On the path to ending smoking
Using the new funding for smoking cessation

March 2026

This briefing has been developed by ASH to support local authorities to maximise the impact of the ring-fenced smoking cessation funding within the Public Health Grant.

Summary of recommendations

Develop an ambitious strategy

1. Refresh or put in place a new local strategy to increase quit attempts and quit success for your local population.
2. The strategy should include local targets for reducing prevalence in the whole population and target groups e.g. people in routine and manual occupations or with mental health conditions.

Prioritise health inequalities

3. Prioritise tailored support for disadvantaged groups, where smoking prevalence and health inequalities are highest.

Provide evidence-based quit support

4. Ensure all smokers have access to NICE-recommended pharmacotherapy and nicotine vapes.
5. Maintain investment in the Swap to Stop scheme and facilitate access to the scheme for NHS trusts and other services.
6. Address misperceptions around the risk from vapes.
7. Develop a workforce strategy and training plan to ensure staff are trained to NCSCT standards.

Increase quit attempts

8. Increase the rate of quitting in the population so that nearly half of all people who smoke make a quit attempt each year.

Work in partnership

9. Identify activity best done collaboratively at ICB or regional level.
10. Ensure you have a high functioning Tobacco Control Alliance, or equivalent, which includes all partners, has strong leadership and a clear mandate to deliver your strategy.
11. Share learning and good practice, recognising the value of diverse local and regional geographies and the building of quality and trusted relationships.

Contents

Context: A smokefree country is within reach

This is a transformative moment for tobacco control. The generational smoking ban – prohibiting the sale of tobacco to anyone born after 2008 – will come into force from 1st January 2027, protecting future generations from lethal tobacco addiction. This will be accompanied by a series of other measures to tackle smoking and regulate tobacco and nicotine products.[1] Alongside this, the Government has announced new national funding for local authority stop smoking services through the Public Health Grant – guaranteed for the next three years – and other tobacco control activity.[2] This is an unprecedented opportunity to accelerate progress towards a smokefree future by reaching people who smoke in *every* community.

Local authorities are uniquely placed to lead a whole-system, population-level response to smoking cessation. This goes beyond commissioning specialist stop smoking services, to shaping a coordinated local system in which every organisation plays a role in reducing smoking and supporting quitting. Local authorities should move from viewing smoking cessation as a discrete service to developing a coordinated stop smoking system, with multiple entry points and flexible, tailored pathways to meet the needs of different populations.

---

[1] The Tobacco and Vapes Bill will give the Government powers to:
- Prohibit the sale of tobacco to anyone born after 2008
- Regulate the marketing, packaging, display and contents of vapes and nicotine products
- Strengthen enforcement of illicit tobacco and vapes
- Introduce retail licensing and product registration schemes for tobacco and nicotine products
- Designate outdoor public places as smokefree and introduce vape-free places
- Close loopholes and future proof existing tobacco control laws
- Ban vape advertising and sponsorship

[2] DHSC. Public health ring-fenced grant financial year 2026 to 2027: local authority circular. Feb 2026.

Current government investment in tobacco control activity

What	Agency	Value	Description
Stop Smoking Services and swap to stop scheme	Local authorities	Approx. £153 million per year for 3 years from 2026/27.	Ringfenced funding for smoking cessation, including funding previously allocated to the Swap to Stop scheme.
Local enforcement	Trading standards	Up to £10 million per year for 3 years from 2026/27.	Funding to support efforts to tackle illicit tobacco and vapes.
National illicit tobacco strategy	HMRC and Border Force	£100 million over five years from 2024/25.	This funding supports implementation of the UK illicit tobacco strategy published March 2024.
National smoke-free pregnancy incentive scheme	NHS trusts	£5 million per year committed for 3 years from 2026/27.	This scheme supports pregnant women and their significant others to quit smoking and stay smokefree.
Mass media and marketing campaigns	DHSC	Funding for smoking cessation campaigns and smokefree generation implementation will be confirmed in due course.	Mass media campaigns are effective for increasing quit attempts and have a high return on investment.
NHS tobacco dependence treatment services	ICBs	Included within Integrated Care Board core allocations.	This funding supports the rollout of tobacco dependence treatment services in the NHS.

