

Reaching out

Tobacco control and stop smoking services in local authorities in England, 2021



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Summary and recommendations

Executive summary

Findings from this report show a welcome increase in the local support available for people who smoke compared to before the COVID-19 pandemic hit. This is in part thanks to local councils' impressive ability to quickly adapt to the challenges of COVID-19 lockdowns, for example by delivering traditionally face-to-face services remotely.

However, as this survey shows, the pandemic also highlighted the consequences of years of cuts to public health budgets which led local authorities to have to make difficult decisions about the services they could offer, with some opting to no longer provide a dedicated specialist stop smoking service. Unsurprisingly as the NHS became overwhelmed with the frontline pandemic response, local authorities who did not have a dedicated offer but instead relied on NHS smoking cessation services in general practice or pharmacies were most likely to report negative impacts from the pandemic. This highlights why it is so important local councils have increased and sustainable funding for tobacco control.

Key findings

The COVID-19 pandemic has had multiple positive and negative impacts on local authority stop smoking services and tobacco control work. The impact overall has been equivocal:

- 36% of survey respondents said that the impact had been positive overall
- 34% of survey respondents said that the impact had been neither positive nor negative
- 30% of survey respondents said that the impact had been negative overall

Most surveyed local authorities experienced a mixture of positive and negative impacts. Where they were felt, positive impacts included:

- the expansion of remote support (telephone and digital)
- an increase in service accessibility and flexibility
- the development of new modes of providing Nicotine Replacement Therapy (NRT), treatments and e-cigarettes
- an increase in smokers' motivation to quit

Where they were felt, negative impacts included:

- the contraction of services
- a decline in primary care support and referrals
- reduced access to face-to-face support
- a decline in wider tobacco control work

Two thirds of surveyed local authorities (67%) commissioned a universal specialist stop

smoking service in 2021, up from 62% in 2020. A further 9% commissioned a restricted specialist service, 15% commissioned a lifestyle service and 7% commissioned a service in primary care only. Two local authorities (1%) commissioned a telephone helpline only and two (1%) had no service.

Local authorities with a specialist service were least likely to report negative impacts from the COVID-19 pandemic (25% did so), whereas those that relied on support in primary care were most likely to report negative impacts (88% did so).

Face-to-face support had been restored in most stop smoking services (of all types) by August 2021:

- 83% of local authority stop smoking services were offering face-to-face advice
- 98% were offering telephone advice
- 60% were offering online advice by video conference

Over the past two years, there has been an increase in the use of telephone advice and especially video conferencing, resulting in a more flexible offer overall.

Local authorities engaged a wide range of advisers to provide stop smoking behavioural support and brief advice including primary care professionals, midwives, drug and alcohol professionals, vape shop staff and firefighters. However, dedicated stop smoking advisers remained the most common choice for providing behavioural support, engaged by 86% of all surveyed local authorities.

The provision of NRT has increased over the past two years with 76% of local authorities offering a full course of NRT in 2021 compared to 65% in 2019. E-cigarette provision has increased dramatically, with 40% of surveyed local authorities offering smokers this option to some or all smokers and a further 15% having plans to do so. This compares to 11% offering e-cigarettes to some or all smokers in 2019, prior to the COVID-19 pandemic.

Most of the surveyed local authorities still engaged in tobacco control work beyond the provision of stop smoking support including tackling illegal tobacco supplies (86%), conducting communications and campaigns about smoking (85%), and enforcing legislation such as age of sale, point of sale and smokefree legislation (82%). However, both the number of local authorities pursuing this work, and the capacity within these local authorities for this work, has declined.

Although 63% of surveyed local authorities claimed to be engaging with their integrated care system (ICS) on tobacco control, 47% of respondents did not know if their ICS had made any commitments on tobacco control. Among those that did, the majority identified the NHS Long Term Plan as the focus of these commitments.

Tobacco control was perceived as being a high priority or an above average priority in 41% of surveyed local authorities, down from 55% in 2016. Tobacco control was perceived to be a low or below average priority in 18% of local authorities. It was rated as a high priority or an above average priority less often than overweight/obesity (65%), drugs (62%), alcohol (57%) and sexual health (50%). Only gambling was rated as a high priority or an above average priority less often (13%).

