Integrated Care Boards and tobacco control: making good progress

Findings from a survey of Integrated Care Boards, an analysis of Joint Forward Plans, and data from tobacco dependence treatment funding services

ash. action on smoking and health

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Summary of key findings

The findings in this report are principally drawn from a survey conducted in February and March 2024, prior to the announcement of the UK General Election.

Priorities and governance

- The priority of tobacco control was perceived to be high in 50% of surveyed Integrated Care Boards (ICBs), up from 29% in 2023.
- All surveyed ICBs had mechanisms in place for the governance of tobacco control. In most cases (82%) this included a board for population health, inequalities, and/or prevention.
- There are many champions of tobacco control in ICBs including ICB/ICS chairs, CEOs, medical directors, directors of population health, directors of public health, and clinical leads.

Tobacco dependence treatment services

- Only 54% of survey respondents were confident that tobacco treatment services would be fully implemented in mental health services by March 2024, compared to 73% for acute services and 88% for maternity services.
- The roll-out of tobacco dependence treatment services has been enabled by the dedicated funding and strong partnerships, and inhibited by long-term financial uncertainty and problems recruiting staff.

Wider tobacco control

- 84% of ICBs were engaged in wider tobacco control beyond tobacco dependence treatment services.
- Some ICBs were building relationships and supporting existing work, others were developing ICS-level tobacco control strategies, and the most advanced were already supporting a wide programme of work.

Joint Forward Plans

- All Joint Forward Plans (JFPs) mentioned smoking or tobacco at least once. Some form of outcome goal for smoking was included in 36 JFPs (90%) including 14 (35%) where the goal was linked to a specific target.
- Operational goals for the delivery of smoking-related services were identified in 36 JFPs (90%).
- Eight documents (20%) mentioned the role of wider tobacco control work such as public communication, tackling the illicit trade, or promoting smokefree environments

Spending on tobacco dependence treatment services

- Although the overall spending on tobacco dependence treatment services increased across the three years from 2021/22 to 2023/24, spending on tobacco dependence treatment services in mental health settings fell between 2022/23 and 2023/24.

Introduction

The important role of Integrated Care Boards (and their wider Partnerships) in tackling the harms of tobacco is emerging. All ICBs are engaged in secondary prevention through the funding of tobacco dependence treatment services, as required by the NHS Long Term Plan.[1] Some are also pursuing primary prevention through wider tobacco control work. All ICBs are required to improve outcomes in both population health and healthcare,[2] so the balance between primary and secondary prevention is at the heart of their mission.

The new UK Government's pledge to 'ensure all hospitals integrate 'opt-out' smoking cessation interventions into routine care'[3] will put further pressure on NHS trusts, including mental health hospitals, to deliver stop smoking services in these settings.

This report offers a snapshot of the engagement of ICBs with tobacco control early in 2024. It draws on a short survey of ICBs, an analysis of their Joint Forward Plans, and data on the funding of tobacco dependence treatment services. The picture that emerges is diverse, reflecting ICBs' freedom to pursue their own priorities, but the importance of population health to ICBs is evident across the findings.

Many ICBs now have Directors of Population Health. It may take time for their roles to settle, not least in relation to existing Directors of Public Health in local authorities, but the emphasis on partnership within Integrated Care Systems creates opportunities for collaboration at all levels[4]. Tobacco control, with its breadth of concerns across primary and secondary prevention, ought to be a key focus of these collaborations.

This small study will be complemented by the annual ASH/CRUK survey of local authorities in the summer of 2024. This will provide an alternative perspective on the ongoing development of tobacco control collaborations between the NHS, local government and voluntary sector partners.

Methods

The findings in this report are drawn from three sources: an online survey of Integrated Care Boards, a content analysis of ICBs' published Joint Forward Plans, and a Freedom of Information request seeking data on ICBs' spending on tobacco dependence treatment services.

The short online survey was conducted using Survey Monkey and was live in February and March 2024. Key contacts in ICBs were asked to complete the survey or to pass it to the lead officer for tobacco control to complete. Non-responding ICBs were followed up by telephone. Twenty-seven valid responses were received from the 42 ICBs in England, a response rate of 64%. Two respondents exited the survey early so the baseline changes across the results.