There are a limited number of conditions attached to the consolidated ring-fenced smoking cessation funding within the Public Health Grant:

1. The ring-fenced smoking cessation funding must be used for the purposes of providing smoking cessation services to support smokers to quit and is the minimum amount that must be spent on this provision.
2. Authorities should deliver increases in the number of people setting a quit date and 4 week quit outcomes, reporting associated activity and financial spend.
3. Authorities should not use this funding to replace programmes in NHS in-patient and maternity settings. This funding should not be used for wider tobacco control activity, such as enforcement, smoking or vaping youth prevention activity.
4. Any authority achieving less than 5% of their smoking population setting quit dates, as set out in NICE NG209[3] and NCSCT guidance,[4] must submit a self-

---

[3] NICE NG209. Tobacco: preventing uptake, promoting quitting and treating dependence. November 2021.
[4] NCSCT. DHSC guidance.

assessment audit within the financial year to DHSC (guidance on self-assessment to be provided by DHSC). For those achieving 5% or above, the audit is recommended but not mandatory.

This funding is committed for the next three years giving local authorities the flexibility to plan and deliver new activity at local and supra-local levels. This enables tailored approaches to stimulate more quit attempts, link people who smoke to the most effective interventions, strengthen existing behavioural support, build capacity, and strengthen partnerships. Local authorities can consider coordinating funding across wider geographical areas for activities that are best delivered more widely (e.g. mass media, outreach, advocacy, digital offers etc.), achieving economies of scale and greater levels of impact.

The guidance states that funding should not be used to fund enforcement activity or NHS inpatient tobacco dependence services, although new collaborations with the NHS are encouraged to drive through-put into services.

The guidance states that funding should not be used on youth vaping prevention activity. Addressing youth vaping is understandably a priority for many areas, but the focus of the ring-fenced funding is reducing the leading cause of preventable death and health inequalities: smoking. National regulations to restrict the appeal, affordability, availability and marketing of vapes will make a much larger contribution to reducing youth vaping than local interventions.

The overall aim of the additional funding is to help people to stop smoking and increase engagement with effective quitting interventions. Local authorities should recognise the key indicators of success for the funding (quit dates set, recorded quits), but we must not miss this once in a lifetime opportunity to galvanise partners across the system to use the proposed legislation and funding in a transformative way to end smoking, everywhere, for everyone.

Recommendations

Develop an ambitious strategy

Refresh or put in place a new local strategy to increase quit attempts and quit success for your local population. Development and implementation of the strategy should involve all local partners, with clear lines of accountability and buy-in from senior leadership within the council. In 2025, most local authorities either had a tobacco control strategy (56%) or were developing one (27%). Of the 56% that had a strategy, 37% had a specific strategy focused on tobacco and 19% had set out their strategy on tobacco within a broader strategy on prevention, population health, and/or inequalities.

The strategy should include local targets for reducing prevalence in the whole population and target groups e.g. people in routine and manual occupations or with mental health conditions. This is in addition to established measures, such as the number of people setting a quit date and quitting with local stop smoking services.

Clear targets help to drive progress, create accountability, and highlights the vital role of local authorities in driving down smoking prevalence locally. Ambitious high-level targets can be complemented by a range of other metrics that serve to communicate the value of tobacco control both within a local authority and outwards to its partners and the community it serves.

Prioritise health inequalities

Prioritise tailored support for disadvantaged groups, where smoking prevalence and health inequalities are highest. Smoking prevalence is highest among the most disadvantaged groups in society, such as people living in social housing, people experiencing homelessness, people with alcohol and drug misuse problems, people with mental health conditions and people on low incomes. This results in major inequalities in illness and mortality, with smoking being responsible for at least half the difference in life expectancy between the richest and poorest in society.[5] Reducing smoking among the most disadvantaged is critical to narrowing this gap and ensuring an equitable transition to a smokefree society. To support this objective, local authorities should:

- Ensure smoking cessation is embedded in local health and wellbeing strategies.
- Tailor the service offer for key priority groups to reduce inequalities and address barriers to access (e.g. by offering flexible in person community-based approaches, digital support, trialling 'cut down to quit' approaches, and longer quit timelines).[6]
- Build links with other services where smoking is common among service users and ensure smoking cessation is embedded in existing support (e.g. family support, income support, foodbanks, addiction, mental health, social housing and homelessness). This should involve ensuring staff are trained in VBA and referral, and co-locating quit support within these settings.
- Use every contact as an opportunity to link people who smoke into other support services (e.g. mental health, employment and housing).

Provide evidence-based quit support

Ensure all smokers have access to NICE-recommended pharmacotherapy and nicotine vapes. Each person who smokes should be offered effective and evidence-based quitting aids including NRT, varenicline, bupropion, cytisinicline, and nicotine vapes. Varenicline and nicotine vapes are the most effective stop smoking aids and can nearly double the odds of quitting compared to using NRT.[7] [8] Vapes are the most commonly used form of support used in quit attempts in England, used by over a third

---

[5] Fair Society, Health Lives. The Marmot Review. 2010

[6] Jayes L et al. Understanding how smoking cessation services can be adapted to improve the uptake and success of smoking cessation for people in low socioeconomic status groups. A mixed method exploratory study. Sept 2024.

