New paths and pathways

Tobacco control and stop smoking services in English local authorities in 2022

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Contents

Summary

Headlines

Not all smokers had access to stop smoking services in England in 2022 but most local authorities remained committed to supporting smokers to quit, especially smokers in high prevalence groups.

The impact of the roll-out of NHS tobacco dependence treatment services is yet to be felt in most areas but these services are likely to have a significant impact on community stop smoking services. They present an opportunity to create more comprehensive and integrated support for smokers.

The proportion of local authorities where tobacco control is perceived to be a high priority increased from 18% in 2021 to 33% in 2022.

Key findings for 2022

- One third of surveyed local authorities (33%) did not commission a universal specialist stop smoking service in 2022. Two did not commission any local support. Over half (54%) commissioned stop smoking support from pharmacists.
- The use of face-to-face advice had returned to pre-pandemic levels in 2022 (95% of surveyed local authorities now use this method) but many services also used remote methods such as telephone, text messaging and video conferencing.
- A majority of surveyed local authorities (52%) offered vapes or e-cigarettes to users of stop smoking services. They were provided directly or via vouchers or other arrangements with vape shops.
- Most surveyed local authorities (86%) were involved in the planning and roll-out of NHS tobacco dependence treatment services, though some local authorities were much more engaged than others. In some areas, local authorities were leading the implementation process.
- The impact of the NHS tobacco dependence treatment services on local authority stop smoking services is likely to be complex and variable across the country. Some local authorities reported an increase in demand, others a decrease. In most areas, impacts were yet to be felt.
- Many survey respondents were optimistic about the opportunity of the roll-out of NHS tobacco dependence treatment services to reach more smokers and to create a more integrated service across the NHS and community. However, some expressed concern that new NHS services could place a burden on community services that local authorities would struggle to meet.
- In the areas where lung health checks have been implemented, 73% of local authorities reported an increase in demand for community stop smoking services. None reported a decrease in demand.
- The role of Integrated Care Systems in advancing tobacco control work was well-developed in some areas but embryonic in others.
- Almost all surveyed local authorities remained committed to tackling inequalities and some had challenging performance targets for reaching high prevalence groups or communities. The leading target groups were pregnant

women, socio-economically disadvantaged areas, and people with mental health conditions.
- Three fifths of surveyed local authorities (59%) had a local tobacco alliance and 79% collaborated with other local authorities in their tobacco control or stop smoking work. Almost all were engaged in some form of wider tobacco control work.
- Tobacco control was perceived to be a high priority in a third of surveyed local authorities (33%), up from 18% in 2021. Alongside directors of public health, members for health and wellbeing remained important champions for tobacco control in local authorities.

Recommendations

Nationally, the UK Government should publish a comprehensive Tobacco Control Plan with ambitious proposals to further reduce smoking prevalence, including targeted investment for communities where smoking does the most harm, and a consultation on increasing the age of sale for tobacco products. Funding for stop smoking services and tobacco control work should be increased and secured through a 'polluter pays' fund, forcing tobacco manufacturers to pay for tobacco control without letting them influence how the funds are spent.

Regionally, Integrated Care Systems (ICSs) should work closely with local authorities to ensure that tobacco dependence treatment services are planned and delivered with due regard to the strengths and capacity of community stop smoking services. Partners in both the NHS and local government should grasp the opportunity to develop a more comprehensive and seamless offer to local smokers. ICSs should also lead an integrated approach to Lung Health Checks and a population health approach to reducing the health inequalities caused by smoking.

Locally, local authorities should continue to tailor their stop smoking services to vulnerable groups, offering behavioural support, medications and e-cigarettes where appropriate. Tobacco control alliances should be sustained or renewed to ensure strong partnerships with the NHS and the voluntary and community sector at a time of major change in local service provision.

Introduction

Nine years after responsibility for public health was handed to local government in England, most local authorities continue to support local smokers to quit while also pursuing wider tobacco control work to reduce the harm of tobacco on local communities. The many changes over these nine years have been described in detail by the annual survey conducted by Action on Smoking and Health with the support of Cancer Research UK, of which this report presents the latest findings for 2022.

The big change that is currently underway across England is the implementation of the commitment in the NHS Long Term Plan to provide tobacco dependence treatment services in acute, maternity and mental health services. This change is bound to have a profound effect on the stop smoking services commissioned by local authorities. This report describes some early impacts and explores survey respondents' hopes and fears of what the future may hold.

As always, there is great diversity in the experience of respondents to this survey. In some local authorities, tobacco control remains a high priority, services for smokers are extensive, and relationships with the NHS are excellent. But that is one end of a complex spectrum. This report seeks to represent this complexity, drawing repeatedly on respondents' accounts of their own experience.

The findings in this report suggest a variety of possible paths ahead for local authorities and the NHS, as new NHS stop smoking services develop and community stop smoking services respond. Future surveys will describe these emerging paths and the changing pathways to support for local smokers.

Methods

The survey was conducted online using Survey Monkey during September 2022. Tobacco control leads and other contacts in English local authorities were emailed a link to the survey and invited to complete it. Non-respondents were followed up by telephone. All 150 local authorities with public health responsibilities were approached: county councils, unitary authorities, metropolitan boroughs and London boroughs.

Completed surveys were received from 118 respondents providing data on 127 local authorities (85%). Eight respondents provided data on more than one local authority due to shared public health arrangements locally. The baseline for analysis and reporting is not consistent across the report as seven respondents did not complete all questions. For some questions, 'don't know' responses were also excluded from the reporting.

Many free-text questions were included in this year's survey. These questions sought to gain detailed information about new areas of experience such as the impact of the NHS Long Term Plan on local authority stop smoking services. The answers to these questions were subject to a content analysis in order to identify key themes and issues but were not quantified. Intelligence gained from these questions will be used to frame quantitative questions in future surveys.

Survey respondents

Most of the 118 respondents to the survey had portfolio public health roles that included tobacco control. Only 14 respondents (12%) gave all their time to tobacco control. Over half (53%) devoted less than half of their time to tobacco control. Table 1 describes respondents' other public health responsibilities.

Ninety-three respondents (79%) described their role as the tobacco control lead for the local authority, or the commissioner of stop smoking services, or both. The remaining respondents had a wide variety of roles including stop smoking service managers, consultants in public health, and public health specialists providing intelligence and support to the development of tobacco control strategies.