Local authorities were pursuing a wide range of approaches to reaching deprived and disadvantaged groups with high rates of smoking. This was the primary focus of action for

some local authorities. Overall:

- 91% were undertaking work with deprived communities or routine/manual workers
- 43% were undertaking tobacco control/smoking cessation work with housing associations or other social housing providers
- 21% were undertaking tobacco control/smoking cessation work with debt or financial advice services
- 97% were undertaking or supporting tobacco control/smoking cessation work with pregnant or post-partum women
- 77% were undertaking or supporting tobacco control/smoking cessation work with people with mental health conditions
- 44% were undertaking tobacco control/smoking cessation work with Black and Minority Ethnic (BME) communities
- 21% were undertaking tobacco control/smoking cessation work with LGBTQ+ communities
- 69% were undertaking tobacco control/smoking cessation work with people with acute or long-term conditions

Recommendations

Many local authorities have shown resourcefulness and innovation in their tobacco control efforts through 2021 despite the pressures of the COVID-19 pandemic. However, with serious pre-existing funding pressures unremedied and unknown challenges in the pandemic's future course, it is unreasonable to expect local government to continue to adapt without additional resource and support. Adding in the strain the NHS is under from the pandemic response, and the impact this is having on NHS smoking cessation service provision, there is a clear need to invest in local government. Not doing so risks not only the viability of local government tobacco control but also the Government's Smokefree 2030 ambition for England and the lives that depend on achieving it.

There are lots of ways to support local tobacco control. Whether that be through national policy action to regional and local measures to improve cessation support.

National action

1. Government should implement the recommendations made by the All Party Parliamentary Group (APPG) on Smoking and Health in its forthcoming Tobacco Control Plan, including:
 - Funding measures to reduce smoking and to support people to quit through a 'polluter pays' amendment to the Health and Social Care Bill, forcing tobacco manufacturers to pay – but without letting them influence how the funds are spent.
 - Targeting investment to tackle high smoking rates in communities where smoking does the most damage, including social housing tenants, pregnant women and people with a mental health condition.
 - Introducing tough new regulations to protect children and young people from becoming smokers and help smokers quit, including consulting on raising the age of sale of tobacco from 18 to 21.

Regional action

2. New Integrated Care Boards should work with their local system to ensure there is a joined-up plan across the NHS and local government to help smokers quit. This should include a shared approach to rolling out new tobacco dependency treatment programmes in the NHS, integrated approaches to Targeted Lung Health Checks, and a population health approach to reducing the health inequalities caused by smoking.

Local action

3. Local authorities should ensure all local smokers have access to behavioural support to help them quit smoking alongside a full course of Nicotine Replacement Therapies (NRT). This offer should be inclusive of e-cigarettes, which should be freely provided where appropriate.
4. Local authorities should ensure that their stop smoking services are resilient and able to withstand unexpected pressures on the NHS, for example by including a dedicated specialist component.
5. Given the importance of tobacco control to tackling health inequalities and improving the economic wellbeing of local communities, local authorities should ensure that comprehensive tobacco control strategies are prioritised and embedded within COVID-19 recovery plans.
6. Local authorities should actively maintain their tobacco control alliances and partnerships where they exist, and aim to establish such alliances where they do not, in order to maximise the joint capacity of partners in tobacco control work and reach as many local smokers as possible.

Introduction

This report presents findings from the eighth annual ASH/CRUK survey of tobacco control leads in local authorities in England. It explores both the ongoing impact of the COVID-19 pandemic and current efforts to reduce the inequalities that define the smoking epidemic in England.

The COVID-19 pandemic exposed the profound disparities that shape the experience of individuals and communities in twenty-first century England, disparities that have recently become the focus of the UK Government's 'leveling up' agenda. This agenda is not new: it has long been central to the work of tobacco control professionals. In English local authorities, tobacco control leads and their colleagues are well aware that smoking remains the single biggest driver of health inequalities in their communities. Despite the remarkable decline in smoking in the population as a whole, smoking prevalence remains stubbornly high in deprived and disadvantaged groups.

Over the past eight years, local efforts to tackle smoking have diversified. Despite long-term cuts in public health funding and the demands of the COVID-19 pandemic, most local authorities continue to invest in stop smoking services and wider tobacco control work, though a few have cut services altogether. As this report reveals, many local authorities have been remarkably resourceful and innovative in responding to the challenges of the COVID-19 pandemic and in reaching out to meet the diverse needs of their local smokers.

Methods

The survey was conducted online using Survey Monkey during August 2021. 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 126 local authorities (84%). Seven respondents provided data on more than one local authority due to shared public health arrangements locally. In addition, three respondents quit the survey early but provided data on the range of stop smoking services commissioned by their local authority. In order to obtain comprehensive data on the range of stop smoking services commissioned, further research was undertaken with non-responding local authorities. Commissioning data were obtained by telephone interview from nine local authorities and by desk research (principally investigation of service profiles on the internet) for 12 local authorities.