[1] NHS Long Term Plan, 2019
[2] NHS England 2023: What are integrated care systems?
[3] https://labour.org.uk/change/build-an-nhs-fit-for-the-future/
[4] Gowar C: As ICSs bed in, how are public health and population health leadership collaborating? King's Fund blog, 15th February 2024.

The content analysis of Joint Forward Plans was undertaken at the end of March 2024. Forty plans were downloaded from ICB websites including 39 full documents and one summary. The content analysis examined how smoking and tobacco control were addressed in these published documents.

The Freedom of Information request was sent to all 42 ICBs in August 2023. ICBs were asked to provide data on their spending on tobacco dependence treatment services in 2021/22 and 2022/23 and on their budgeted spend for 2023/24, broken down by trusts and by service type (acute/maternity/mental health). Responses were received from 39 out of 42 ICBs.

Survey respondents

Of the 27 respondents to the online survey, 23 (85%) were employed by ICBs including two joint appointments with local authorities. Of the remaining 4 respondents, 2 were employed by local authorities and 2 were employed by NHS trusts.

Respondents included prevention/inequalities/public health specialists and leads, tobacco dependence and smokefree programme managers, directors of population health, tobacco dependency clinical leads, and consultants in public health.

Ten respondents (37%) spent more than half of their time on tobacco control including 6 (22%) who spent all their time on tobacco control. The remainder spent around half (7, 26%) or less than half (10, 37%) of their time on tobacco control.

The priority of tobacco control

Half of the surveyed respondents (50%) perceived a high priority for tobacco control in their ICB and 23% reported an above average priority (Table 1). This is a significant increase on 2023.

Table 1: Respondents' perceptions of the priority of tobacco control in their ICBs

priority of tobacco control	*2024 (n= 26)*	*2023 (n=28)*
high	13 (50%)	29%
above average	6 (23%)	21%
average	4 (15%)	43%
below average	2 (8%)	0
low	1 (4%)	2%

Governance and champions

All surveyed ICBs had mechanisms in place for governance of tobacco control. Of the 27 ICBs, 24 (89%) had a tobacco dependence treatment steering group, and 7 (26%) had a tobacco control board including 5 ICBs that had both.

Most respondents (22, 81%) also reported governance for tobacco control operating through a board for population health, inequalities, and/or prevention. In all but one of the surveyed ICBs this was in addition to a tobacco dependence treatment steering group or tobacco control board.

Only 4 respondents (15%) reported that their ICB had a policy restricting engagement with the tobacco industry, though most respondents did not know whether or not the ICB had such a policy (19, 70%). Four reported that the ICB did not have such a policy.

Asked if anyone championed tobacco control in their ICB, nearly all respondents (25, 93%) replied positively (the remaining 2 did not know). Respondents identified a diverse range of individuals in ICBs, NHS trusts and local authorities who championed tobacco control including:

- chairs of ICBs, ICSs and population health boards within ICBs
- CEOs and medical directors
- directors of population health, public health and health inequalities
- clinical leads for tobacco dependency, prevention, respiratory illness, and cardiovascular disease

As ICBs are part of integrated care systems, there are potentially many individual and organisational champions of tobacco control, as in the following examples:

> *Multiple people including Clinical Lead for Tobacco Dependency, Chair of ADPHE NE who joint chairs the ICB Healthier & Fairer Board, the chairs of the Prevention Board who report into the Healthier & Fairer Board, and Fresh via the director and staff. (North East and North Cumbria ICB)*

> *Medical Director champions regional approaches to tobacco control. Tobacco Dependence Treatment programme (QUIT) is chaired by Chief Executive of two Trusts, ICB local authority rep is a Director of Public Health who champions tobacco control. (South Yorkshire ICB)*

> *Our Medical Director champions tobacco control work through the clinical care professional forum. Our Chief Executive, ICB Chair, Chair of the Health and Care Partnership, Medical Director and Lead DPH for the Health and Care Partnership all endorsed an open letter on the smokefree generations. Our Associate Director of Improving Population Health champions tobacco control work at all opportunities. We could improve on this, and are taking active steps to develop champions across the organisation. We also have the Chair of the Respiratory Clinical Network for West Yorkshire as champion. (West Yorkshire ICB)*

NHS tobacco dependence treatment services

At the time of the survey, respondents' confidence in the full implementation of NHS tobacco dependence treatment services by March 2024 varied across the three settings of maternity, acute, and mental health services (Table 2). Most respondents (88%) were confident that tobacco dependence treatment services would be in place in maternity services by this date, and 73% were confident that they would be running

in acute services. Fewer (54%) were confident that they would be fully implemented in mental health services.