Table 1. Survey respondents' work responsibilities other than tobacco control

Topic	*Respondents (n=118)*
Healthy lifestyle services	56 (47%)
NHS health checks	52 (44%)
Healthy weight	47 (40%)
Drugs and/or alcohol	36 (31%)
Workplace health	27 (23%)
COVID response	23 (19%)
Mental health	20 (17%)
Sexual health	13 (11%)
Gambling	10 (8%)
Children/young people	17 (14%)

The offer to smokers from local authorities

Stop smoking services commissioned or provided by local authorities in 2022

Local authorities in England commission and provide a diverse range of support for smokers. Specialist stop smoking services remain the most common commissioned service: in 2022, 74% of surveyed local authorities commissioned or provided a specialist service. Stop smoking support from pharmacists, the second-most common form of support, was commissioned by over half of surveyed local authorities (54%).

Nine of the surveyed local authorities that commissioned a specialist service restricted this service to specific client groups. Overall, a universal specialist service was commissioned by 85 of the surveyed local authorities (67%).

Table 2 describes the services for smokers commissioned or provided by local authorities in England in 2022. The mix of services commissioned is described in Table 3. Some local authorities commission support from primary care and other NHS providers alongside a specialist service. For example, of the 85 surveyed local authorities that commissioned a universal specialist service, 65% also commissioned support in primary care. Of the 127 surveyed local authorities, one had no commissioned service for smokers and one offered only a regional telephone helpline.

Table 2 and Table 3 make plain the extent of local authority engagement with the NHS in meeting the needs of smokers. This relationship is long-standing. Figure 1 illustrates the changes in local authority commissioning of the three most common forms of person-to-person support over the last five years. Stop smoking support in primary care (from pharmacists and/or GPs) has been commissioned by the majority of surveyed local authorities over this period.

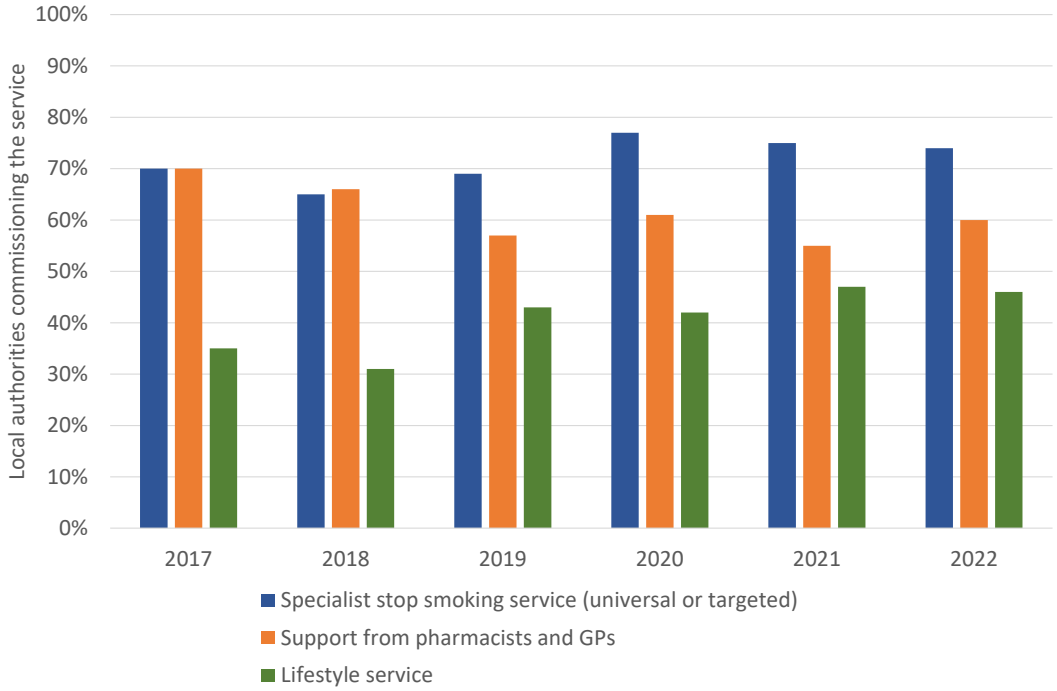
Table 2. Services commissioned or provided for smokers by local authorities in England, 2022

Commissioned services	*local authorities (n=127)*
Specialist stop smoking service (universal)	85 (67%)
Specialist stop smoking service (targeted)	9 (7%)
Support from pharmacists	69 (54%)
Integrated lifestyle service	59 (46%)
Support from GPs	56 (44%)
Telephone helpline	50 (39%)
Support from midwives	34 (27%)
Support within NHS acute services	30 (24%)
Support within mental health services	21 (17%)
Support within drug and alcohol services	25 (20%)
Support from health visitors	12 (9%)
Support from vape shops	9 (7%)
Support within prisons	3 (2%)
Web-based information	67 (53%)
Phone app	23 (18%)
No service	1 (1%)

Table 3. Mix of services commissioned or provided for smokers by local authorities in England, 2022

Primary service commissioned (exclusive categories)	*local authorities (n=127)*	*Additional services commissioned (% of this primary commissioned service)*		
		Pharmacists/ GPs	*Integrated lifestyle service*	*Other support in the NHS*
Specialist stop smoking service (universal)	85 (67%)	55 (65%)	33 (39%)	36 (42%)
Specialist stop smoking service (targeted)	9 (7%)	4 (44%)	3 (33%)	4 (44%)
Support from pharmacists/GPs	17 (13%)	-	9 (53%)	10 (59%)
Integrated lifestyle service	14 (11%)	-	-	6 (43%)
Telephone helpline	1 (1%)	0	0	0
No service	1 (1%)	0	0	0

Figure 1. Three leading forms of person-to-person support for smokers commissioned by local authorities in England 2017-2022



Methods used to provide stop smoking advice and support

The principal methods used to provide stop smoking advice and support in services commissioned by local authorities are described in Table 4 with comparative data for last year. The number of surveyed local authorities providing face-to-face advice has returned to its pre-COVID level.

Mobile phone apps were used as a method of providing stop smoking advice in 31 surveyed local authorities. Although stop smoking apps were commissioned in only 23 of these local authorities (Table 2), smokers were not required to pay for their apps anywhere.