The respondents

The 121 respondents who answered all or part of the survey gave details of their role, the time they spent on tobacco control, and the other work they were involved with.

Ninety-three respondents (77%) identified as a tobacco control lead, a commissioner of tobacco control, or both. Some of these respondents also identified as a consultant in public health (n=4), a stop smoking service manager (n=7), or an integrated lifestyle service manager (n=5). Of the remaining 28 respondents, 4 identified as a consultant in public health with responsibility for tobacco and 11 identified as a manager of a stop smoking service, an integrated lifestyle service, or both. Other roles volunteered by respondents included director of public health, health improvement/public health practitioner, health interventions coordinator, and Smokefree Action Alliance lead.

Across all respondents, a majority reported that they spent less than half their time on tobacco control and smoking cessation including 16% who spent 'very little time' on this part of their brief (Figure 1). Only 30% of respondents spent more than half their time on tobacco control and smoking cessation.

Table 1 describes the other areas of work that respondents spent their time on. At the time of the survey half of respondents were still devoting time to their local COVID-19 response. Other areas of work volunteered by respondents included sexual health, mental health, workplace health, children and healthy schools, social care, food insecurity, health inequalities, gambling, homelessness, fuel poverty, and air quality.

Figure 1. Time spent on tobacco control or smoking cessation by survey respondents (n=121)

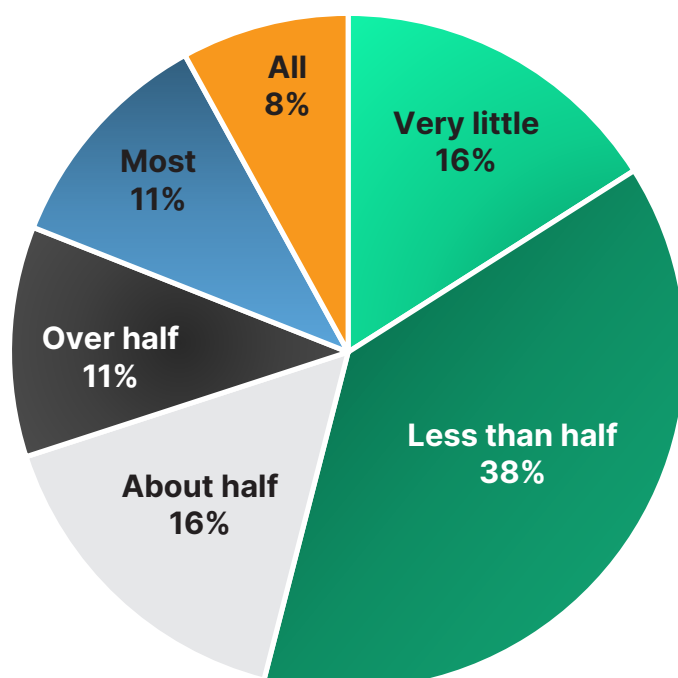


Table 1. Areas of work other than tobacco control/smoking cessation that respondents spent their time on (n=121)

Area of work	Respondents
Healthy lifestyle services	69 (57%)
COVID-19 response	61 (50%)
Healthy weight services	56 (46%)
NHS Health checks	49 (40%)
Drugs and/or alcohol services	30 (25%)

The lasting effects of the COVID-19 pandemic

In 2020, many local authorities in England responded with speed and resourcefulness to the challenges of the COVID-19 pandemic, adapting stop smoking services to the constraints of a radically changed working environment.¹ In the summer of 2021, when some of the constraints of the pandemic had been eased, it was possible to investigate the lasting effects of the pandemic on the delivery of stop smoking services and wider tobacco control work in English local authorities.

Respondents to the 2021 survey were asked to assess the overall impact of COVID-19 on their stop smoking services and wider tobacco control work. Their responses were evenly distributed:

- 36% said that the impact had been positive overall
- 34% said that the impact had been neither positive nor negative
- 30% said that the impact had been negative overall

This equivocal finding disguises a range of positive and negative impacts which affected local authorities in different ways and to different degrees. These impacts are identified in Table 2, which summarises respondents' free-text descriptions of the lasting effects of the pandemic on local stop smoking services and wider tobacco control work. These impacts are explored in more detail in the rest of this report.