Survey respondents were also asked how likely they thought it was that tobacco dependence treatment services would be retained after March 2024. Most (23, 88%) thought this was likely and none thought it unlikely. The remaining three respondents either did not know or thought this outcome neither likely nor unlikely.

Table 2: Respondents' perceptions of the likelihood of full implementation of NHS tobacco dependence treatment services by end of March 2024

	Already implemented	*Confident of full implementation*	*Not confident of full implementation*
Maternity	13 (50%)	10 (38%)	3 (12%)
Acute	12 (46%)	7 (27%)	7 (27%)
Mental health	8 (31%)	6 (23%)	12 (46%)

Factors enabling and inhibiting roll-out

Respondents were asked to identify factors that had enabled and inhibited roll-out of tobacco dependence treatment services (Table 3). This was a closed question with options derived from a free-text question in the 2023 survey.

The most common enabling factor, alongside strong partnerships, was the dedicated funding. The most common inhibiting factor, alongside problems recruiting staff, was the long-term financial uncertainty about this funding.

Table 3: Factors enabling and inhibiting the roll-out of tobacco dependence treatment services

Enabling factors		*Inhibiting factors*	
The dedicated funding	24 (92%)	Long-term financial uncertainty	20 (77%)
Strong partnerships	24 (92%)	Problems recruiting staff	20 (77%)
Local government leadership/support	20 (77%)	Competing priorities/lack of capacity across the system	16 (62%)
A dedicated manager	19 (70%)	IT and reporting differences across the system	16 (62%)
ICB leadership	18 (69%)	Insufficient funding	15 (58%)
Leadership in NHS trusts	17 (65%)	Problems with pharmacotherapy provision including NRT	10 (38%)
Regional support	17 (65%)	Industrial action	7 (27%)
The NHS mandate to deliver	14 (54%)	COVID-19 and its impact on NHS trusts	7 (27%)
Good governance arrangements	12 (46%)	Lack of community stop smoking services	5 (19%)
A process of review and learning	11 (42%)	Lack of NHS leadership	5 (19%)
		An over-ambitious timetable	4 (15%)
		Lack of ICB leadership	3 (12%)

		Poor governance arrangements	1 (4%)

Respondents were also asked to describe in their own words what distinguished NHS trusts in their area that had successfully implemented tobacco dependence treatment services from those that had not. The enabling factor identified most often was executive leadership within trusts. Respondents also mentioned capacity within trusts, dedicated roles and teams, appreciation of the benefits of the service, and differences across trusts in the timetable for implementation.

> *The key to strong implementation has been Trust leadership and governance, and programme management capacity. (Kent and Medway ICB)*

> *Strong executive champion/ leadership from the very start. Understanding of the positive benefits of service - return on investment and outcomes for patients. (Cheshire and Merseyside ICB)*

> *Trusts with team members whose roles incorporated the mobilisation of services set them up faster. The trusts where the mobilisation was added on to an already large workload made it much slower. (North East London ICB)*

Recruitment problems were again identified as an inhibiting factor. This is explicitly linked to the long-term financial insecurity of the programme in the following example:

> *Many of our trusts had six or seven bouts of recruitment before they hired tobacco dependence advisors which delayed the process massively. The uncertainty of funding and delay in information being fed through is a real barrier to recruiting. As soon as they were hired, the implementation has advanced at a good speed. (Surrey Heartlands ICB)*

Wider tobacco control

Overall, 21 ICBs (84%) were engaged in wider tobacco control work beyond the roll-out of tobacco dependence treatment services (2 were not, 2 respondents did not know). Survey respondents described this work in their own words.

The involvement of ICBs in wider tobacco control work is at different stages of development across England. Some ICBs were building relationships and supporting existing work, others were developing ICB-level tobacco control strategies, and the most advanced were already supporting a wide programme of work.

