On the path to ending smoking: using new funding

Briefing | March 2024

This paper

With a major opportunity to reset our local strategies and make rapid progress towards ending smoking for all populations this paper has been developed by ASH in partnership with DsPH and Humber and North Yorkshire's Centre for Tobacco Control Excellence to support local decision making in spending new funding to address smoking. It has been reviewed and endorsed by the Association of Directors of Public Health.

Key recommendations:

1. Review local strategy and partnerships against the goal to end smoking.
2. Allocate sufficient investment in activity to motivate people who smoke in all communities to quit.
3. Skill up stop smoking services to increase capacity and act as hubs of excellence for wider services.
4. Identify activity best delivered collaboratively across local authority boundaries to maximise impact.

Detailed recommendations are at the end of this short briefing with signposting to further tools that can support strategy and service development.

The opportunity: Proposed legislation and funding present an unmissable opportunity to end smoking, everywhere, for everyone

The Government's smokefree generation plans combine new local and national funding with a commitment to raise the age of sale for tobacco, so no one born on or after January 1st 2009 can legally be sold tobacco.[1] This is a moment on a footing with the 1998 Smoking Kill's White Paper;[2] which established stop smoking services, bought forward landmark legislation on tobacco advertising, and paved the way for smokefree legislation. Together these actions accelerated stagnant rates of decline in smoking rates

and heralded the first drop in teen smoking for two decades.

To summarise, the new investment into tobacco control is as follows:[1,3]

What	Purpose	Value
New funding for LA stop smoking support	To increase support for people who smoke to quit	£70 million from 24/25 committed for 5 years
Swap to stop scheme	Give LA led bids access to free vapes to support quitting	£45 million over two years
New enforcement funding	Address illicit products, largely through national agencies	£30 million from 24/25 for 5 years
National mass marketing campaigns	To motivate quitting	£15 million from 24/25 for 5 years
National financial incentive scheme for pregnant women	To increase quitting in pregnancy and among partners	£10 million over two years

This is in addition to existing local authority spending on tobacco control of ~£70m and NHSE investment in inpatient support for acute and mental health patients and for pregnant people who smoke.[4,5]

There are a limited number of conditions to the new funding for local authorities:[8]

1. Invest in stop smoking services and support, in addition to, and while maintaining existing spend from the public health grant.
2. Build capacity to deliver expanded local stop smoking services and support.
3. Build demand for local stop smoking services and support.
4. Deliver increases in the number of people setting a quit date and 4 week quit outcomes, reporting associated activity and financial spend.

Local authorities who accept these four conditions, will receive 70% of their funding at the beginning of the first year, with the remaining 30% payment eligible to claim in the fourth quarter.[6]

This funding is committed for the next five years allowing time and flexibility to plan, and implement, new activities across local and supra-local footprints. These footprints can tailor activity to stimulate more quit attempts, link people who smoke to the most effective interventions, boost existing behavioural support schemes, build capacity, and strengthen partnerships. The accompanying guidance for local authorities highlights the opportunity for coordination of funding across wider geographical areas for activities that we know are best delivered more widely (e.g. mass media, outreach, advocacy, digital offers etc.), achieving economies of scale and greater levels of impact.[6]

The accompanying grant letters also state that funding should not be used to fund enforcement activity or NHS inpatient tobacco dependence services, although new collaborations with the NHS are encouraged and will be needed to drive through-put into

services. Addressing youth vaping is a big priority for many areas, but there are opportunity costs to funding this work and areas will want to review such activity against its contribution to reducing the leading cause of preventable death and health inequalities, smoking.

The overall aim of the additional funding is to help people to stop smoking and increase the number of people engaging with effective interventions to quit smoking.[6] 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 our partners across the system to use the proposed legislation and funding in a transformative way to end smoking, everywhere, for everyone.

This briefing focuses on the system that helps people who smoke to quit tobacco use and does not explore regulatory requirements and the wider environment.

Further resources around the proposed legislation and additional funding can be found here:

- **Stopping the start: our new plan to create a smokefree generation**
- **Local stop smoking services and support: funding allocations and methodology**
- **Local stop smoking services and support: guidance for local authorities**
- **NHS England: Stop Smoking Services Collection**

What we know

"Nearly half of people who smoke want to quit and nearly half try to quit without support."