The following apps were used within surveyed local authority stop smoking services:

- Quit with Bella (8 local authorities)
- My Quit Route (7)
- Smokefree app (7)
- The NHS Quit Smoking app (4)
- Best you (2)
- ORCHA (1)

Table 4. Methods used to provide stop smoking support and advice in services commissioned by local authorities, 2021-2022

Method	*Local authorities*	
	2022 (n=127)	*2021 (n=150)*
Telephone advice	122 (96%)	98%
Face-to-face advice	121 (95%)	83%
Text messaging	80 (63%)	75%

Video conferencing	65 (51%)	60%
Email	50 (39%)	47%
Mobile phone apps	31 (24%)	40%

Nicotine replacement therapy

Dual-form NRT (nicotine replacement therapy) was provided to smokers in 95% of surveyed local authorities (n=112). Only one local authority offered single-form but not dual-form NRT. Overall, 77% of surveyed local authorities offered a full 12-week course of dual-form NRT and 18% offered a part course.

E-cigarettes and vaping

Just over half of surveyed local authorities (52%) provided e-cigarettes or e-liquids to smokers through the services they commissioned or provided in 2022. This is up from 40% in 2021 and 11% in 2019. Of the service that provided e-cigarettes, 58% supplied e-cigarettes directly to clients. The remainder relied on relationships with local vape shops to supply the products. Smokers were variously given vouchers or codes to be redeemed in vape shops, or orders were sent to the shops, or the shops invoiced the service. One respondent described a semi-autonomous service run by the vape shops.

> *Similar to a voucher scheme. The patient is sent a unique code to redeem with selected local vape shops to collect their device. [London borough]*
>
> *The vape supplier receives orders and distributes direct to the smoker. [County council]*
>
> *The vape shop provides them directly to clients and vape shop invoices us. [London borough]*
>
> *We use Quit Manager to manage clients. Clients just sign up in store and that's it. Each client that signs up and sets a quit date, we pay the store £25 which is spent on the client. Each client has a Quit Manager reference so a client will be blocked at another venue if they attempt to misuse the service. [Unitary authority]*

Although vape shops were principally used to supply e-cigarettes to smokers, other functions were identified by respondents. Nine local authorities commissioned vape shops to provide stop smoking advice to local smokers (in addition to other commissioned support). Training went both ways: while some stop smoking services had trained vape shop staff in level 2 advice, others had received training from vape shops about e-cigarettes and the complex range of vaping options available. Stop smoking services had also built relationships with vape shops to encourage referrals into the service for smokers who wanted to quit. The involvement of trading standards in monitoring vape shops was also identified by survey respondents.

Of the 52% of local authorities that provided e-cigarettes to smokers, directly or indirectly, three quarters (76%) made their offer to all adult smokers. Between them, the local authorities that restricted their offer of e-cigarettes targeted pregnant women, people with mental health conditions, staff, homeless people, smokers who had failed with other methods, and people living in social housing. Although four

respondents identified pregnant women as a target group, a further two respondents reported that e-cigarettes were available to all adults *except* pregnant women.

All survey respondents were asked if there were any obstacles to the provision of e-cigarettes or vapes by their stop smoking service. Overall, 49 (45%) said there were and went on to describe a wide range of issues. The most common problems concerned the unlicensed nature of the products and, in some cases, related problems with insurance:

> *They are not licensed - we have had some questions over liability if something happens to the patient in the longer term i.e. provider has struggled to get insurance to provide them. Capacity to properly look at this and put a process in place. [County council]*
>
> *Both the providers and the commissioners would prefer to prescribe a regulated product with more specific guidelines around where and which e-cig should be recommended for use. [County council]*
>
> *A provider recently withdrew from a contract offer to provide e-cigarettes for a 3-year project which is being piloted with our main social housing provider. The company withdrew as they were unable to secure affordable Public Liability Insurance - they said that a lot of insurance companies had withdrawn policies for vaping companies. [Metropolitan borough]*
>
> *We had an issue getting insurance for the scheme - but then the provider managed to do this - but it took a bit of time. [County council]*

Specific concerns about the suitability of e-cigarettes for use by stop smoking services were also cited, particularly the lack of long-term evidence about the impact of vaping and the rise in use of e-cigarettes by children and young people.

> *In spite of the Khan review, PHE and NICE guidance, there is a reluctance at senior leadership level to directly fund any vaping provision as a quit aid due to what is felt to be a lack of evidence about the long-term impact of vaping, concerns about people continuing to smoke while they vape and vaping in the long-term and also concerns about young people then seeing it as harmless and it potentially being a gateway to smoking in the future. There is an acceptance that stop smoking services should talk about vaping as an option in supporting a quit attempt but people would have to find these themselves unlike NRT. [Metropolitan borough]*
>
> *Executive elected member and other senior public health officers are not supportive of using vapes. This is on the basis of harm to children and young people and conflicting evidence papers. [Metropolitan borough]*
>
> *Recent growing concerns about the use of illicit vapes and underage use have resulted in our local stop smoking service taking a cautious approach and moving away from the option of dispensing e-cigs via service. Having said that, the service continues to offer support for smokers that wish to quit smoking using e-cigarettes. [Metropolitan borough]*

In a few instances, lack of support within the council, or outright opposition, were identified as the principal obstacles to the use of e-cigarettes within stop smoking

services. Some respondents were more positive but described being held back by the lack of an agreed policy position within the council.

> *We are currently working on a vaping position statement and this will be discussed at the Local Tobacco Control Alliance. We recognize the benefits of using e-cigs but the priority for last year has been around service improvement and delivery. [Metropolitan borough]*

Other obstacles identified by respondents were funding constraints, the ongoing impact of COVID, uncertainty about the use of e-cigarettes by pregnant women, supply problems, diversity of practice across integrated care partnerships, and client beliefs that vaping is more harmful than smoking.

Working with the NHS

Local authority involvement in the planning of NHS tobacco dependence treatment services

Most surveyed local authorities (86%) were involved in the planning of NHS tobacco dependence treatment services. Many of the respondents to the survey sat on planning and implementation groups, including groups at ICS, CCG and NHS Trust level. In some areas, the local authority contribution went beyond participation in planning groups to detailed involvement in delivery or even overall leadership. In other areas, however, respondents felt that the level of local authority involvement was inadequate. Table 5 illustrates the variety of experience among survey respondents.