Respondents' descriptions of wider tobacco control work primarily focused on engagement with system partners, including representation on local tobacco control alliances, working relationships with local authority public health colleagues, membership of alliances or steering groups at ICS level, and contribution to regional tobacco control programmes. In some places, such as Greater Manchester and the North East, ICBs supported established regional programmes of tobacco control work. Elsewhere, ICBs provided a new focus for the development of regional approaches. The following examples illustrate this range of possibilities:

Engaged in tobacco control alliances across all local authorities in footprint (Buckinghamshire, Oxfordshire and Berkshire West ICB)

We have a tobacco alliance that is system wide (Birmingham and Solihull ICB)

As part of the new Lancashire & South Cumbria Tobacco Free Strategy, the ICB is actively collaborating on a host of recommendations in the strategy around these areas with the focus for 24/25 being on delivering on the priority areas (Lancashire & South Cumbria ICB)

The wider tobacco control team cover illicit, behaviour change campaigns, changes in policy, working with housing and other allied groups (Greater Manchester ICB)

Setting up Centre for Excellence covering wider tobacco control (Humber and North Yorkshire ICB)

Additionally, respondents were asked if their ICB had used any health inequalities funds for tobacco control work. Eleven ICBs (44%) had done so. This money had been used both to support tobacco dependence treatment services, for example by enabling patient pathways, and to develop regional tobacco control work.

Half of the surveyed ICBs (12, 48%) had signed the NHS Smokefree Pledge. The Pledge is designed to be a clear and visible way for NHS organisations to show their commitment to helping smokers to quit and to providing smokefree environments which support them.

Joint Forward Plans

Joint Forward Plans (JFPs) sit alongside other strategic documents within Integrated Care Systems including Integrated Care Strategies, local authority Health and Wellbeing Strategies, and regional tobacco control strategies. Consequently, this analysis of JFPs provides only a partial view of ICBs' strategic commitments. Nonetheless, as JFPs are the core long-term delivery plans for ICBs, a quantitative assessment of the place of smoking and tobacco within them offers some additional insight into the importance of tobacco control to these organisations.

The length of the 40 JFPs studied ranged from 44 to 229 pages. All 40 JFPs mentioned smoking or tobacco at least once, with a range of mentions from 1 to 106.

Smoking was most often mentioned in discussions of population health, prevention and health inequalities. All 40 JFPs included a section describing their population health approach and all but one of the documents mentioned smoking in this context. The prominence of smoking in these discussions varied considerably. Some JFPs highlighted smoking as the leading cause of preventable deaths and a primary driver of health inequalities, whereas other JFPs only acknowledged smoking as one of the many issued to be addressed. This diversity is likely to have diverse causes ranging from the style and brevity of the documents themselves to the priorities of ICBs and their leaders and staff.

Some form of outcome goal for smoking was included in 36 JFPs (90%) including 14 (35%) where the goal was linked to a specific target. Goals were described for

population smoking prevalence, smoking prevalence among pregnant women, smoking prevalence in deprived communities, prevalence of households with a smoker, and smoking-attributable mortality. Nine JFPs specifically referenced the national smokefree goal of 5% smoking prevalence by 2030.

Operational goals for the delivery of smoking-related services were identified in 36 JFPs (90%). Most often, these related to the roll-out of NHS tobacco dependence treatment services. These services were mentioned in 34 JFPs (85%), of which 30 (75% of all JFPs) included an operational goal for the deployment of these services. Local authority smoking cessation services were mentioned in 26 JFPs (65%), of which 20 (50% of all JFPs) included an operational goal for these community services.

Wider tobacco control work was not often included in JFPs. Eight documents (20%) mentioned the role of wider tobacco control work such as public communication, tackling the illicit trade, or promoting smokefree environments. Only 3 JFPs (8%) described a full programme of wider tobacco control work.

Spending on tobacco dependence treatment services

Of the 39 ICBs that responded to the FOI request, 36 provided specific data on spending on tobacco dependence treatment services. Of these, 31 provided data for all three years from 2021/22 to 2023/24. The average spend per ICB for these 31 ICBs was:

- £457,154 in 2021-22
- £850,644 in 2022-23 (an increase of 86% on 2021-22)
- £934,876 budgeted in 2023-4 (an increase of 10% on 2022-23)

Table 4 shows the average spend per service type for the 15 ICBs that provided data by service type for all three years. The total average spend per year is lower for this smaller sample, due to the exclusion of some ICBs with large budgets from this sample because they did not provide data by service type. However, the overall pattern of change in spending is comparable to the change in the larger sample of 31 ICBs described above. Table 4 indicates that spending on tobacco dependence treatment services in acute mental health services declined between 2022/23 and 2023/24.