[7] Lindson N et al. Electronic cigarettes for smoking cessation. Cochrane Database of Systematic Reviews. 2025(1).

[8] NCSCT. Varenicline: effectiveness and safety. November 2025.

(38.1%) of those trying to quit in 2025.[9] However, only a minority use prescription medications like NRT (6.5%) and varenicline (1.4%), despite these being highly effective for smoking cessation. Varenicline is particularly under-prescribed to people with mental health conditions, despite the high smoking prevalence in this population.[10] [11] The 'gold standard' combination of prescription medication and behavioural support is only used by 3.3% of people who smoke, despite improving chances of quitting by around 80%.

Most popular methods of quit support used by people who smoke in England (data from the Smoking Toolkit Study)
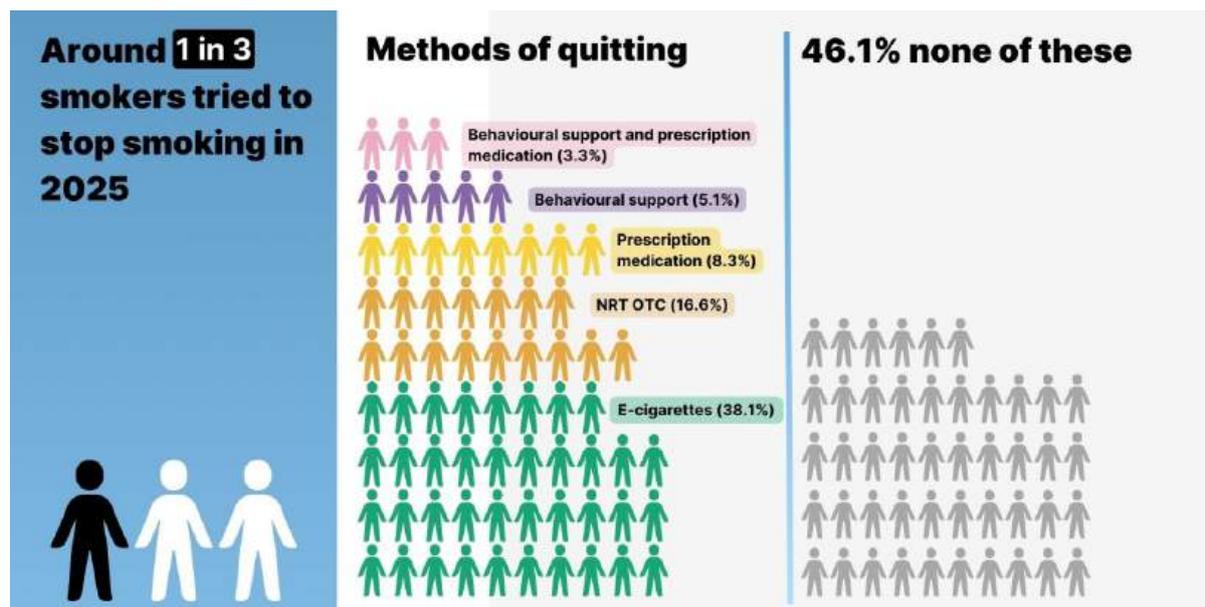
Maintain investment in the Swap to Stop scheme and facilitate access to the scheme for NHS trusts and other services. Swap to Stop is a world-leading scheme aiming to encourage one million people in England to switch from smoking to vaping by providing free vape starter kits, alongside some form of behavioural support.[12] Funding for the Swap to Stop scheme now sits with local authorities as part of the ringfenced smoking cessation funding within the public health grant. The scheme has been highly effective and popular with service users, with nearly every local authority (97%) participating in 2025.[13] Councils should maintain investment in Swap to Stop to ensure that service users, particularly those from the most disadvantaged backgrounds, are able to access evidence-based quitting aids. Local authorities should also continue to facilitate access to the scheme for NHS trusts and other

---

[9] 2025 data from the Smoking Toolkit Study.
[10] Byrne P. So why don't psychiatrists prescribe varenicline or cytisine? 2025.
[11] ASH. Space to breathe: Findings from a survey of smokefree policies and tobacco dependence treatment services in NHS mental health trusts in England, 2024. March 2025.
[12] NCSCT. Swap to stop resources.
[13] ASH. Breaking new ground: Local authority stop smoking services and wider tobacco control in England, 2025. December 2025.

services where smokers are overrepresented (e.g. family support, income support, foodbanks, addiction, mental health, social housing and homelessness).