Table 5. Forms of local authority involvement in the planning of tobacco dependence treatment services

Level of involvement	*Examples*
Planning led by local authority	*Public Health colleagues across the locality have been the driving force for the NHS TTD programme, leading on pathways, interventions, recruitment of staff, budgets, data collection and reporting, with a significant amount of time spent on trying to engage with NHS leads to roll out the programme within their Trusts [Unitary authority]*
	Project managers for each area of the Long Term Plan (aside from mental health) are employed by the local authority. The LA chair a steering group which oversees the implementation and delivery of all Long Term Plan services, in partnership with NHS and other relevant authorities. [City council]
High level of local authority involvement in planning and delivery	*Involved in multi-agency steering group, task-and-finish groups, directly delivering services (community Serious Mental Illness), providing ad hoc professional support and advice to NHS colleagues [Unitary authority]*
	We are involved via the ICS tackling tobacco dependency workstream and have been working to recruit clinical leads and stop smoking advisors within

	the acute, mental health and maternity trusts. [Unitary authority]
Close local authority involvement in planning and partnerships	*Working at regional and sub regional level with foundation trusts and other local authorities and providers to ensure that the community offer supports and aligns with the NHS offer. [City council]*
	We are active members of the steering group led by the ICS lead. We are also on the task and finish groups for each of the two areas established (maternity & mental health) and there are plans to include us on the acute group when established. [County council]
Limited local authority involvement	*Input into development of specification for service and in shaping our smoking in pregnancy services but would benefit from having more involvement [Metropolitan borough]*
	There is little involvement, however the service is involved to ensure pathways into community are linked - which is a concern with the current set up from the secondary services. [London borough]
Local authority bypassed	*We were involved in conversations re the design of maternity-based services, based on several years of developing a local pathway with maternity. The Local Maternity and Neonatal System by-passed public health to get their preferred model implemented within maternity. This was frustrating as it undermines several years of local systems working to address barriers in local maternity pathway and we are concerned that will end up making same mistakes. The acute trust has been difficult to engage in the discussion and have other pressures within the trust and are not intending to start in-patient tobacco dependency work until 2023/24. [County council]*

NHS tobacco dependence treatment services: impacts, opportunities and threats

A majority of respondents to the survey were not aware of any impacts on local stop smoking services from the implementation of NHS tobacco dependence treatment services beyond the demands on officer time of the planning process, described above. This was principally because local roll-out was at too early a stage to have had any substantial impacts on service delivery.

Sixteen respondents reported a change in referrals to their stop smoking service, of whom ten described an increase in referrals and six described a decrease. Increases in referrals were primarily due to the rise in smokers seen in acute services and then discharged to the community. Decreases in referrals had more diverse causes including new stop smoking support in NHS maternity services, diversion of patients to new advanced pharmacy services, and a decline in mental health referrals.

In most areas, the impact of new NHS tobacco dependence treatment services on demand for community stop smoking services was a big unknown. New demand was widely perceived to be both an opportunity and a threat. A common concern was that any increase in footfall to community services could put pressure on capacity and funding. The following example illustrates this tension:

> *The NHS pathway to the LA Stop Smoking Service is being finalised. Already the referrals to our service have increased. This is both an opportunity and a threat. As the funding available to NHS trusts for these services does not cover enough staff to be able to treat all smokers presenting in hospital, the pathway will rely on the LA-funded Stop Smoking Service to a great extent to pick up those smokers. While the local service welcomes an increase in referrals from hospitals, there is a risk of it being overwhelmed with the numbers of referrals continually increasing as the programme becomes embedded. [London borough]*

The potential for new stop smoking support within the NHS to reduce demand for community stop smoking services was also perceived both as an opportunity and as a threat. Changes to pharmacy and maternity services are key factors which are likely to have different impacts in different locations. In the following example, they were both perceived as threats:

> *Our acute provider referrals have dropped massively over the last quarter as a net result of the acute unit starting to refer clients into pharmacy services rather than community stop smoking services. We currently have no ways of identifying how many clients are being cared for by this route or how many quit dates set/4 week quits are being achieved so cannot include on our data returns. The directive in the NHS Long Term Plan that maternity services should be provided end to end in house would necessitate undoing a lot of strong work that has been done in partnership over the last 5 year and resulted in a significant drop in our SATOD figures [City council]*

In contrast, in the following examples, new pharmacy and maternity services were perceived as opportunities to reach more smokers in need:

> *The Pharmacy Smoking Cessation Service, part of the NHS LTP, is seen of as an opportunity as it gives residents more choice and if inpatients can access this service the commissioned service could undertake more targeted work in under-represented populations with high smoking rates. [Unitary authority]*

> *There are opportunities to reach more smokers especially with the expansion of the midwifery in house offer in the county. This has also given us much better access to mental health partners and acute who have been tricky to pin down in the past. [County council]*

In the former example, the Long Term Plan frees up capacity to pursue more targeted work; in the latter, new relationships with the NHS enable greater access to smokers in need. Either way, access to services for the whole local population of smokers improves.

Exactly how these factors play out locally is likely to depend on the strength and quality of the relationships between local authorities and their NHS partners. This issue dominated respondents' descriptions of opportunities: 40 respondents identified

improvements in relationships and communication and greater service integration as opportunities of the roll-out of NHS tobacco dependence treatment services. For some, closer collaboration and the integration of services offered a big opportunity to deliver better outcomes for local smokers:

> *Increased opportunities for developing quality streamlined pathways from acute to community, with better outcomes for patients. Improved relationships with acute and community services. [County council]*

> *More collaborative working with our local NHS trusts to help reduce smoking prevalence in those with the highest needs. Potential for data sharing, including uptake and outcomes. Evaluation of services and where improvements are needed. Cross city consistency in offer and delivery of treatment service. [Unitary authority]*

An integrated view of services for smokers across local authorities and the NHS sits well with a population view of smokers' needs. Some local authorities were already rethinking their own services to realise the opportunities of a fully integrated approach in partnership with the NHS:

> *We are currently in the process of re-tendering the community service and have reverted back to an exclusive tobacco dependency service rather than being part of an integrated healthy lifestyle service. The community service will be a key element of the emerging integrated tobacco dependency service for the city along with NHS partners. [City council]*