Table 2. Respondents' perceptions of the lasting effects (positive and negative) of the COVID-19 pandemic

Perceived positive impacts	Perceived negative impacts
Expansion of remote support (telephone and digital)	Contraction of service
Increase in service accessibility and flexibility	Reduced access to face-to-face service
Development of new modes of providing NRT, treatments and e-cigarettes	Decline in primary care support and referrals
Increase in smokers' motivation to quit	Lack of CO monitoring
Greater political focus on health	Decline in wider tobacco control work
Stronger focus on inequalities	Loss of outreach and engagement with deprived communities
Increase in referrals, footfall and quit rate	Decline in referrals, footfall and quit rate

The last row of Table 2 demonstrates how the multiplicity of the effects of the epidemic resulted in radically different outcomes in different places. Where services were able to respond to smokers' newly incentivised quit attempts, service throughput and quit rates increased. In contrast, in areas where referrals dropped and services contracted, footfall and quit rates fell.

However, this is a simplification, as most respondents reported both positive and negative impacts of the pandemic. For example:

In this local authority, the impact of COVID-19 was perceived to be positive overall:

"Increased amount of quit dates set and 4 week quits. Quit for COVID campaign increased interest in stop smoking services. Digital offer of support was created. Smokefree schools gates has had to be put on hold due to schools time restraints." — County Council

In this local authority, the impact of COVID-19 was perceived to be neither positive nor negative overall:

"We continue to offer telephone support and this has been positive as it has removed the geographical limitations that prevented some smokers in the past from accessing our clinics. The pressure on pharmacies and GP surgeries, however, has led to a decrease in clients supported within primary care which has placed pressure on our team. This has also impacted our ability to obtain CO readings." — County Unitary Authority

In this local authority, the impact of COVID-19 was perceived to be negative overall:

"Communication breakdown, loss of contacts in prime settings, less referrals, strain on pharmacy scheme, Champix supply issues, lack of CO monitoring impacting motivation for patients and validity of quits. Training implications for those not used to technology. BUT training in fact is better, easier, cheaper and effective when up and running." — Urban Unitary Authority

Methods of delivering stop smoking advice

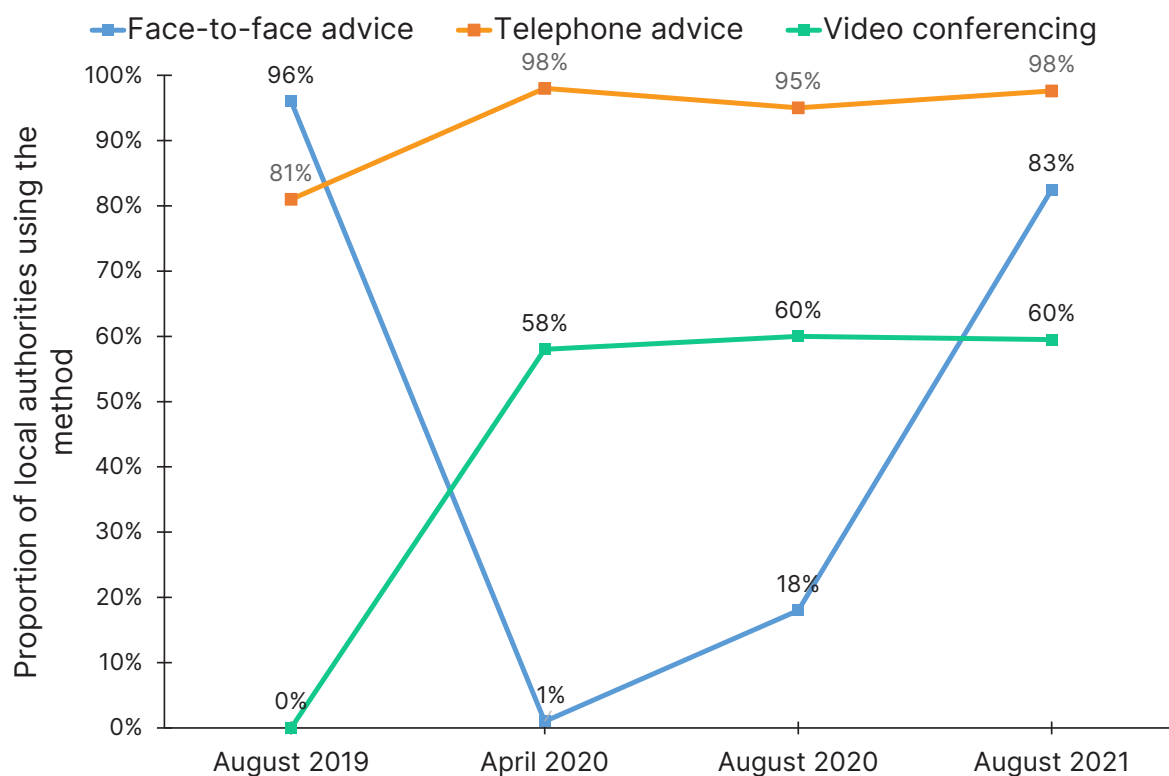
The most immediate impact on stop smoking services of the first COVID-19 lockdown, in April 2020, was the loss of face-to-face advice. Sixteen months later, at the time of the survey in August 2021, this change had been largely reversed and face-to-face advice was on offer in 83% of surveyed local authorities (Table 3). Over the same period, remote methods of providing advice and support had become widely established. Telephone advice was almost universal (98%) and video conferencing was being used by three fifths (60%) of local authority stop smoking services.