There are no secrets to stopping smoking; we need to keep encouraging people to make a quit attempt and increase their chances of success. We know that treatment and behavioural support can support people in maintaining their strength of resolve over the urge to smoke, by dampening down this urge and boosting resolve to stay abstinent. We also know that the majority of people who smoke want to quit, with the most common motives underlying quit attempts being concerns about future health problems, current health problems and costs to the individual.[7]

Supporting all people who smoke to quit

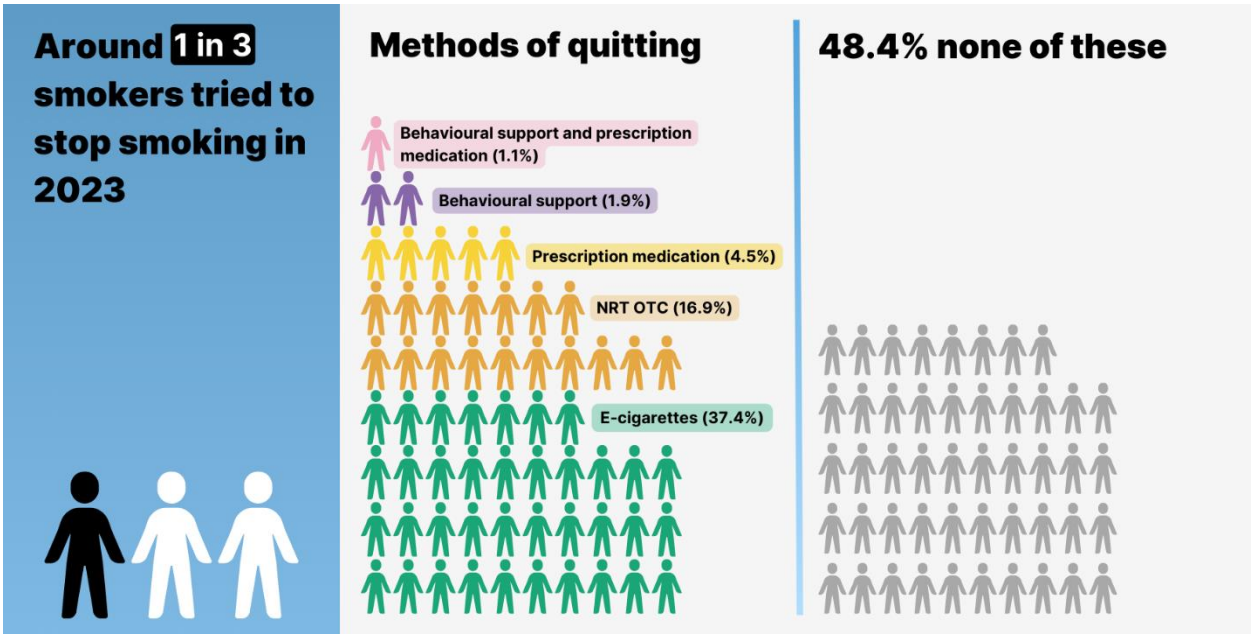
Routes to quit

Nearly half of people who smoke try to quit without any support, and only ~3% of people who smoke use specialist stop smoking services to quit.[7][8][9] Stop smoking support can improve peoples' chances of success, compared with going it alone. Routes of support to cater for all peoples' needs and preferences should be available and should ideally include:[10]

- Specialist support and treatment
- Brief advice and treatment
- Self-support

Methods of quitting

All routes of support should utilise effective and feasible quitting methods with products such as stop smoking medications and e-cigarettes. Varenicline and e-cigarettes are shown to be the most effective methods in real-world conditions, and people who smoke who use them have nearly double the odds of quitting compared with those who do not. E-cigarettes are the most common method used by people who smoke (just over one third) attempting to quit in England. However, only a minority (around 5%) use prescription medications, like varenicline. The 'gold standard' combination of prescription medication and behavioural support is only used by 1.1% of people who smoke, despite improving chances of quitting by around 80%.[7]



A figure to show the methods of support most commonly used by people who smoke in England (data from the Smoking Toolkit Study)[8]

More quit attempts will always lead to more quit success

To increase quit success across the whole population, we need to encourage more people who smoke to attempt to quit more often. We know that most of these people will need multiple quit attempts to achieve quit success, but the more who try, the more who will succeed, reducing smoking prevalence.[7]