Table 4: ICB spending on tobacco dependence treatment services 2021/22 to 2023/24 by service type (data from 15/40 ICBs)

	2021/22	2022/23	Change on 2021/22	2023/24 budgets	Change on 2022/23
Acute inpatient	£199,451	£356,405	79%	£360,970	1%
Maternity	£47,399	£135,527	186%	£210,569	55%
Mental health	£49,091	£123,551	152%	£103,128	-17%
Total	£295,940	£615,483	108%	£674,667	10%

Discussion

Integrated Care Boards are only two years old. Given the extent of their responsibilities, and the pressure they have been under, it is encouraging that tobacco control was perceived to be a high or above average priority in three quarters (73%) of surveyed ICBs. This may reflect the prominence of tobacco control in the national policy debate following the announcement in October 2023 by the Conservative government of its smokefree generation policy and the addition funding for local authority stop smoking services. However, credit is also due to the many champions for tobacco control in leadership roles not only within ICBs but also within their wider partnerships across integrated care systems. Partnerships have been crucial to the roll-out of tobacco dependence treatment services and are the foundation of ICBs' wider tobacco control work, albeit still in its early stages in many ICBs.

The deadline for the full implementation of NHS tobacco dependence treatment services was 31st March 2024. At the time of the survey, two months earlier, 88% of respondents were confident of the full implementation of these services in maternity care by this deadline, and 73% were confident of full implementation in acute services, but only 54% were confident of full implementation in mental health services. This disappointing result for mental health is supported by the analysis of ICB spending on tobacco dependence treatment services which suggests that mental health was the only context where spending fell between 2022/23 and 2023/24. The funding for all tobacco dependence treatment services has, however, fallen significantly short of the original government projections.

The principal enabling factors for the roll-out of tobacco dependence treatment services were the dedicated funding and strong partnerships, and the leading inhibiting factors were long-term financial uncertainty and problems recruiting staff. A survey by ASH of members of the Smokefree NHS Network reported consistent findings from tobacco dependence treatment staff, 44% of whom identified workforce shortages as hindering implementation. They cited the following enablers of recruitment and retention: professional recognition, structured training, mentoring and CPD opportunities, opportunities to work more closely with community stop smoking services, opportunities for career progression, and permanent contracts (55% were on fixed term contracts)[5].

The roll-out of tobacco dependence treatment services was specified and scheduled in detail by NHSE but ICBs' wider tobacco control work was not. The importance of wider tobacco control to the core goal of improving population health is widely recognized, but different ICBs are at different stages in their development of this work. Each is finding its own way, drawing on local strengths as far as possible. Where regional tobacco control programmes already exist, ICBs have got up to speed rapidly. Where they do not, ICBs can take a lead in developing them with their many local partners. This is already happening in many areas and has the potential to transform the scale and range of tobacco control work in England.

[5] The ASH Smokefree NHS Survey was conducted online in February and March 2024. This survey was sent to all 750 members of the network; 252 responses were received, a response rate of 34%.

The NHS Confederation has drawn attention to the importance of ICB leadership for leading secondary prevention,[6] and has argued that 'ICBs can play a major role in winning the war on tobacco,' principally because of their key role in binding stakeholders together in partnerships with common goals.[7] It is encouraging that 90% of Joint Forward Plans include an outcome goal for smoking or tobacco. Given the scope of tobacco control, such goals are well-suited to the shared interests of integrated care systems at both system and place levels.[8]

The new Labour government is committed to ensuring that 'all hospitals integrate 'opt-out' smoking cessation interventions into routine care'.[9] In practice, this will require not only sustained funding of NHS tobacco treatment services but also of local authority community stop smoking services, given the importance of the latter to smokers following discharge from hospital. Now that ICBs and integrated care systems are established, the government has the means to foster a system-wide approach to tobacco control. This should include supporting smokers to achieve their goals in the settings that are most appropriate for them and ending the inequality in service provision between mental and physical health settings.

[6] Mahmoud H, Fagg M: Prioritising prevention policy in integrated care systems. NHS Confederation, June 2023,
[7] Bloor A, Symington S, Eames s: ICBs can lead the way to a smoke-free future. NHS Confederation, November 2023.
[8] DHSC: Shared outcomes toolkit for integrated care systems, October 2023.
[9] https://labour.org.uk/change/build-an-nhs-fit-for-the-future/