This is the 'Change NHS: help build a health service fit for the future' consultation response written by Action on Smoking and Health.

1. What does your organisation want to see included in the 10-Year Health Plan and why?

Smoking is a leading cause of preventable disease, disability and premature death in England. It kills around 64,000 people every year, 408,700 hospital admission per year are attributed to smoking, and accounts for half the difference in life expectancy between the most and least deprived in society. In 2023 smoking in England cost public finances in England over £11.3 billion, after tobacco excise tax income of around £7.1 bn and reduced pension payments of £0.2 bn are netted out. Smoking costs the NHS £2.6 billion per year and smokers on average need social care ten years earlier than non-smokers.

Most of the burden on public finances is due to the damage smoking does to the productivity of the nation, with the total economic cost of smoking in England amounting to £46 bn. Smoking affects earning and employment prospects, having a cumulative impact amounting to productivity losses of £28.7B per year. An estimated 252,000 people in England are out of work due to smoking, with around 1 million people receiving informal social care from their friends and family. In order to tackle the growing demand on the NHS and wider healthcare system, reducing smoking needs to be one of the cornerstones of the NHS 10-year plan and it's shift to prevention.

The benefits of quitting smoking are such that investment in smoking cessation and tobacco control measures provide a net benefit to public finances from year one onwards, as well as supporting economic growth and reducing pressure on our NHS and social care services. When people who smoke quit it has multiple benefits to health outcomes, for example speeded recovery time, reduced exacerbations, improved effectiveness of treatments – all of which reduce the stay of hospital admissions and the likelihood of readmission.

Benefits grow for individuals and society over time. Reducing smoking prevalence has a significant impact on the population's healthy life expectancy, particularly in our most disadvantaged communities with the highest rates of smoking. ASH found that the impact of one year of a fully established tobacco dependency treatment service across England would result in an additional 523 bed spaces created per day.

Treating tobacco dependency is central to an effective prevention strategy, however the current approach within government is disjointed and without a clear overarching goal and as such is likely to be less than the sum of its parts with organisations unclear of their role. The 10 Year Plan can offer a vision for prevention that is succinct, scalable and can be embedded into the DNA of all NHS organisations. The Darzi review is the latest in many calls for the NHS to prioritise prevention and public health since the 'fully engaged scenario' set out by Wanless

in 2003. It hasn't happened yet, treatment continues to trump prevention, both in the NHS and the DHSC, to the detriment of population health and wellbeing. Real term cuts of a quarter in the public health budget to local authorities since 2015 (45% to tobacco control) tell the story. If the pivot to prevention is to be more than just alliteration it needs concrete commitments from the NHS.

There are some clear opportunities through which to set ways of working that can be translated across other areas of prevention:

1. **Link to population level measures**: The passage of the Tobacco and Vapes Bill is a change moment, as was smokefree legislation. It will allow organisations to rethink their approach to smoking in light of the phased-out sale to the next generation. It brings real attention to the issue, raising its saliency for staff and patients. There are also direct implications for NHS organisations from the proposals to prohibit smoking on hospital sites which can be an opportunity to accelerate quitting. However, the Bill on its own will only make a minor difference to current smoking rates – it will be how this is built on that will define whether smoking rates fall. The 10 Year Plan should maximise the opportunity of legal ban on smoking on hospital sites and develop a system-wide comms plan and policy for all trusts to follow, unifying services and leadership in enforcing smokefree hospitals.

2. **Maintain established programmes built on evidence**: We know what works to help people quit. NHSE have put significant effort into establishing in-hospital treatment services for smokers following the commitments in the NHS Long Term Plan. Funding for this is £15m below projected funding needed. ASH undertook a scoping review of implementation earlier this year for NHSE and found that good progress was being made but that lower funding levels, funding uncertainty, uneven join up with local government and gaps in training were inhibiting progress. These can be addressed at relatively low cost enabling the NHS to deliver the Labour manifesto commitment for services to support smokers to be embedded in hospital care. The groundwork has been laid. This can be most clearly seen in the roll out in maternity, which was fully funded, had well embedded professionals buy-in, effective training and strong organisational commitment due to other levers in the system. As a result, smoking at time of delivery rates are dropping at their fastest ever rate. This is a major success and with small additional investment services in acute and mental health could also be seeing similar results.