Address misperceptions around the risk from vapes. The evidence is clear that using a nicotine vape is much less harmful than smoking in the short and medium term.[14] Despite this, over half of British adults – including over half of all those who smoke – believe that vaping is as or more harmful than smoking.[15] This makes it less likely that people who smoke will try using a vape to help them quit – meaning that they continue to smoke. These misperceptions are also prevalent among health professionals and other stakeholders. Local authorities should ensure that stop smoking advisors and other professionals delivering VBA are informed about the role of vapes in smoking cessation (e.g. through NCSCT training and resources).[16] Councils should also seek to address public misconceptions through wider communications activity.

Develop a workforce strategy and training plan to ensure staff are trained to NCSCT standards. Staff involved in smoking cessation activity should be drawn from a range of bands including senior leaders who can drive up quality across the area. The strategy should include training on delivering VBA for staff in settings where smoking is common among service users (e.g. family support, income support, foodbanks, addiction, mental health, social housing and homelessness).

Increase quit attempts

Increase the rate of quitting in the population so that nearly half of all people who smoke make a quit attempt each year. More quit attempts = more quit success. This means encouraging more people who smoke to make a quit attempt more often. Most people need multiple quit attempts to achieve quit success, but the more who try, the more who will succeed.[17] This can be achieved through:

- Amplifying national mass media campaigns with strong and funded local and regional/ICB communications strategies to connect people to the range of stop smoking support, including local quit services.
- Funding digital models of support either locally or in collaboration with other local authorities (some of these digital models can capture four-week quit data).
- Equipping the wider workforce through training to prompt quitting and drive referrals. This can be done through the development of a high-quality stop smoking 'hub' which can reach out and/or through a shared approach to workforce development.
- Improving referral pathways and increasing the number of referrals into local stop smoking services or into other forms of support. This is alongside

---

[14] OHID. Nicotine vaping in England: 2022 evidence update main findings. September 2022.
[15] ASH. Use of vapes (e-cigarettes) among adults in Great Britain. July 2025.
[16] NCSCT. Vaping resources.
[17] Dr Sarah Jackson: Methods of Quitting [Internet]. University College London; 2024. Available from: https://www.youtube.com/watch?v=Dbic-yTvx9E

improving reengagement processes for those who have previously accessed stop smoking services.

- Maximising the opportunities from the 'swap to stop programme' to reach people who smoke with a new aid to quitting.

Work in partnership

Identify activity best done collaboratively at ICB or regional level. System-wide collaboration can achieve economies of scale, expand the reach of local activity (e.g. comms campaigns), enable sharing of learning and expertise, and reduce duplication. Over half (54%) of local authority stop smoking services are fully or substantially integrated with NHS tobacco treatment services, ensuring that expertise can be shared and strengthening referral pathways between inpatient and community settings.[13] Nearly every region in England now has a regional tobacco control lead who can facilitate collaboration between local partners and develop a regional strategy.

Ensure you have a high functioning Tobacco Control Alliance, or equivalent, which includes all partners, has strong leadership and a clear mandate to deliver your strategy. In 2025, 76% of local authorities had a local Tobacco Control Alliance, up from 54% in 2021.[13] Alliances are a key forum to bring together all partners around an effective, co-ordinated strategy. They should have clear goals and strong lines of accountability, for example to Health and Wellbeing Boards.

Share learning and good practice, recognising the value of diverse local and regional geographies and the building of quality and trusted relationships.

Links and resources

Guidance

- ASH. Tobacco control: what you need to know.
- ASH and Fresh. The End of Smoking. 2022.
- ASH. Evidence into practice: motivating quitting through behaviour change communications. 2021.
- ASH. Toolkit: Developing a system-wide tobacco control programme.
- ASH. 10 high impact actions for local authorities and their partners. 2022.
- ASH. Developing a system-wide tobacco control programme.

Data

- The ASH Ready Reckoner has a breakdown of the costs of smoking broken down by region, local authority, combined authority, constituency and ward.
- The ASH Inequalities Dashboard shows the health and wealth related inequalities caused by tobacco at a national, regional, local authority and combined authority level.
- The DHSC Smoking Profile provides information on tobacco use, tobacco-related harms, mortality and inequalities.
- UCL Smoking Toolkit Study with data on smoking and vaping in England.

Presentations

- Dr Sarah Jackson. Methods of quitting: which are most effective and which do people use most? March 2024.
- Dr Sharon Cox. Supporting smokers to stop: who needs the most support to stop and what works best? November 2023.
- Prof Robert West. Modelling how to get down to 5%. What is the data telling us and what will be key to achieving this? November 2023.