the data from the survey or follow-up research was unclear or inconsistent. This web research was undertaken in November 2018.

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

Analysis of government spending data

Every year the Ministry of Housing, Communities and Local Government publishes detailed budgets and spending data for all local authorities in England. For this study, an analysis was undertaken of the most recent spending data for 2017/18. This was compared to the spending data for 2014/15.

The Isles of Scilly were excluded from all calculations due to the authority's small population and nil spending in both 2014/15 and 2017/18. The City of London was excluded from calculations of costs per resident smoker as its services are principally for its working, not resident, population.

In addition, the data for each case were inspected to ensure that no obviously invalid data were included. Where there were inconsistencies or apparent problems within the MHCLG data, they were compared to data obtained through the annual CRUK/ASH survey of local authority leads to further test their validity.

Cases judged to be problematic were excluded from the in-depth analysis of spending by local authorities, which involved comparisons of groups of authorities with different approaches to commissioning, but not to the aggregate results for England or the regions which would have been affected by the reduction in cases.

The following cases were excluded from the in-depth analysis:

- One local authority which had a nil spend reported in the 2014/15 data despite a budget for the year and relatively consistent spending in 2013/14 and 2015/16.
- Four local authorities which had nil or near-nil spending reported in the 2017/18 data despite significant budgets for the year, and ongoing services reported to CRUK/ASH.
- One local authority that had anomalous budget and spending data across the entire period including exceptionally high spending reported in the 2017/18 data despite a very low budget and a low spending data the previous year.

A further issue with the MHCLG data was identified through the CRUK/ASH survey. In the 2017 CRUK/ASH survey, seven local authorities reported that they no longer had a budget for stop smoking services as they now commissioned an integrated lifestyle service. Yet each of these local authorities reported under the 'stop smoking services' heading to the MHCLG for 2017/18. It is clear from the CRUK/ASH data that at least one of these local authorities allocated all of its spending on its lifestyle service to the 'stop smoking services' heading and at least one allocated part of its lifestyle spending to this heading. None of these cases was excluded from the analysis but local authorities' different approaches to reporting spending on integrated services may affect the validity of these MHCLG data and thus of the findings reported here related to this spending.

3. Budgets and spending 2014-2018

Key findings

- Between 2014/15 and 2017/18 total local authority spending in England on stop smoking services and wider tobacco control fell by £41million (30%).
- In 2018, 18% of surveyed local authorities reported having no specific budget for stop smoking services due to a shift to an integrated lifestyle model; 3% had no budget due to decommissioning.
- Of the surveyed local authorities that had a budget for stop smoking services in 2018, 36% had cut this budget compared to 4% that increased it.
- The principal reasons for budget cuts in 2018 were, as in previous years, the cuts in the public health grant and the wider reductions in central government funding for local authorities.

This chapter examines changes to budgets and spending on stop smoking services and tobacco control in English local authorities, drawing on data from both the CRUK/ASH surveys and the annual local authority spending data published by the Ministry of Housing, Communities and Local Government (MHCLG). The following are described:

- The extent to which stop smoking and tobacco control budgets still exist within English local authorities
- The year-on-year changes to these budgets in the four years from 2014 to 2018
- The reasons for cuts to budgets
- The change in reported spending from 2014/15 to 2017/18

The survival of stop smoking and tobacco control budgets

Over the last five years, the CRUK/ASH survey has tracked changes to the following local authority public health budgets:

- Budgets for stop smoking services (excluding stop smoking medications)
- Budgets for stop smoking medications
- Budgets for wider tobacco control activity

Over this period, some of these budgets have disappeared altogether, for diverse reasons.

Budgets for stop smoking services

In 2018, 79% of the local authorities surveyed had a specific budget for stop smoking services. Over a fifth (21%) no longer had such a budget. This is principally due to a shift in commissioning away from specialist stop smoking services to 'integrated lifestyle services', designed to address the multiple health behaviours of individual clients. In many cases, though not all, this integrated approach to commissioning goes hand-in-hand with an integrated budget.

Nineteen of the local authorities surveyed (18%) did not have a budget for stop smoking services because they had moved to this commissioning model. Only three of the local authorities surveyed (3%) had decommissioned stop smoking services altogether, one of which was in the process of recommissioning.

Both of these shifts have increased in the past year. In 2017, seven local authorities reported no stop smoking service budget due to integrated commissioning and one did so because of complete decommissioning.

Budgets for stop smoking medications

In 2018, 86% of local authorities surveyed had a budget for stop smoking medications. In this instance, non-existent budgets are principally due to differences in practice at the time of the transfer of public health to local government in 2013: most local authorities took on the medications budget but some did not.

There were a few cases where medications budgets had been lost since the public health transition. Among the 14 local authorities with

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no reported medications budget in 2018, four reported that they had held the budget prior to 2018 but no longer did so.

Budgets for wider tobacco control

In 2018, three fifths (59%) of local authorities surveyed had a budget for wider tobacco control. However, the lack of a budget for tobacco control did not necessarily mean zero activity in this area. In thirty of the local authorities surveyed (28%), respondents described tobacco control work undertaken by their local authority despite reporting having no public health budget for this work.

Year-on-year budget changes, 2014 to 2018

Since 2014, the annual CRUK/ASH survey has asked participants how, if at all, their stop smoking service and tobacco control budgets had changed year-on-year. This provides a broad-brush picture of how these budgets have been affected by the pressures on local government and public health since the transfer of responsibility for public health in 2013.

Figure 3.1 illustrates the year-on-year changes to stop smoking service budgets over the last five years in those local authorities that hold such budgets (the denominator has decreased due to the loss of these budgets in some places). After a brief honeymoon period in 2014 when budgets increased as often as they decreased, the frequency of budget cuts grew to a peak in 2016, when HM Treasury made an in-year budget cut of £200 million to the public health grant, and subsequently declined. They remain more common than increases in stop smoking budgets: in 2018, 36% of local authorities that had a budget cut it compared to 4% that increased this budget.

The pattern of change over the period is similar for budgets for stop smoking medications (Figure 3.2) and wider tobacco control (Figure 3.3).

Reasons for budget cuts

In 2018, 40 of the local authorities surveyed had cut at least one tobacco-related public health budget (44%). They were subsequently asked to identify the reasons for these budgets cuts from a predefined list, derived from a content analysis of the answers to a free-text question in the 2017 survey. Table 3.1 describes their responses.