3. **ICB leadership and strategy**: A commitment to spending resources beyond NHS walls by ICBs could further accelerate progress to reduce prevalence. Secondary prevention, such as smoking cessation, can be delivered in hospitals and primary care but improving population health needs partnership working at scale on a wider footprint in collaboration with local authorities. Collaboration across local government and local NHS services should be fostered with lessons to be drawn from ICBs which have sought to create greater alignment (e.g. North East and North Cumbria, Humber and North Yorkshire, Cheshire & Merseyside and Greater Manchester). This is a way of knitting together treatment and population level interventions, local government and the NHS to drive forward a shared plan to reduce smoking within a population. All ICBs should implement this model and consider it for alcohol and obesity.

4. **Commitment to dedicated NHS funding for prevention** which cannot be raided to address treatment emergencies and a planned growth in funding over time (in line with Hewitt 1% of NHS budget). This would enable investment in proven models of support

to scale up quitting within lung health checks, Talking Therapies, A&E and outpatient clinics.

5. **Maintain local government delivery**: There is significant expertise in smoking cessation and wider tobacco control in local government. No NHS model is going to thrive in reducing smoking if community action is diminished. Well-funded Public Health Grant and the involvement of local government in shared ICB plans to tackle smoking is crucial for ensuring all populations are supported.
6. **National plan and national investment**: A Roadmap to Smokefree Britain would give coherence to the mission to end smoking and spell out the role of responsibilities of all. It can set targets and vision for change describing how they will be delivered. A new plan alongside recommitted funding for mass media, swap to stop, financial incentives for pregnant women and enforcement will take the momentum of the Tobacco and Vapes Bill and drive it forward to reductions in rates of current smoking.

2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Regional/ ICB level population reduction programmes

Regional collaborative programmes have demonstrated success in reducing smoking prevalence faster than areas without them – the ICB structure offers a way to spread this approach to other parts of the country and has recently been adopted in Humber and North Yorkshire and Cheshire and Merseyside.

The longest running regional programme is Fresh in the North East, which has been running since 2005 and has achieved a reduction in adult smoking prevalence from 29%, at the time of the programme's launch, to 11% in 2023 – going from the region with the highest rates of smoking to the region with the second lowest. Funding for this programme has varied over the decades but it is currently funded collaboratively by the ICB and local authorities. Meanwhile Greater Manchester's strong investment in mass media campaigns has been associated with a higher rate of quite attempts.

In 2022, ASH released a report Delivering a Smokefree 2030: The role of supra-local tobacco control which outlined interventions best delivered on regional, or sub-regional levels and factors associated with success of such programmes. ASH has also developed a series of resources designed to assist areas aiming to collaborate on tobacco control at a supra-local level and proposes models of tobacco control that focus on evidence-based activities which are best enacted at scale in order to drive down rates of smoking further and faster. They are not designed to replace or duplicate activity at a local authority level but instead should add value to current work. Partnerships beyond NHS walls will see prevention move upstream, improving population health requires a wider footprint in collaboration with local authorities.

Collaboration across the NHS and local government

Tackling smoking and reducing health inequalities requires collaboration between local government services and NHS trusts.

The increased investment in Local authority (LA) Stop Smoking Services has highlighted the importance of collaboration between the NHS and local government. Whilst collaboration has already been rated as important in enabling delivery of Tobacco Dependency Treatment Services (TDTS), there are significant variations in local authority involvement. In a survey of

LA's only 26% of local authorities reported being 'equal partners' with the NHS in planning and delivery of TDTS, and this did not guarantee operational alignment between NHS and LA services. Lack of operational alignment risks less joined-up care for patients and missing opportunities to capitalise on assets across the system, reducing efficiency. Almost 40% of local authorities were either not involved or only consulted, demonstrating room for improvement in cross-sector collaboration.