> *We are considering how we might be able to co-commission tobacco services moving forward. It has increased membership and collaboration across our Tobacco Control Alliance. We are considering where the ICS tobacco steering group will sit in the system and whether we can link that with the TCA. [County council]*

The journey towards a fully integrated approach may, however, take some time. There are likely to be many problems on the way. Respondents identified the following threats:

- capacity and cost pressures
- problematic relationships with the NHS
- disruption to established pathways and services
- workforce challenges
- confusion for users
- monitoring and reporting problems

Table 6 illustrates this range of threats. Even where problems are addressed and plans put in place, the risk remains that implementation will present a new slew of difficulties or unexpected outcomes, as in the following examples:

> *Referrals are high but not always appropriate and the pathway has not been followed correctly by secondary care - leading to significant impact on CSSS in sorting out referrals rather than just picking up transference of care. [City council]*

> *Some pharmacies in local area have not signed up to the advance pharmacy programme, resulting in a reliance on LA stop smoking service. Inconsistent*

offer of support/treatment across localities. Issues around data sharing and demand for extra work to share data and report back. [Unitary authority]

Primary care activity on smoking cessation has declined significantly and pharmacy stop smoking support has also reduced significantly so most referrals going to our specialist service (embedded within integrated lifestyle service) [Unitary authority]

Finally, there are longer-term threats associated with the funding of NHS tobacco dependence treatment services:

There is a concern as to the future of recurrent funding for the NHS Tobacco Dependency services and so time and resources are being spent developing these services with the very real risk that they will be scaled back once the LTP funding has ended as NHS Trusts are unable to match the suggested model to the funding envelopes provided to ICS's and NHS Trusts. There is also a perception from senior public health colleagues that the NHS is now funding Stop Smoking Support and so there is pressure that funding can be moved either into Tobacco Control programmes that are not service provision, or be diverted to other public health programmes and fund Agenda for Change pressures on other public health commissioned services. [London borough]

Table 6. Threats to local authority stop smoking services of the roll-out of NHS tobacco dependence treatment services

Threats	*Examples*
Capacity and cost pressures	*Risk that community services cannot cope with referrals or have long waiting lists if there is a large increase in smokers identified and referred who take up the offer of support. NRT costs to local authorities will also increase significantly for ongoing support [Metropolitan borough]*
	Potential to increase referrals and costs associated with more cases and the increased costs of prescribing. NHS services may not comply with the formulae that we have locally for NRT and other products. [City council]
	Expecting increased costs from increase TTD referrals and NRT costs - if this can't be absorbed by the service current finances we will need to redesign service to offer more targeted service and hence remove the current universal access for all smokers [County council]
Problematic relationships with NHS	*The NHS approach to supporting roll out of the long-term plan at a place and system level has been clumsy. Local place-based working led by public health, including LSSS, only works well when stakeholders have good relationships. The NHS are working in a silo from national to regional through to local level without consideration or understanding of the importance and nature of systems thinking. [County council]*
	Negotiation as equal partners in the planning and delivery of Stop Smoking support has been difficult - NHS processes took over that don't support partnership working. [Metropolitan borough]

Disruption to established pathways and services	*Pre-existing system is working well, potential disruption to how this will work together if not planned effectively. [City council]*
	Too many referrals to cope within our capacity and destabilises the pathways we already have in place [Metropolitan borough]
	This has been a traumatic experience and more difficult than it should have been to stitch together and deliver the service by the LA commissioner. Having services that don't fit completely within the current system or when duplicate services are developed undermines the whole of the tobacco control programme and our ability to deliver patient-centred care effectively. [City council]
Workforce challenges	*The biggest concern is loss of experienced Stop Smoking Advisors to the NHS TDT services where higher salaries are available. We are already losing very experienced advisors and there are limited specialist advisors that can fill the vacancies left behind. [London borough]*
	NHS providers in the system offering similar jobs, different salary bands, potential workforce pressures. [County council]
Confusion for users	*The variety of pathways available to patients could be confusing, which could risk exacerbating health inequalities. [City council]*
	Clients starting quit attempts elsewhere. Mixed messaging around services in hospital and locally. [Metropolitan borough]
Monitoring and reporting problems	*We have been told that certain clients will not be able to be submitted in our Department of Health return (smokefree for longer than 14 days), this is impossible based on our current system, but even if it was possible it would mean the service setting fewer quit dates and not hitting target. [Unitary authority]*
	Could affect our ability to report data accurately as systems are likely to be using our database and we are likely to be helping to fund NRT costs which will affect cost per quitter reporting. [Unitary authority]

Lung Health Checks

The NHS Lung Health Checks programme is being gradually rolled out across England. At the time of the survey, Lung Health Checks were live in the 23 areas of the first two phases of the programme and in some of the areas of the third phase.

Eighteen survey respondents represented local authorities covering areas in the first two phases of the Lung Health Checks programme. Three of these respondents did not know that Lung Health Checks were live in their local authority area. Of the 15 respondents who knew about the local programme, 11 (73%) said that the programme had had an impact on stop smoking services commissioned by their local authority. When asked to describe this impact in their own words, every one of these 15

respondents cited additional referrals to their local stop smoking service. However, the size of this impact varied considerably:

> *The service has seen a large increase in referrals as a result of the lung health checks programme especially from smokers who have not previously accessed the service before - which is positive [Unitary authority]*
>
> *There has been a significant increase (15-17%) in the number of referrals received by the community stop smoking service [City council]*
>
> *Some referrals into the Wellness Service [Metropolitan borough]*
>
> *A low number of referrals into service have been received [City council]*

One respondent went further and described how the process of referral had been improved:

> *Significant increase in referrals from Lung Health Checks. The process of referrals has been streamlined - the service previously received 'batches' of referrals, this has now been changed to a continuous stream of referrals which has improved service take up. There is good evidence of close collaboration between our stop smoking provider and the Lung Health Check provider [city council]*

The third phase of the Lung Health Check programme was still in its initial stages in most areas at the time of the survey. However, five survey respondents were able to identify impacts of the programme. Once again, all cited an increase in referrals to the community stop smoking service. One respondent gave more detail about the local authority's engagement with the programme:

> *The service has been involved in supporting the Lung Health Checks in specific areas. Training has been made available to support VBA. A URL link has been made available to enable the service to monitor referrals and report on outcomes. [County council]*