The two leading reasons for budget cuts – reductions in the public health grant and wider government cuts to local authority budgets – are identical to those reported in the 2017 survey.

Table 3.1. Reasons for cuts to local authority budgets for stop smoking services and wider tobacco control, 2018 (survey data, n=40)

Reason for budget cut	Frequency
Reductions in the public health grant from central government	27 (68%)
Reductions in central government funding of the local authority as a whole	25 (62%)
Fall in demand for stop smoking service	10 (25%)
Fall in the priority of stop smoking services/tobacco control within the local authority	9 (22%)

Figure 3.1. Year-on-year changes to local authority budgets for stop smoking services (excluding medications), where these budgets exist 2014-2018 (survey data)

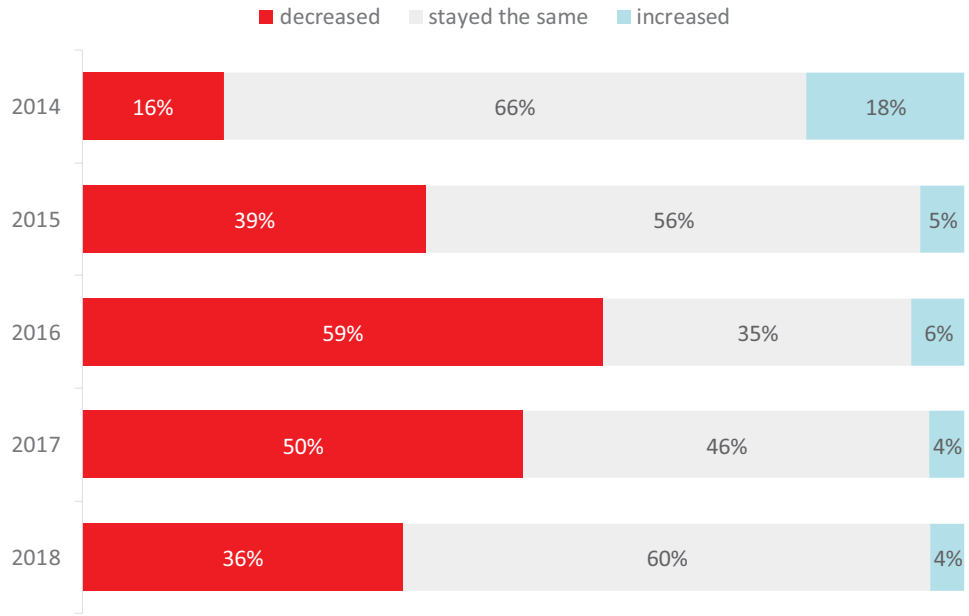


Figure 3.2. Year-on-year changes to local authority budgets for stop smoking medications, where these budgets exist 2016-2018 (survey data)

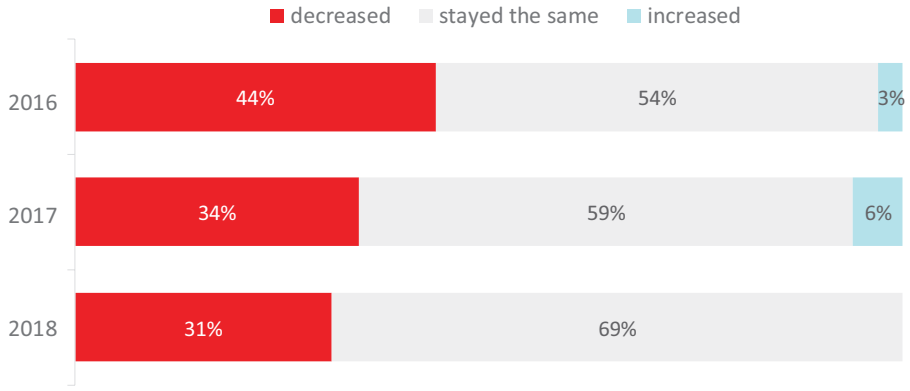
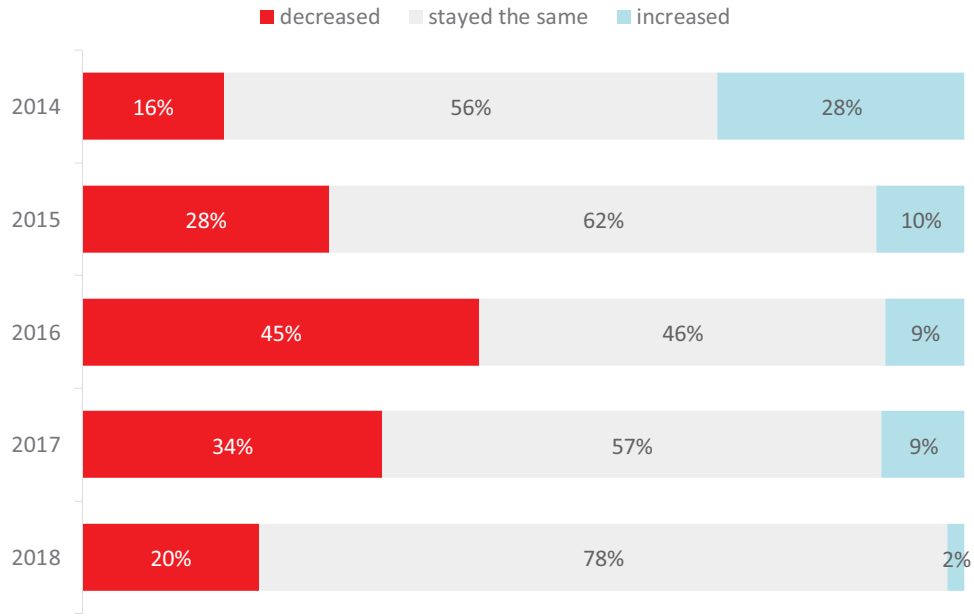


Figure 3.3. Year-on-year changes to local authority budgets for wider tobacco control, where these budgets exist 2014-2018 (survey data)



The change in reported spending from 2014/15 to 2017/18

Between 2014/15 and 2017/18 total local authority spending in England on stop smoking services and wider tobacco control fell by £41million (30%). Spending per resident smoker fell from £17.87 to £14.86 (19%) (Table 3.2). The decline in spending per resident smoker is not as steep as the decline in overall spending as the total number of smokers in England fell by 14% over these three years.