The denormalisation of smoking can increase quit attempts, quit success and prevent relapse. This is best achieved across wider geographies through activity including: mass media and communications, policy and intervention development, supporting local implementation of tobacco control, and making the case for tobacco control. The promotion of hope and the annual quit attempt can also increase quit attempts; this can be achieved at individual level through very brief advice and at supra-local level through mass media. It is important to recognise that system-wide collaboration can achieve economies of scale, grow levels of impact by supplementing local action, support local policy development by concentrating expertise, and target activity to reduce health inequalities.[9]

Moreover, providing a diverse range of routes to quit can increase quit attempts, increase success of attempts, and prevent relapse. We should expand the delivery of stop smoking support via stop smoking services whilst recognising capacity issues, and maximising opportunities to get people who smoke into a route for stop smoking support of any kind. Smoking prevalence is higher in groups such as people in social housing, people who are homeless, people with alcohol and drug misuse problems, people with mental health conditions and people on low incomes. These groups are not less motivated to quit, they just find it harder and need more support.[9 11]

A recent study of providers, users and non-users of stop smoking services found that the potential impact of stop smoking services for deprived populations could be improved with a flexible, in-person, community-based approach to services. This would mitigate issues such as: access barriers, including for NRT and e-cigarettes; staffing; consistency of service provision; and visibility, awareness and understanding of services.[12]

This range of routes should promote pharmacotherapies, such as, stop smoking medications and e-cigarettes, as well as behavioural support as methods to quit. This is especially since e-cigarettes are effective, popular and low-cost quitting aids.

Misperceptions around the harms of e-cigarettes should be tackled, as they are much safer compared with tobacco products, but this is not the belief of the majority of the public. There are also opportunities with new drugs to market like cytisine, as an alternative to varenicline. Every successful quit begins with a quit attempt, so we must encourage more people who smoke to attempt to quit more often. Any population increase in quit attempts for people who smoke will be reflected in a greater uptake of stop smoking services, higher sales of nicotine replacement therapy and e-cigarettes, and more prescriptions from GPs for pharmacotherapies.[7 9]

Further resources to support the evidence explored in this section can be found here:

- The End of Smoking: report by ASH and FRESH
- Evidence into practice: motivating quitting through behaviour change communications: report by ASH
- NCST Monitoring guidance
- Smoking in England: findings from the Smoking Toolkit Study.
- Sarah Jackson (UCL): video on methods of quitting.
- Professor Robert West (UCL): video on modelling how to get down to 5%.
- Dr Sharon Cox (UCL): supporting people who smoke to stop, who needs the most support to stop and what works best
- Toolkit for developing a system-wide tobacco control programme: toolkit by ASH
- 10 high impact actions for local authorities and their partners: paper by ASH

Recommendations

Directors of Public Health, commissioners of stop smoking services, NHS leads and service managers all have a vital role in taking action across the system to stimulate increased rates of quitting and maximising success rates. Directors of Public Health are ideally positioned to lead their local places and wider footprints in taking action to utilise the additional funding opportunities transformatively to end smoking, everywhere, for everyone.

Strategy, partnership and leadership are needed to secure transformational change and support many more people who smoke to quit:

- Refresh or put in place a new local strategy to increase quit attempts and quit success for your local population. Include local targets for the whole population and target groups
- 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.
- Identify activity best done collaboratively at ICB or regional level (i.e. TV media regions).
- Share learning and good practice, recognising the value of diverse local and regional geographies and the building of quality and trusted relationships.

To accelerate progress, we need to increase the rate of quitting in the population so that nearly half of all people who smoke make a quit attempt each year:

- Amplify 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.
- Consider 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).
- Equip 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.
- Improve referral pathways and increase the number of referrals into local stop smoking services or into other forms of support.
- Maximise the opportunities from the 'swap to stop programme' to reach people who smoke with a new aid to quitting.

Our high-quality stop smoking services must be the hubs for our community, supporting people who smoke and driving up standards and knowledge in other settings:

- A service offer that uses all frontline treatments including: e-cigarettes, varenicline, cytisine and combination NRT.
- Prioritise 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).
- Use every contact as an opportunity to link people who smoke into other support services (e.g. mental health, employment and housing)
- Staff should be trained to NCSCT standards and be from a range of bands including highly qualified leaders who can drive up quality across the area.

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