The Darzi review is the latest to identify that "too great a share is being spent in hospitals, too little in the community". Struggling community Stop Smoking Services need to be supported to deliver targeted upstream prevention. There is significant expertise in smoking cessation and wider tobacco control in local government. No NHS model is going to thrive in reducing smoking if community action is diminished. Well-funded Public Health Grant and the involvement of local government in shared ICB plans to tackle smoking is crucial for ensuring all populations are supported.

Ensuring VBA in primary care

A survey commissioned by ASH found 28% of smokers say that the advice would prompt them to make a quit attempt. A further 35% would be encouraged to quit at a later date or to cut down the number of cigarettes smoked. Even among smokers who don't expect their doctor to advise them to stop, more than half (53%) would take some action to address their smoking if their GP advised them to do so. This highlights the difference trusted healthcare professionals can make.

Despite the impact that professionals such as GPs can make to people's attempt to quit smoking there has been a decline in GP prompted quit attempts.

GPs have bee incentivised to ask about smoking through the Quality and Outcomes Framework (QOF) however this requires reform to ensure more smokers are prompted to quit in primary care. QOF currently incentivises the recording of a patients' smoking status and delivery of cessation advice. When it was first introduced GP prompted quit attempts peaked at 9% in 2011, but over the last decade has declined to 3% and produced "no change in prescribing pharmacotherapy for cessation." This demonstrates that QOF isn't going far enough. QOF should be reformed to require an opt out referral to smoking cessation support.

GPs are well-placed to offer smoking prevention, 2 in 5 smokers expect their GP to tell them to stop smoking and would respond positively to interventions of this kind, even when visiting about a non-smoking related matter. In GP patients wanting to quit, a randomised trial showed that a call from the services to the patient increased engagement with stop smoking support 13-fold compared with asking the patient to initiate contact. Overall, this strategy, known as opt-out as opposed to opt-in, can increase quitting fourfold. QOF requires reforming to become an effective upstream prevention mechanism.

3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

The shift from analogue to digital should include maximising use of effective digital smoking cessation tools in ways that are inclusive. There are models of digital support shown to increase quit success. These can be centrally commissioned on behalf of local government and NHS organisations to minimise the costs of commissioning and the risk of investing in poor quality services.

An example of a digital solution with a good evidence base is the Smokefree app. It is effective because it uses behavioural change techniques developed over many decades in more traditional services and combines these with; an interface with a real expert, access to medication and vapes and digital characteristics such as updates on benefits, progress, virtual badges, a chatbot and daily 'missions' with push notifications. Users who have engaged with both the chat bot and missions have been three times more likely to quit.

The Smokefree app has been used with NHS staff helping to achieve a strong quit rate and engage staff who struggle to access services due to their work patterns. Increasing NHS staff quit rates has the potential to reduce staff absences and bring about a smokefree culture within NHS walls. Other apps are also available but assessing the quality of these requires expertise and commissioning should be regional or central to maximise benefits and minimise bureaucracy. Digital services may meet the needs of many smokers but not all and consideration needs to be given to ensuring that those who face digital exclusion have access to alternatives. Smokers are over-represented in digitally excluded groups such as should cater to the most vulnerable smokers in society.

Recording smoking status needs to be improved to maximise support the otherwise excluded groups. Smoking rates are high in some excluded groups e.g. inclusion health groups who have an "overreliance" on emergency healthcare and fail to access primary care settings. At present, there is a "pressing concern" over inclusion health groups'. "digital exclusion" from services. Inclusion health group members, like the homeless, struggle to access online appointments and sign-up via digital booking systems. As a result, inclusion health group smokers are absent from monitoring data; they are not visible in standard NHS data sets. There are many such groups where smoking rates are high but their visibility in the data is low. The NHS 10-year plan should include the most vulnerable smokers in their data. Smoking cessation is the leading intervention to reduce the Core20PLUS5 health inequalities. Smoking rates are likely to be high amongst inclusion health groups. The Homeless Health Needs Audit of 2,776 people found that 76% smoke, 46% of whom had been offered smoking cessation advice or help. The NHS 10-year plan should target offering vulnerable groups smoking cessation support.