Mean local authority spending on stop smoking services and tobacco control fell from £900,000 to £629,000 between 2014/15 and 2017/18. There were, however, large variations in the direction and size of budget changes between different local authorities. Although the great majority of local authorities (84%) cut their budgets over these three years, some by more than 50%, around one in six (16%) increased their spending on stop smoking services and tobacco control (Figure 3.4).

Among major local authority public health budgets, budgets for stop smoking services and tobacco control have suffered the biggest proportionate cuts over this three year period. Table 3.3 compares the changes to smoking and tobacco control spending with changes to spending on sexual health, substance misuse, and obesity and physical exercise. Although the cuts to substance misuse and sexual health spending have been greater in absolute terms, these are much larger budgets overall. Total spending on obesity and physical health has risen over this period.

There were big regional variations in the changes to local authority spending on stop smoking services and tobacco control between 2014/15 and 2017/18 (Table 3.4). The biggest falls in spending were in the East Midlands and West Midlands, and the smallest in the North East. Taking account of the decline in smoking prevalence in each region, the spending per resident smoker rose in the North East but fell in all other regions.

Table 3.2 Aggregate and mean changes in local authority spending on stop smoking services and tobacco control, 2014/15 – 2017/18 (MHCLG spending data and PHE tobacco control profiles)

	Stop smoking services	Wider tobacco control	Total spend	Spend per resident smoker
England				
2014/15	£121.2m	£14.7m	£135.9m	£17.87
2017/18	£85.2m	£9.7m	£95.0m	£14.56
change	-£36.0m (-30%)	-£5.0m (-34%)	-£40.9m (-30%)	-£3.31 (-19%)
Local authority average				
2014/15	£803,000	£97,000	£900,000	£18.72
2017/18	£564,000	£64,000	£629,000	£15.40
change	-£238,000 (-30%)	-£33,000 (-34%)	-£271,000 (-30%)	-£3.32 (-18%)

Figure 3.4. Size and direction of changes in local authority spending on stop smoking services and tobacco control, 2014/15 – 2016/17 (MHCLG)

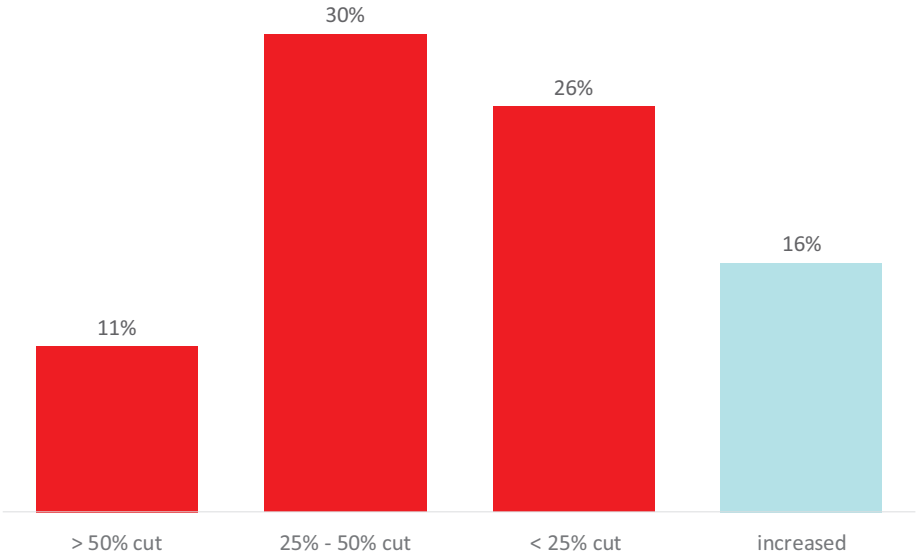


Table 3.3 Local authority spending on key public health responsibilities, 2014/15 – 2017/18 (MHCLG)

	Stop smoking services and tobacco control	Substance and alcohol misuse	Sexual health	Obesity and physical activity
England				
2014/15	£135.9m	£822.5m	£656.1m	£215.2m
2017/18	£95.0m	£695.0m	£527.1m	£232.8m
change	-£40.9m (-30%)	-£127.5m (-16%)	-£84.1m (-13%)	£17.6m (8%)
Local authority average				
2014/15	£900,000	£5,447,000	£4,345,000	£1,426,000
2017/18	£629,000	£4,603,000	£3,788,000	£1,542,000
change	-£271,000 (-30%)	-£844,000 (-16%)	-£557,000 (-13%)	£116,000 (8%)

Table 3.4. Local authority spending on stop smoking services and tobacco control 2014/15 – 2017/18 by region (MHCLG spending data and PHE tobacco control profiles)

	2014			2017 (% change from 2014)		
	total spend (£ million)	residents smokers (1,000s)	spend per res. smoker	total spend (£ million)	resident smokers (1,000s)	spend per resident smoker
North East	£9.3m	415	£22.48	£8.2m (-12%)	343 (-17%)	£23.89 (+6%)
North West	£18.7m	1101	£17.00	£13.2m (-30%)	920 (-16%)	£14.30 (-16%)
Yorks. & Humber	£14.9m	840	£17.70	£10.7m (-28%)	730 (-13%)	£14.73 (-17%)
East Midlands	£13.0m	668	£19.46	£6.9m (-47%)	594 (-11%)	£11.62 (-40%)
West Midlands	£14.9m	744	£20.01	£8.0m (-46%)	650 (-13%)	£12.27 (-39%)
East	£14.2m	837	£16.97	£11.3m (-21%)	688 (-18%)	£16.42 (-3%)
South West	£10.8m	735	£14.63	£6.6m (-38%)	611 (-17%)	£10.87 (-26%)
South East	£19.2m	1150	£16.72	£16.0m (-17%)	978 (-15%)	£16.34 (-2%)
London	£20.9m	1138	£18.35	£14.0m (-33%)	996 (-12%)	£14.09 (-23%)
England	£135.9m	7605	£17.87	£94.9m (-30%)	6519 (-14%)	£14.56 (-18%)

4. Services for smokers commissioned by local authorities

Key findings

- In 2018, 65% of all local authorities commissioned a specialist stop smoking service, down from 74% in 2017. Only 56% commissioned a *universal* stop smoking service available to all smokers.
- 22% commissioned an integrated lifestyle service instead of a specialist stop smoking service.
- 9% commissioned stop smoking support from professionals in primary care only.
- 3% did not commission any stop smoking services or only a service for pregnant women.
- Smokers could see a specialist stop smoking adviser in 75% of the services commissioned by local authorities, though access was restricted to target groups in 10%.
- 71% of surveyed local authorities offered full courses of both dual form Nicotine Replacement Therapy (NRT) and Champix through their principal commissioned service.
- The highest CO-validated quit rates were in local authorities which still had specialist stop smoking services.
- All local authorities surveyed in 2018 reported that their principal commissioned service supported service users who wanted to use e-cigarettes as part of their quit attempts.