Other work with the NHS and integrated care systems

Although the roll-out of the NHS Long Term plan was taking up a great deal of respondents' time and energy, it was not the sole focus of local authority engagement with the NHS. Respondents were invited to describe any other collaborative work on tobacco control with the NHS and integrated care systems. Their responses included:

- working directly with hospital wards and departments to improve patient pathways and support
- joint tobacco control programmes
- multi-agency smokefree pregnancy partnerships
- training NHS staff and supporting them to quit
- specific projects investigating and addressing local inequalities
- joint campaigns and communications
- shared information, learning and problem-solving
- setting up an NHS leadership group to address CVD through action on tobacco
- a vaping pilot on a respiratory ward
- developing healthy living hubs

The role of integrated care systems in advancing tobacco control work beyond the specific requirements of the NHS Long Term Plan was well-developed in some areas but embryonic in others. Table 7 illustrates this diversity with accounts ranging from a fully-implemented, wide-ranging approach through formative planning to minimal engagement.

Table 7. Examples of integrated care system action on tobacco

Type of action	*Examples*
Wide-ranging action in partnership	*The ICS works very closely in tackling health inequalities and a strategy has been produced where smoking has been identified as a priority. NHS and LA comms work in partnership for stop smoking campaigns such as Stoptober and No Smoking Day. Some LAs within the ICS contribute to commissioning an illegal tobacco post that works across the region and teams work collaboratively to tackle illegal tobacco and counterfeit products such as puff bars/elf bars/vapes being sold illegally to children and young people. The local maternity teams work very closely and specialists midwifes and support workers often share best practice or work on addressing challenges as a system. All LAs are contributing to a Sector Led Improvement Programme on Smokefree Homes and enhancing the pathway between maternity and health visitors to sustain quits achieved during pregnancy, trigger a quit attempt postnatally and advocate for a smokefree home for new parents. The local Making Every Contact Count (MECC) strategy to support behaviour change conversations is also delivered as an ICS and trainers have been identified from local NHS Trusts and trained by LA staff to help embed MECC within their organisation and to sustain training for all staff. Public Health Specialists and Consultants from across the ICS meet regularly to share learning / challenges / actions on tobacco control and to identify opportunities to collaborate and avoid duplication of work. [City council]*
Planning wider tobacco control work	*Attend the ICS Tobacco Programme board, which is also chaired by the consultant in public health. Looking at wider programmes of work across the LAs within the ICS footprint, e.g. Illicit tobacco [City council]*
Not engaged	*The ICS still doesn't seem to know its remit or what it is trying to do and seems to have non-experts leading on key topic areas which is concerning [Metropolitan borough]*

Tackling inequalities

Target groups and populations

In almost all surveyed local authorities, high prevalence groups or populations were targeted by local stop smoking services (Table 8). A quarter (25%) of local authorities targeted between zero and four groups and 75% targeted five to nine groups.

In some local authorities, this targeting was supported by key performance indicators relating to the profile of service users or smoking quitters, as in the following examples:

> *A minimum of 65% of all clients supported by the community stop smoking service should be routine & manual workers or unemployed [City council]*
>
> *60% of those that smoke need to come from IMD 1-4 [London borough]*
>
> *At least 30% of four-week quits should be achieved by the following target groups: pregnant women, routine & manual workers, people with mental health conditions [County council]*

The methods used by local authority stop smoking services to target people with mental health conditions and people who live in social housing were quantified in this year's survey (Table 9 and Table 10).

Table 8. High prevalence groups or populations targeted by local authority stop smoking services (n=120)

Target groups	*Local authorities (n=120)*
Pregnant women	106 (88%)
Socioeconomically disadvantaged/low-income areas	100 (83%)
Routine and manual workers	95 (79%)
People with mental health conditions	87 (73%)
People with acute or long-term conditions	71 (59%)
BAME communities	54 (45%)
Residents of social housing	49 (41%)
Post-partum women	38 (32%)
LGBTQIA+ communities	23 (19%)
Other	20 (17%)
None of the above	3 (3%)

Table 9. Methods used to reach people with mental health conditions (n=87)

Methods used	*LAs targeting people with mental health conditions (n=87)*
Improving referral pathways for people with mental health conditions	58 (67%)
Training mental health trust staff to deliver behavioural support and brief advice	56 (64%)
Providing specialist stop smoking support within mental health services	33 (38%)
Adapting/tailoring stop smoking support to people with mental health conditions	45 (52%)
Targeting communications to reach people with mental health conditions	24 (28%)

Table 10. Methods used to reach people living in social housing (n=49)

Methods used	*LAs targeting people living in social housing (n=49)*
Training housing staff in very brief advice	32 (65%)
Including tobacco control messaging in communications to residents	20 (41%)
Delivering stop smoking services on-site	18 (37%)
Targeted provision of e-cigarettes	12 (24%)

Reaching smokers in high prevalence communities or populations

Survey respondents were asked to describe in their own words the factors that enabled their local authority to reach smokers in high prevalence communities or populations. The following is a summary of their responses:

- intelligence about local communities and needs
- working in partnership across the local community
- embedding support in services close to communities including primary care, maternity services, drug and alcohol services, social housing providers, and vaccine providers
- service outreach to communities, deprived areas and community events
- providing support in work-places
- effective referral pathways
- training professionals and community champions in VBA and MECC
- tailored and targeted advertising and promotion including social media
- remote support online or by phone
- e-cigarettes
- national campaigns

Table 11 illustrates these factors with examples from respondents' own accounts. Working in partnership is identified as one of the key factors enabling local authorities to reach smokers in high prevalence communities and populations. It is also a theme which cuts across the examples in Table 11. Some respondents described their approaches to tackling inequalities in detail. Each of the following three examples has a different focus but they all emphasise the importance of partnerships and of working with organisations and professionals that have reach into populations with high smoking prevalence:

> *Presence in pharmacies, GP surgeries and maternity services across the borough. Engaging with the voluntary sector, community hubs and other commissioned services. MECC training is delivered by our service provider. Digital and social media presence with culturally appropriate messaging. Seamless referral from the healthy lifestyles service to the smoking cessation service. Attend community events. [London borough]*