To reach low income and inclusion health groups the NHS should consider offering smoking cessation support in A&E. The CoSTED trial provided brief interventions in A&E to smokers waiting to be seen. This consisted of brief advice, referral to further support and immediate access to a vape. Quit rates were high in the study with a greater impact on the most deprived who more frequently access A&E. The trial found at t 6 months 23.4% of the intervention group (about 1 in 4) and 12.9% of the control group (about 1 in 8) reported having quit smoking. This shows that people were around twice as likely to report quitting smoking having received the intervention than not. People living in more deprived areas were more likely to have attended an Accident and Emergency (A&E) department between March 2021 and March 2022 compared with those living in less deprived areas, with the odds of A&E attendance increasing with the level of deprivation. The CoSTED initiative is already being piloting in several A&E's including West Yorkshire and expanding this scheme provides a way to interact with vulnerable populations and reduce smoking among the CORE20Plus5 populations.

4. **What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?**

Tackling smoking is a priority as the leading preventable cause of illness and premature death, responsible for half the difference in life expectancy between the most and least deprived in

society. Smoking is a risk factor for all six of the conditions identified as contributing 60% of total Disability Adjusted Life Years in England. Best known are smoking and cancer, CVD and COPD (smoking is responsible for 27%, 13% and 90% of deaths from these causes). However, smoking is also a leading avoidable risk factor for dementia and diabetes, mental health conditions and MSK disorders. Quitting smoking is the only effective treatment for avoiding COPD progression, significantly reduces anxiety and depression and can nearly double the life expectancy of those diagnosed with lung cancer.

There has been significant progress made since the NHS Long Term Plan introduced tobacco dependence treatment services in hospitals, specifically in, maternity services and mental health inpatient settings. However, funding for this is £15m below projected funding needed. Without addressing the funding gap and fully rolling this programme out it will be challenging to deliver the Labour manifesto commitment for services to support smokers to be embedded in hospital care. The groundwork has been laid and with fairly minimal additional funding (£15m) services would be flying. It is vital that NHS prevention funding is ringfenced and cannot be raided to address treatment emergencies to ensure prevention services such as TDTS can be fully established and working to their full potential. Piecemeal and short-term funding for the system is inhibiting the transformational change that is needed. For example, even though there is a national commitment to invest in new tobacco dependence treatment services in the NHS with ring-fenced transformation funding there is a lack of confidence within systems and trusts that resources will be maintained long term, or even year to year. Freedom of information requests for ICB investment in TDTS showed that investment by ICBs in TDTS in mental health inpatient settings dropped by 17% in 23/24. This has created significant barriers to implementation and slowed progress in some areas, which can only be addressed by securing commitment to long-term ring-fenced funding. Insufficient funding, variation of services and implementation in deprived areas, uncertainty about future funding, and patchy collaboration with local government are impeding further progress and require attention.

King's Fund research with ICB chairs and other system leaders identified that they had been recruited to address "health inequalities, population health, social and economic wellbeing" but were being judged on "a safe winter, the money being delivered, waiting times, and … performance" Moving resources towards prevention at a time when the NHS is in crisis and services are under massive and multiple pressures is challenging but essential as the crisis cannot be addressed without improving the health of the population. Systems need incentives to put longer-term prevention plans in place. The loss of regional prevention leads and further headcount reductions in ICBs threatens to undermine the proposed 'shift to prevention' on smoking. There are serious concerns that the system will not have the capacity to implement either the tobacco dependence treatment services it has already committed to, nor go further and develop the radical system-wide programmes currently only in place in Greater Manchester, the North East and Humber and North Yorkshire. Regions such as the North East & Yorkshire continued investment in prevention leadership and saw their implementation of service fully established faster than other regions. Sustained leadership from NHSE to support ICBs and disseminate best practice is essential if prevention and population level interventions are to be effectively implemented and maintained longer-term.