Introduction: different approaches to commissioning

Since responsibility for commissioning stop smoking services moved to local government in England in 2013, the local offer of support and advice to smokers has diversified. The majority of local authorities still commission a specialist stop smoking service but some have replaced these services with integrated lifestyle/wellbeing services and others only commission support from primary care professionals (GPs and pharmacists). In a handful of cases, local authorities have decommissioned their services for smokers altogether. The following examples illustrate these four approaches to commissioning:

> *The specialist service is open to every smoker wanting to quit but targets pregnant smokers, mental health and routine and manual workers. The specialist service offers specific advice and training to other organisations around smoking and policies. The specialist service supports primary care providers to deliver stop smoking support which does not target particular groups but offers less intensive support.*

> *We commission an integrated lifestyle service where those meeting the eligibility criteria receive face to face support to address multiple risk behaviours, including support to quit smoking in line with national standards. All others can access our online website to find advice and resources to help them quit.*

> *Service is provided by selected Community Pharmacies in the Borough who are required to provide behavioural support, alongside access to stop smoking medications.*

> *We do not commission any stop smoking services.*

There are overlaps within this typology of approaches to commissioning. Many local authorities commission support in primary care in addition to specialist or lifestyle services. And some local authorities commission both a lifestyle service and a specialist stop smoking service. In such cases, the lifestyle service may triage smokers to the specialist service, or simply offer an alternative service depending on the needs

of the individual. In some cases, the specialist service is not universal but the lifestyle service is.

The distinction between universal and restricted services is itself an important characteristic of the diversity of services offered by local authorities, especially among specialist stop smoking services. Most but not all lifestyle services are universal (the example above is not). Where local authorities only commission smoking support from GPs, the service is always open to all.

Even in those local authorities where the stop smoking service has been completely replaced by a lifestyle service, the professionals who engage with clients may still be specialist stop smoking advisers. In other local authorities that only commission a lifestyle service, these professionals have a broader brief and consider all the lifestyle/wellbeing needs of their clients. Only the former approach retains the evidence base of effectiveness that underpins specialist services[6].

Types of service commissioned

Table 4.1 describes the principal service commissioned for smokers in all local authorities in England in 2018. As the focus of Table 4.1 is the principal commissioned service, the categories are exclusive. Those local authorities that commissioned both a specialist stop smoking service and a lifestyle service (n=13, 9% of all local authorities) are included in the data for the former service type and not the latter.

Overall, 65% of local authorities commissioned a specialist stop smoking service in 2018, down from 74% in 2017. Only 56% that commissioned a *universal* stop smoking service that is open to all local smokers. Elsewhere, 22% commissioned an integrated lifestyle service instead of a stop smoking service, 9% commissioned stop smoking support from professionals in primary care only, and 3% did not commission any services or (in one case) only a service for pregnant women.

The professionals who deliver the service

An alternative way of looking at the data in Table 4.1 is to focus on the type of adviser that smokers meet when they are seeking support to quit. This has the effect of collapsing the distinction between specialist stop smoking services and the lifestyle services that employ specialist stop smoking advisers (Table 4.2).

Overall, smokers could see a specialist stop smoking adviser in three quarters (75%) of the services commissioned by local authorities, though access was restricted to target groups in 10%. Smokers could only see a lifestyle/wellbeing counsellor in 12% of local authorities and in 9% of local authorities the only option they had was to see a GP or pharmacist.

Survey participants were asked to identify the training that advisers had received both in specialist/lifestyle services and in primary care. Table 4.3 describes the range of training that the advisers in local authorities' principal commissioned service had received by adviser type. Allowing for the different group sizes, the results are largely consistent across the adviser types, especially the proportion of advisers who have received National Centre for Smoking Cessation and Training (NCSCT) online training or any face-to-face training.

Table 4.1. Approaches to commissioning service for smokers in local authorities in England, 2018 (all 151 local authorities) Percentages are of all local authorities.

Principal commissioned service	**Access**		**Total**
	universal	**restricted**	
Specialist stop smoking service	85 (56.3%)	13 (8.6%)	98 (64.9%)
Integrated lifestyle service	31 (20.5%)	3 (2.0%)	34 (22.5%)
with specialist stop smoking advisers	*14 (9.3%)*	*2 (1.3%)*	*16 (10.6%)*
with lifestyle/wellbeing advisers	*17 (11.3%)*	*1 (0.7%)*	*18 (11.9%)*
Service from primary care professionals only	14 (9.3%)	-	14 (9.3%)
No commissioned services	-	-	5 (3.3%)

6 Public Health England: *Models of delivery for stop smoking services, options and evidence*, PHE 2017

Support and medications offered

Excluding the local authorities that had decommissioned their services altogether, all local authorities surveyed offered face-to-face support through their principal commissioned service. Group support was offered by half (52%) of local authorities and telephone support by 88% (Table 4.4).

The principal stop smoking medications offered to smokers were Champix (varenicline), Zyban (bupropion) and various forms of NRT. The evidence-based 'gold standard' treatment offer is the combination of dual form NRT and Champix for 12 weeks with behavioural support.

A full course of Champix was more often available than a full course of dual form NRT (Table 4.5). Overall, 71% of surveyed local authorities offered full courses of both dual form NRT and Champix through their principal commissioned service. There was no difference between specialist and lifestyle services in the availability of this offer (74% vs. 73% respectively) but, among local authorities that had reduced their service to support in primary care, only half (50%) made this gold standard offer to their smokers, principally because of a relatively low rate of prescribing of dual form NRT.

Table 4.2. Type of professional delivering stop smoking advice in principal commissioned service, 2018 (all 151 local authorities). Percentages are of all local authorities.