> *We have high deprivation rates. Ward data and support from public health analysts has helped the service to target and prioritise some residential estates/areas. The service can also access routine and manual smokers via the workplace programme delivered by colleagues in the Health Improvement Team. Good partnership working takes place between colleagues such as Health Trainers and Health Check Officers who will refer internally into the*

service. Good partnership working with Drug and Alcohol services and CAB as well as GPs, pharmacies, midwives, family nurse partnerships, and respiratory health teams to encourage referrals into the service. [Unitary authority]

Regional partnerships & transformation programmes (such as the smokefree pregnancy programme in North Central London); national programmes (secondary care); clinical leadership (e.g. mental health and COPD); local partnerships with community and voluntary sector; proactive targeted outreach (e.g. routine and manual workplaces; community and faith groups); targeted bespoke communications work (although impact is hard to define). [London borough]

Table 11. Factors enabling local authorities to reach smokers in high prevalence communities or populations

Enabling factors	*Examples*
Intelligence about local communities and needs	*Good quality needs assessments to identify where these communities are; robust, targeted service delivery; multi-agency working; engaging with key groups e.g. social housing provider [City council]*
Working in partnership across the local community	*Partnership working, especially with community partners such as community and voluntary sector organisations and housing associations [County council]*
Embedding support in services close to communities	*Delivery of services in areas of high deprivation via community pharmacies and within substance misuse treatment services [Metropolitan borough]*
Service outreach to communities	*Placing the service at heart of communities and also delivering more sessions by phone as well as the delivery from the city centre market stall [City council]*
Providing support in work places	*Proactively seeking routine and manual workers and delivering onsite at suitable work-places and delivering from specific localities where there is known to be high prevalence. [City council]*
Effective referral pathways	*Strong links with GP practices to ensure high prevalence areas have easy access to local clinics and strong referral programmes with local practices. We also work closely with our Maternity providers to ensure strong referral programmes. [London borough]*
Training professionals and community champions in VBA/MECC	*Development of partnerships and pathways, we have also trained 19 Smoking Cessation Community Champions to embed a MECC approach and provide VBA. [Unitary authority]*
Tailored and targeted advertising and promotion	*Targeted social media campaigns, community outreach clinics, use of GP Text messaging systems [County council]*
Remote support online or by phone	*Our smoking provider is purely remote, which has seen a higher engagement of people. Specific*

	webinars are held for target groups, e.g. pregnancy [County council]
E-cigarettes	*E-cigarette offer and a dispersed model to utilise local partnerships and organisations [Metropolitan borough]*
National campaigns	*Removing barriers to accessing service e.g. offering remote support through video conferences. Mobile clinic. Campaigns like Stoptober. [County council]*

Respondents were also asked to describe in their own words any factors that inhibited their efforts to reach smokers in high prevalence communities or populations. Their responses were dominated by two issues: the lasting impact of the COVID pandemic and a lack of capacity, resources or time. The following factors were also reported:

- problems with support and referrals in primary care
- poor data about, or understanding of, specific communities
- community norms and willingness to engage
- language issues
- a loss of face-to-face support
- the lack of national campaigns

Table 12 illustrates these inhibiting factors with examples from respondents' own accounts. COVID has had many adverse effects including diverting resources and staff, preoccupying primary care, disrupting services, reducing face-to-face support, and broadly setting back programmes of outreach and engagement.

The post-COVID changes to how stop smoking support is delivered appear in both Table 11 and Table 12. Remote methods such as telephone and online support were valued as opportunities to reach people who cannot easily access face-to-face support, but face-to-face support remained important in the wider task of engaging with marginalised communities or vulnerable individuals.

Table 12. Factors inhibiting local authorities' efforts to reach smokers in high prevalence communities or populations

Inhibiting factors	*Examples*
Lasting impact of COVID	*Covid 19 significantly impacted on access to community venues previously used to deliver services, such as children centres. Subcontractors e.g. GPs and pharmacies are still not delivering services to the levels they were pre Covid. [County council]*
Capacity and resources	*The community stop smoking budget has not been increased once in the last 7 years - lack of additional investment as salary costs rise puts additional pressures on capacity to deliver interventions that could proactively reach high prevalence communities. [City council]*
Problems with support and referrals in primary care	*Increasing pressures/ challenges in GP practices and community pharmacies which result in a*

	reduced smoking cessation offer by these providers [London borough]
Poor data/understanding of specific communities	*Lack of time, resource and a lack of understanding around why these cohorts are not accessing local stop smoking services. We need more community engagement / insights/intel into barriers for communities [City council]*
Community norms and willingness to engage	*Distrust in the council and public system and the reluctance to enrol in any lifestyle service provided by the council. [London borough]*
Language issues	*Advertisement of service is only in English, Quit with Bella App is only in English. [City council]*
Lack of face-to-face support	*Impact of the pandemic removing most opportunities for face-to-face engagement with communities, especially those individuals who are digitally excluded. [City council]*
Lack of national campaigns	*Comms not always consistent across organisations/lacking altogether. Lack of national campaigns [City council].*

Wider tobacco control work and alliances

Almost all surveyed local authorities were engaged in some form of wider tobacco control work such as tackling illegal tobacco, running campaigns, and enforcing age of sale, point of sale and smokefree legislation (Table 13). However, the decline in some areas of this work between 2019 and 2021, largely due to COVID, has not been reversed.

Seventy surveyed local authorities (59%) had a local tobacco alliance or partnership at the time of the survey, up from 54% in 2021, and 94 (79%) reported that they collaborated with other local authorities in their tobacco control or stop smoking work.

Table 13. Wider tobacco control work undertaken by local authorities, 2012-2022

	2022 (n=119)	*2021 (n=126)*	*2019 (n=117)*
Tackling illegal tobacco	103 (87%)	86%	91%
Communications and campaigns	102 (86%)	85%	88%
Enforcing legislation (age of sale, point of sale, smokefree)	99 (83%)	82%	87%
Smokefree public spaces	68 (57%)	56%	62%
Smokefree homes	49 (41%)	39%	44%
Regional support/action	47 (39%)	39%	48%
Research	14 (12%)	13%	21%
None of the above	2 (2%)	4%	3%

Priorities and champions

Respondents to the survey were asked how they perceived the priority given to tobacco control in their local authority. In a third of surveyed local authorities (33%), tobacco control was perceived to be a high priority (Figure 2). It was perceived to be a low priority in only four local authorities. Respondents to this year's survey were much more positive overall than in 2021 when only 18% felt that tobacco control was a high priority (Table 14).