5. **Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:**
    a. **Quick to do, that is in the next year or so**
    b. **In the middle, that is in the next 2 to 5 years**
    c. **Long term change, that will take more than 5 years**

Quick to do, that is in the next year or so

- Deliver the prevention activity already underway The NHS Long Term Plan committed to roll out tobacco dependence treatment services in the NHS. Funding for this is £15m below projected funding needed. Without addressing the funding gap and fully rolling this programme out it will be challenging to deliver the Labour manifesto commitment for services to support smokers to be embedded in hospital care.
- Funding commitments need to be sustained: Funding commitments made for tobacco control in the last parliament such as the £70m stop smoking services need to be maintained and rolled out.
- National plan and national investment: A Roadmap to Smokefree Britain would give coherence to the mission to end smoking and spell out the role of responsibilities of all. It can set targets and vision for change describing how they will be delivered. A new plan alongside recommitted funding for mass media, swap to stop, financial incentives for pregnant women and enforcement will take the momentum of the Tobacco and Vapes Bill and drive it forward to reductions in rates of current smoking.
- Commitment to dedicated NHS funding for prevention which cannot be raided to address treatment emergencies and a planned growth in funding over time (in line with Hewitt 1% of NHS budget)
- Establish pilot programmes of initiatives with good evidence base with a commitment to scale up those shown to be effective. Programmes such as the COSTED scheme and IAPT which have been piloted across the country and produced higher quit rates, using evidence base, case studies and good practice to inform good practice and innovation.
- Targeted Lung Health Checks – as these are rolled out there is a major opportunity to reach a vulnerable population at a teachable moment (the target population for screening is people who have smoked 55-74 and over 70% of lung cancer and 90% of COPD is caused by smoking and for a vulnerable population (smokers 50+). ASH and UCL have modelled the impact of tobacco dependence treatment, and it should be embedded, but as yet there is no commitment for that to happen.

In the middle, that is in the next 2 to 5 years

- ICB leadership and strategy: commitment to spending resources beyond NHS walls – secondary and tertiary prevention, such as smoking cessation, can be delivered in hospitals and primary care but improving population health needs partnership working at scale on a wider footprint in collaboration with local authorities. Collaboration across local government and local NHS services should be fostered with lessons to be drawn from ICBs which have sought to create greater alignment (e.g. North East and North Cumbria, Humber and North Yorkshire, Cheshire & Merseyside and Greater Manchester).

- Sustained leadership from NHSE to support ICBs and disseminate best practice is essential if prevention and population level interventions are to be effectively implemented and maintained longer-term.

- Maximise the opportunity of legal ban on smoking on hospital sites. The Tobacco and Vapes Bill will introduce legislation to create some public outdoor places as smokefree. The Government has said that they will start with hospital sites to roll out these regulations to. There is already a legal underpinning to smokefree hospital sites in Wales and Scotland with variable success.

- Develop a comprehensive workforce plan, including mandatory smoking cessation training for all NHS and local authority staff, this will ensure adequate quality and capacity within the new tobacco dependence advisor and stop smoking advisor professional group.

Long term change, that will take more than 5 years

- Develop a clear set of priorities for evidence-based action to address the leading avoidable causes of ill health: tobacco, alcohol and unhealthy foods
- Set outcome measures and targets for action on prevention by ICBs (e.g. for smoking number of quit attempts, quit success, smoking prevalence). Targets must be long-term and tailored to give areas time to make an impact.
- If the government is not able to provide the funding needed to deliver these recommendations, they should introduce a polluter pays levy on tobacco manufacturers, as recommended in the Khan review and by the APPG on Smoking and Health. A levy could raise £700 million a year for tobacco control without increasing the cost of tobacco for consumers.