Adviser type	Access		Total
	universal	restricted	
Stop smoking specialist	99 (65.6%)	15 (9.9%)	114 (75.5%)
Lifestyle/wellbeing counsellor	17 (11.3%)	1 (0.7%)	18 (11.9%)
GP or pharmacist	14 (9.3%)	-	14 (9.3%)
No service	-	-	5 (3.3%)

Table 4.3. Smoking cessation training received by professional advisers in local authorities' principal commissioned service, 2018 (survey data, n=107). Row percentages exclude 'don't know' responses and missing data.

Adviser type	Number of cases	Very Brief Advice	NCSCT online	Face-to-face training		
				NCSCT	Other	Any
Specialist	78	34 (44%)	59 (76%)	36 (46%)	44 (56%)	69 (88%)
Lifestyle counsellor	14	6 (43%)	11 (79%)	8 (57%)	4 (29%)	11 (79%)
GP/pharmacist	12	3 (25%)	9 (75%)	3 (25%)	7 (58%)	10 (83%)

Table 4.4. Forms of support offered to smokers by local authorities' principal commissioned service, 2018 (survey data, n=107). Row percentages exclude 'don't know' responses and missing data.

Principal commissioned service	Number of authorities	Service offers individual face-to-face support	Service offers group support	Service offers telephone support
Specialist	68	68 (100%)	39 (57%)	65 (96%)
Lifestyle	24	24 (100%)	15 (62%)	22 (92%)
Primary care only	11	11 (100%)	2 (18%)	7 (64%)
No service	3	-	-	-
Total	107	104 (97%)	56 (52%)	94 (88%)

Table 4.5. Stop smoking medications offered to smokers by local authorities' principal commissioned service, 2018 (survey data, n=107). Row percentages exclude 'don't know' responses and missing data.

Principal commissioned service	Number of authorities	Service offers dual NRT		Service offers Champix		Dual NRT + Champix
		part course	12-week course	part course	12-week course	12-week course
Specialist	68	12 (19%)	48 (76%)	4 (6%)	58 (92%)	46 (74%)
Lifestyle	24	4 (17%)	17 (74%)	0	19 (90%)	16 (73%)
Primary care only	12	3 (30%)	5 (50%)	1 (9%)	9 (82%)	5 (50%)
No service	3	-	-	-	-	-
Total	107	19 (20%)	70 (73%)	5 (5%)	86 (91%)	67 (71%)

Primary care prescribing and commissioning

All survey participants were asked to describe GP prescribing practice in their local authority areas (Table 4.6). GP prescribing of full 12-week courses of dual NRT and Champix was reported more often by local authorities that had a specialist stop smoking service (62%) or a lifestyle service (68%) than by local authorities that only commissioned stop smoking support from GPs and pharmacists (50%). Among the three local authorities with no commissioned services, only two provided data on GP prescribing. Both reported that NRT was not available from GPs, in either single or dual form, but Champix was.

Overall, 70 surveyed local authorities (66%) commissioned some form of stop smoking support in primary care. Additional commissioning in primary care was more common when a specialist stop smoking service was the principal commissioned service (69%) compared to when a lifestyle service was the principal commissioned service (50%).

Where local authorities did commission services in primary care, the offer of stop smoking medications was more likely: full courses of dual form NRT and Champix were available from GPs in 69% of areas where the local authority commissioned support in primary care compared to 42% of areas where no primary care services were commissioned by the local authority.

Table 4.6. Stop smoking medications prescribed by GPs in each local authority area, by local authorities' principal commissioned service type, 2018 (survey data, n=107). Row percentages exclude 'don't know' responses and missing data.

Principal commissioned service	Number of authorities	GPs prescribe dual NRT		GPs prescribe Champix		dual NRT + Champix
		part course	12-week course	part course	12-week course	12-week course
Specialist	68	10 (18%)	36 (65%)	2 (3%)	50 (83%)	35 (62%)
Lifestyle	24	2 (11%)	13 (68%)	1 (5%)	15 (75%)	13 (68%)
Primary care only	12	3 (30%)	5 (50%)	1 (9%)	9 (82%)	5 (50%)
No service	3	0	0	0	2 (100%)	0
Total	107	19 (20%)	70 (73%)	4 (4%)	76 (82%)	53 (61%)

Commissioning costs

It is not possible to directly compare the cost of commissioning a specialist stop smoking service with other commissioning models because the costs reported to MHCLG under the 'stop smoking services' heading include not only the principal service commissioned but also other services such as any stop smoking support commissioned in primary and secondary care. Nonetheless a comparison of spending is useful as an indication of the financial commitment being made to smokers by local authorities taking different approaches to commissioning.

Table 4.7 compares local authority spending on all services for smokers using the MHCLG data for 2017/18 and data on local authorities' principal commissioned service from the 2018 ASH/CRUK survey. On average, local authorities that commissioned a specialist stop smoking service spent 25% more per resident smoker on all their services for smokers than local authorities that commissioned a lifestyle service as their principal service for smokers, and more than twice as much as those local authorities that limited their service to primary care.

Stop smoking service outcomes

National statistics on stop smoking services for the first quarter of 2018/19 were used to compare the outcomes of different commissioning models. Unfortunately, these statistics have been affected by the changing landscape of commissioning with many local authorities no longer submitting data. Thirty-six out of 151 local authorities were excluded because they no longer ran a service (n=5), did not provide data (n=12), or provided data in which the proportion of cases with a not known/lost to follow up outcome was higher than 40 per cent (n=19). Local authorities that had moved away from commissioning specialist stop smoking services were less likely to submit valid data on stop smoking service outcomes.

Table 4.8 describes the number of smokers setting a quit date and the number of successful 4-week CO-validated quitters per 100,000 resident smokers by local authorities' principal commissioned service. The highest quit rate – 414 CO-validated quitters per 100,000 resident smokers – was reported for local authorities that still had specialist stop smoking services. There was little difference in the rates between other models. Integrated lifestyle services with specialist stop smoking advisers appeared to have similar outcomes to integrated lifestyle services with lifestyle/wellbeing advisers. The results for local authorities where the service was limited to primary care are compromised by the low number of submissions of valid data.

Table 4.7. Annual spending on stop smoking services by local authorities' principal commissioned service, 2018 (all local authorities with valid data for 2017/18 MHCLG outturn, PHE tobacco control profiles).

Principal commissioned service	Number of authorities	Mean spending on all stop smoking services	Spending per resident smoker
Specialist stop smoking service	93	£647,000	£15.90
Integrated lifestyle service	33	£560,000	£12.76
Service from primary care professionals only	14	£345,000	£7.61

Table 4.8. Stop smoking service outcomes in first quarter of 2018/19 by local authorities' principal commissioned service.