Respondents were also asked to identify who, in their opinion, championed tobacco control in the local authority. The Director of Public Health was identified in most local authorities (84%) and the Member for health and wellbeing in 59% (Table 15). Other champions described by survey respondents were:

- consultants in public health and other public health officers
- trading standards and environmental health officers
- service commissioners
- stop smoking and community wellbeing teams

Figure 2. Perceived priority of tobacco control in local authorities

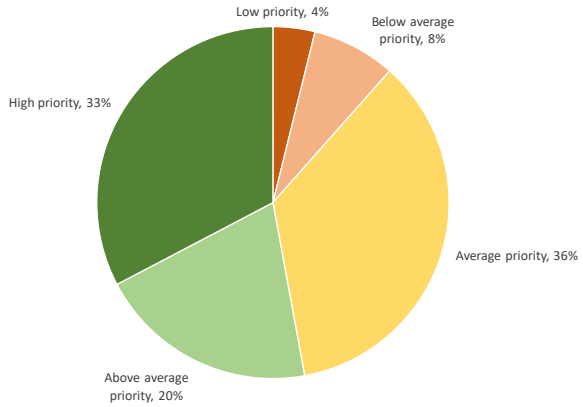


Table 14. Perceived priority of tobacco control in local authorities: 2022 vs 2021

Perceived priority	*2022 (n=104)*	*2021 (n=114)*
High priority	33%	18%
Above average priority	20%	23%
Average priority	36%	41%
Below average priority	8%	16%
Low priority	4%	2%

Table 15. Tobacco control champions in local authorities

Champions	*Local authorities (n=107)*
Director of Public Health	90 (84%)
Member for health and wellbeing	63 (59%)
Council leader	18 (17%)
Chief Executive	15 (14%)
Director of Communications	13 (12%)
No-one	5 (5%)

Discussion

The findings in this report are based on survey responses from 85% of the local authorities in England that have responsibility for public health. This high response rate underpins confidence in the findings. Some of the local authorities that did not respond may have had few or no services for smokers but the overall picture is likely to be accurate. Twice in the past decade a 100% response rate has been achieved for this survey. On each occasion the service profile of the initially non-responding local authorities was not significantly different from that of the local authorities that responded[1].

The 2022 survey explored the experience, expectations and concerns of local authority officers at an early stage of an important period of change. The roll-out of new services for smokers within the NHS, as required by the NHS Long Term Plan[2], presents opportunities for stakeholders across the NHS and local government to create a more extensive and integrated offer for local smokers. Yet there are evidently significant threats as well. The most common impact to date has been an increase in demand for community stop smoking services, which has come with no attendant increase in funding. In some areas, however, demand was reported to have fallen. The resilience of local authority stop smoking services is likely to be tested once again as the roll-out gathers pace.

Although a majority of local authorities (86%) had been involved in the planning of the new NHS services, this involvement varied widely. Some survey respondents were unhappy about how established services had been disregarded by the NHS, while other local authorities were leading the planning and implementation of the new services. There has never been a more important time for communication, co-operation and partnership between the NHS and local government. At a local level, Tobacco Control Alliances have long been a locus for such partnerships, but there are now new partners to engage, especially NHS trusts.

Integrated Care Systems (ICSs) have an important role to play as they fund and oversee the roll-out of local tobacco dependency treatment services. They ought to enable communication between local partners to ensure that the roll-out of tobacco dependence treatment services is not only consistent across local authorities but also complementary and supportive to existing services. The findings from this study suggest that the experience of local authorities in engaging with ICSs and is extremely diverse, principally because some ICSs have progressed strategically and operationally much faster than others.

The delivery model for tobacco dependence treatment services published by the NHS identifies 'local authority engagement and cross-organisational pathways' as an 'essential measure of success'[3]. This engagement should, however, go beyond the creation of seamless pathways between services to a wider strategic consideration of how a joint approach can deliver population outcomes, driving down smoking

[1] ASH and CRUK: *Reaching out, Tobacco control and stop smoking services in local authorities in England, 2021*
[2] National Health Service: *The NHS Long Term Plan*, 2019
[3] NHS England and NHS Improvement: *Tobacco dependence treatment services: delivery model*. July 2021

prevalence and health inequalities. Smoking cessation is acknowledged by the NHS to positively impact all five of the key clinical areas of health inequalities within the CORE20PLUS5 inequalities framework[4].

If ICSs are struggling to articulate and act on the task of reducing health inequalities[5], they would do well to draw on the experience of local tobacco control professionals, who have wrestled with this challenge for many years. In 2022, almost all stop smoking services targeted groups where smoking prevalence remains high. This is a diverse population, ranging from people living in deprived areas and social housing to people with mental health, acute or long-term conditions. The scope and complexity of the task for tobacco control professionals helps to illuminate the scale of the wider task of reducing health inequalities at a population level.

Local authorities in England have faced, and continue to face, significant funding challenges. Since 2015/16, cuts in the public health grant and other pressures have resulted in a 41% real terms decline in local authority spending on stop smoking services and tobacco control[6]. In some local authorities this has resulted in the diminution or even disappearance of stop smoking services. Nonetheless, this report reveals that the great majority of local authority decision-makers understand the impact of smoking on the health of their local populations and continue to invest in stop smoking services and wider tobacco control work. It is encouraging that a third of survey respondents felt that tobacco control was a high priority in their local authority, and only 12% felt that it was a low or below average priority.

The expertise and experience of local authorities should be valued and fully exploited in the journey towards a smokefree nation. As budgets continue to squeeze, the case has never been stronger for providing long-term support to local authority tobacco control teams through a national 'polluter pays' levy on the tobacco industry, a simple and fair measure that would guarantee universal access to high quality stop smoking services throughout England.

[4] NHS England: *Reducing healthcare inequalities, the CORE20PLUS5 approach* (infographic) www.england.nhs.uk/wp-content/uploads/2021/11/Reducing-healthcare-inequalities-Core20PLUS-infographic.pdf

[5] Olivera JN, Ford J, Sowden S, Bambra C: *Conceptualisation of health inequalities by local healthcare systems: A document analysis*. Health and Social Care in the Community, 2022;00:1-8.

[6] Finch D: *Public health grant: What it is and why greater investment is needed*. Health Foundation online blog, 26th October 2022