Principal commissioned service	Number of authorities		Rate per 100,000 resident smokers	
	total	submitting valid data	setting a quit date	CO-validated quitters
Specialist stop smoking service	98	84 (86%)	1,116	414
Integrated lifestyle service	34	25 (74%)	902	308
with specialist stop smoking advisers	*16*	*13 (81%)*	*835*	*316*
with lifestyle/wellbeing advisers	*18*	*12 (67%)*	*975*	*299*
Service from primary care professionals only	14	5 (36%)	1,131	330

Approaches to the use of e-cigarettes

Survey participants were asked to describe local services' approaches to the use of e-cigarettes. In the local authorities that commissioned or ran specialist stop smoking services or integrated lifestyle services, support for the use of e-cigarettes by smokers was universal. In most cases, this meant that the service was happy to support clients who wanted to use e-cigarettes as part of their quit attempt but did not provide the product, as in the following example:

> *E-Cigarette friendly. Supply through service is not made. However, clients are free to purchase their own E-cigarette and access the service for weekly behavioural support.*

Some services were going beyond this and including e-cigarettes in their offer to some or all of their clients. Others were considering doing so. An alternative approach, adopted in a few areas, was to partner with local vape shops.

> *We are E-Cig friendly and have recently gone through a procurement process to provide E-Cigs alongside conventional therapy. This will include a starter kit as well as follow on liquids to anyone wishing to use E-Cigs.*
>
> *We are an EC friendly service and encourage smokers who want to quit with an EC to come into the service. We are also piloting the use of EC in harm reduction with vulnerable groups. This involves giving starter packs and e-liquids for free for three months to a select group of individuals.*
>
> *We are an e-cigarette friendly service. We work closely with some of our vape shops and direct smokers to them for advice and guidance on how to vape and what strength device to use. This allows the vape shops to say they are working closely with the local public health team at the council.*

Other local authorities remained more cautious. However, this caution was never expressed as active discouragement of the use of e-cigarettes. Their place in the mix of options was always acknowledged:

> *The service does not recommend the use of e-cigarettes however if a client is already using one or wants to use one they will be told about the evidence and not discouraged.*
>
> *We offer the service to anyone using e-cigs/vapes but encourage clients to come for support and to use NRT or Zyban or Champix as their 1st option. We believe that the use of e-cigs/vapes should be after they have tried these other methods first so as a final option not the first.*

In areas where there was no specialist or lifestyle service and support for smokers was only available through primary care, survey participants consistently reported that primary care professionals supported the use of e-cigarettes. As in the specialist services, this did not usually extend to providing the product, though one respondent described pilot provision through pharmacies:

> *There are two community pharmacies who are piloting the free supply of e-cigarettes. Other pharmacies promote the use of e-cigarettes if clients wish to use them or enquire about them.*

5. Wider tobacco control and local partnerships

Key findings

- In 2018, 85% of surveyed local authorities reported some wider tobacco control activity.
- A third of these local authorities (33%) had no specific budget for wider tobacco control.
- The main areas of work undertaken were trading standards and tackling the supply of illicit tobacco, promoting smokefree environments, local media and campaigns and work with young people.
- 81% of surveyed local authorities were involved in a local group or partnership to tackle smoking, such as a tobacco control alliance.
- The stakeholders that were most often identified as being important to surveyed tobacco control leads were NHS trusts, trading standards teams, primary care professionals and clinical commissioning groups.

Wider tobacco control work

Participants in the 2018 CRUK/ASH survey were asked to describe in their own words any wider tobacco control work undertaken by their local authority. An account of current work was given by 87 local authorities (81%). Figure 5.1 illustrates the range of work identified. As this was an open, free-text question, with answers subject to content analysis, Figure 5.1 reflects the relative frequency of the work areas identified and not necessarily their actual prevalence.

Four respondents did not describe any wider tobacco control activity but did report having a budget for this work. Taking account of these local authorities, there was evidence of wider tobacco control activity in 91 local authorities (85%).

Some of the local authorities that were pursuing wider tobacco control work had no budget for this. Of the 91 local authorities for which we have evidence of some wider tobacco control work being undertaken, 30 (33%, 28% of all local authorities) reported having no identified budget for this work.

Figure 5.1. Areas of wider tobacco control activity reported for local authorities, 2018 (survey data, n=107)

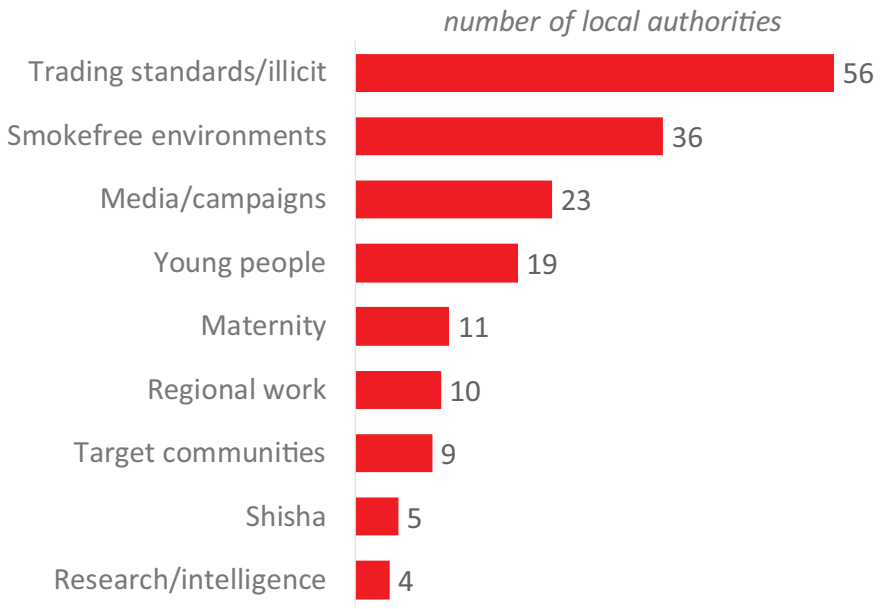
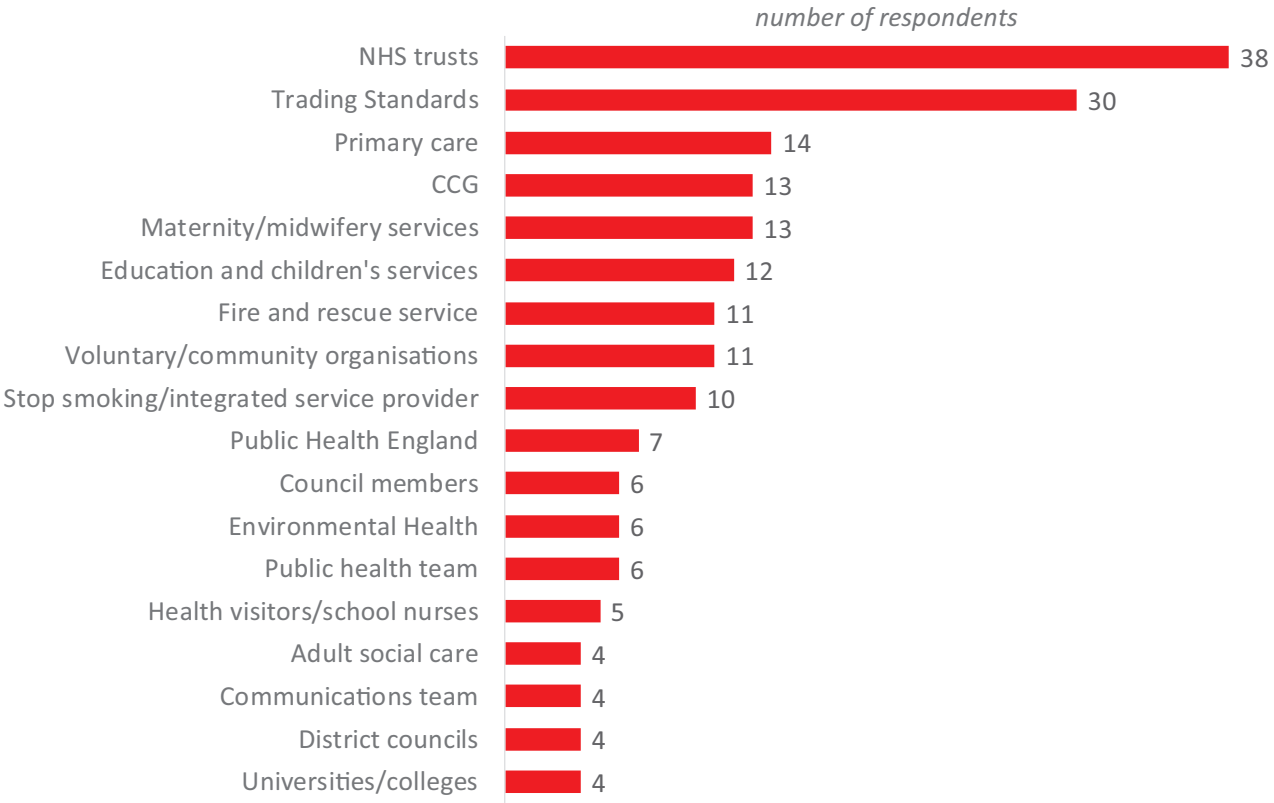


Figure 5.2. Local stakeholders identified by 4+ survey respondents as being especially helpful in tackling smoking, 2018 (survey data, n=102 respondents)



The approach to commissioning services for smokers adopted by local authorities did not appear to affect whether or not any wider tobacco control work was undertaken. Even among the three surveyed local authorities where no services had been commissioned for smokers, two respondents described some wider tobacco control activity. The following examples of wider tobacco control are from local authorities with specialist stop smoking services, lifestyle services, support in primary care only, and no services for smokers respectively. None of the following local authorities had a budget for wider tobacco control.

> *The broader work undertaken includes tackling illegal and counterfeit tobacco products; enforcing smokefree and sales legislation; ensuring that cigarettes, tobacco and niche tobacco products are displaying the appropriate health warnings; creating smokefree zones such as children's playgrounds; and ensuring Shisha premises are regularly inspected and supplied with advice on compliance.*
>
> *There is an active Smokefree Alliance chaired by the Elected Member for Adult Social Care, Public Health & Protection. Support is given to NHS trusts that have smokefree sites or are introducing smokefree sites in 2019. Commissioned Drug & Alcohol services will be introducing support for smokers and smokefree sites. Messages about second hand smoke and stop smoking are promoted within children services. The Trading Standards team is proactive in identifying and seizing illicit tobacco. The LA supports national PHE smokefree campaigns.*
>
> *Smokefree school gates (pilot undertaken), smokefree playgrounds (currently working on), Stoptober campaign, e-cigarette as a pathway to quit smoking.*
>
> *We do not undertake wider tobacco control work except for that undertaken by trading standards on illegal tobacco.*

Partnerships and stakeholders

Overall, 87 local authorities were involved in some form of local group or partnership to tackle smoking (81%). Survey participants were asked to describe these groups or partnerships in their

own words. Some account of local partnerships was given by 76 local authorities.

Local partnerships were described most often, by 65 local authorities. These included tobacco control alliances or similar strategic partnerships, maternity working groups, and task-focused partnerships with local NHS trusts. Regional or subregional partnerships or networks were described by 42 local authorities. Overall, 24 distinct groups were identified, most of which had a broad strategic focus or networking function. Five had a specific focus on illicit tobacco.

Regional and subregional groups and partnerships were most often identified in London, Yorkshire & Humber, the North East and North West. None were repoted in the East region.

Survey participants were also asked which stakeholders inside or outside the local authority had been especially helpful in tackling smoking (a free-text question). Seventy-two responded. Their responses were diverse with many stakeholders being mentioned by only one respondent. Figure 5.2 describes the stakeholders that were identified by four or more respondents. As Figure 5.2 is derived from a content analysis of responses to an open question, it only provides a measure of the relative importance of these stakeholders to local stop smoking leads.

6. Discussion

In the three years from 2014/15 to 2017/18 local authority spending on tobacco control and stop smoking services in England fell by £41.3million (30%). The principal drivers of this change have been the cuts to the public health grant and the broader pressures exerted by government on local government spending. The principal outcome has been the disappearance of the universal offer of specialist stop smoking services: if you are a smoker, where you live now makes a big difference to the support you can receive, if any, to help you quit.

Among the local authorities in England that have responsibility for public health, a majority (56%) still commissioned a universal specialist stop smoking service in 2018, offering all local smokers one-to-one support from specialist advisers and access to pharmacotherapy. In a further 9% of local authorities, smokers could access a specialist stop smoking service only if they were in a target group. Elsewhere, smokers seeking support to quit were directed to an integrated lifestyle service (22%) or to their GP or pharmacist (9%). And in 3% of local authorities, no services to support smokers had been commissioned, leaving approximately 114,000[7] smokers with no access to support.

It is not easy to predict what these changes mean for individual smokers, except in the few local authorities where no services exist at all. The quality and effectiveness of the interaction between the service user and their adviser will always depend on much more than how the service as a whole is designed. A skilled and focused adviser ought to be able to do a good job regardless of whether she or he is working in a specialist service, a lifestyle service or a primary care setting. In this respect, an important finding from this year's survey is that the training in smoking cessation that advisers had received did not appear to vary across these service models.

Though some 'integrated lifestyle services' still offer this specialist support, others deliver smoking cessation advice as part of a broader discussion of risky health behaviours. There is no evidence that this approach is effective for smokers, however useful it may be in addressing other health issues[8]. This may be reflected in the outcomes data reported here: CO-validated quits were 34% higher in local authorities that commissioned a specialist service compared to those that commissioned a lifestyle service.

More generally, there is a risk that the shift away from specialist stop smoking services goes hand in hand with a contraction in the offer to smokers. Spending certainly falls with each step away from the specialist model, such that local authorities that only commissioned support in primary care spent less than half as much per resident smoker than local authorities that commissioned specialist services, many of which also commissioned support in primary care. We might expect that if the only service commissioned is in primary care, the offer to smokers would be maximised through it. Yet GPs were less likely to prescribe NRT in areas where the only commissioned service was in primary care than in areas where specialist or lifestyle services were also commissioned. If clinical commissioning groups do not step in to the gap in these circumstances, smokers are left with nowhere to go for stop smoking medications[9]. The lower rates of submission of national outcomes data (CO-validated quitters) by local authorities commissioning lifestyle or primary-care based services is an additional indicator, albeit a technical one, of the potential long-term costs of moving away from the specialist model.

Given the ongoing cost pressures on local authorities, including the government's most recent cut to the public health grant in December 2018, the question of how best to deliver cost-effective services for smokers is vital. It may be that the typology of services presented here disguises a range of more innovative approaches to achieving lower-cost but still effective services, especially within the specialist model. The London Smoking

7 Figures from Public Health England. Local Tobacco Control Profiles. Accessed 11 March 2019. Available here: https://fingertips.phe.org.uk/profile/tobacco-control/data#page/0/gid/1938132885/pat/6/par/E12000007/ati/102/are/E09000015

8 Public Health England: *Models of delivery for stop smoking services, options and evidence*, PHE 2017

9 British Lung Foundation: *Less Help to Quit. What's happening to stop smoking prescriptions across Britain*, BLF 2018.

Cessation Partnership, for example, has sought to maximise the number of quit attempts made by the local population of smokers by directing them through an online portal to the most appropriate form of support for their needs[10]. Local innovation in smoking cessation service delivery is important at a time of cost constraint but this should not involve the loss of the core specialist support that is key to service effectiveness.

One area where there is scope for innovation is the integration of e-cigarettes as a quitting tool within service models. Although all local authorities reported that their services followed national guidance[11,12] and supported smokers who want to use e-cigarettes as part of their quit attempts, only a few were going further than this, for example in providing e-cigarettes directly to service users or partnering with local vape shops. E-cigarettes are far less harmful than tobacco products and are now the most popular aid used by smokers who try to quit[13]. Yet the harm of e-cigarettes is still overestimated by most smokers. Their potential contribution to future reductions in smoking prevalence is therefore considerable, though more evidence is needed of how best to integrate them in smoking cessation support.

The wider tobacco control work undertaken by local authorities is also crucial to reducing smoking prevalence and local health inequalities. It is encouraging that most local authorities surveyed (85%) were still active in some aspect of this work, including enforcement and tackling the supply of illicit tobacco, promoting smokefree environments, and running local campaigns. Local authorities' diverse relationships with local communities remain a great opportunity to promote a smokefree future for these communities, even when specific budgets for tobacco control are small or even non-existent. In many areas, however, the value of acting on these issues at a supra-local or regional level remains under-exploited.

Despite the problems described in this report, it is clear that the majority of local authorities remain committed to tobacco control. It is vital that both local and national government do not lose sight of the key facts that underpin this work: that smoking remains the biggest cause of preventable death in England and that evidence-based stop smoking services continue to be exceptional value for money[14].

Recommendations

The government's commitment to more NHS action on prevention and health inequalities[15] should extend to supporting local government. In England, local authorities play a vital role in delivering interventions for the population of smokers through specialist stop smoking services and wider tobacco control work.

Rather than cutting the public health grant further, the government should be reversing the decline in the public health grant and seeking a sustainable long-term funding solution so that local authorities can provide the public health services required to meet the needs of the population.

Local authorities should explore every possible means of sustaining evidence-based specialist stop smoking support at the heart of their offer to smokers (regardless of how the service as a whole is configured).

Local authorities should maximise the value of their partnerships, community relationships and profile to shape a smokefree future: working with local stakeholders and to reach out to smokers and shaping environments that discourage the uptake of smoking.

Local authorities should work together to tackle regional tobacco control problems (such as the supply of illicit tobacco), deliver media campaigns across a larger footprint, and develop innovative approaches to the delivery of specialist stop smoking services.

Local authorities should consider how best to integrate e-cigarettes as a quitting tool into their offer to smokers, especially in reaching high prevalence disadvantaged groups. Innovative approaches should be evaluated in order that a fully evidenced-based approach to the utilisation by services of e-cigarettes can be developed.

10 https://stopsmokinglondon.com/

11 McNeill A, Brose LS, Calder R, Bauld L, Robson D: *Evidence review of e-cigarettes and heated tobacco products*, Public Health England, 2018

12 National Centre for Smoking Cessation Training: Electronic cigarettes: *A briefing for stop smoking services*, NCSCT, 2016.

13 West W, Beard E, Brown J: *Trends in electronic cigarette use in England*. Smoking Toolkit Study, January 2019 www.smokinginengland.info

14 NICE: *Guideline 92 Stop smoking services and interventions*, 2018.

15 *NHS Long-term Plan*, NHS England 2019

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