Figure 2 illustrates the changes over the last two years in the use of face-to-face support, telephone support and video conferencing by local authority stop smoking services.

Table 3. Methods of providing stop smoking advice in local authority commissioned services 2019-2021

	August 2019	April 2020 (First lockdown)	August 2020	August 2021
Face-to-face advice	96%	1%	18%	83%
Telephone advice	81%	98%	95%	98%
Video conferencing	0%	58%	60%	60%
Text messaging	-	81%	81%	75%
Email	-	-	-	47%
Mobile phone apps	-	-	-	40%

Figure 2. Changes in the use of face-to-face advice, telephone advice and video-conferencing in the delivery of stop smoking support 2019-2021



The increase in use of remote methods was mentioned by 66 survey respondents in their descriptions of the lasting effects of the pandemic. Improved flexibility, accessibility and cost effectiveness were cited as the reasons for this retention:

“Now offering a mix of face-to-face and virtual support making the service more versatile and cost effective. Some service users are finding this preferable and are more likely to engage and continue treatment.”

— County Council

“Services have adopted a blended approach to consultations which clients seem to prefer: some face to face but telephone and text consultations working well.”

— City Council

“We now have a more varied offer which has saved time and capacity through using a range of engagement methods using digital, etc. We have become more efficient in how we support people. The service has shown a lot of innovation and agility in responding to the changing situation.”

— County Unitary Authority

The difficulty in obtaining CO-confirmed quitting data was the most commonly cited negative effect of the move to remote support, not least in maternity services:

“Ongoing lack of CO monitoring compromises the integrity of reported quits and is also a loss as a motivational tool.”

— City Council

“We have found that telephone support has worked well for smokers and allowed more flexibility in the delivery of the service. The negatives for us have been not being able to do carbon monoxide testing as some clients like the accountability of this.” — City Council

“CO monitoring paused. Some people preferred virtual support, some missed face to face. Impact of CO monitoring paused has been biggest in maternity - now there is quite a lot of work that has had to happen to get activity back to where it was.” — County Council

Providers of stop smoking services

In 2021, three quarters of surveyed local authorities (76%) commissioned some form of specialist stop smoking service (Table 4). The proportion of local authorities commissioning or providing a specialist service has risen: in 2018, only 65% of surveyed local authorities had a specialist service, rising to 69% in 2019 and 77% in 2020.

Thirteen of the local authorities that commissioned a specialist service restricted this level of specialist support to target groups including three that only offered specialist support to pregnant women and their partners. Overall, 67% of local authorities offered a universal specialist service, up from 62% in 2020.

Many local authorities commission a combination of services for local smokers. For example, a specialist service with dedicated stop smoking advisers may be complemented by support from GPs and pharmacists. Table 4 describes the principal service commissioned for smokers in 2021/22, and Table 5 describes the services commissioned in addition to this principal service. Table 5 reveals that 45% of the local authorities that commissioned a specialist service also commissioned a lifestyle service. In practice, these may not always be distinct services, for example if they are different functions of the same commissioned service.

Table 4. Principal service commissioned for smokers by Local Authorities (LAs) for 2021/22 (n=150)

Principal service offer	Eligibility	Local Authorities
Specialist service	Universal	100 (67%)
	Target groups only	10 (7%)
	Pregnant women only	3 (2%)
Integrated lifestyle service	Universal	22 (15%)
Service from GPs and/or pharmacists	Universal	11 (7%)
Telephone helpline	Universal	2 (1%)
No service	-	2 (1%)

Table 5. Services commissioned in addition to principal service for 2021/22 (n=150)

Principal service offer	n (% of all LAs)	Additional commissions (% of LAs with this principal service offer)		
		Lifestyle service	GP/ pharmacist service	Services in other NHS settings
Specialist service (universal)	100 (67%)	45 (45%)	61 (61%)	49 (49%)
Specialist service (target groups only)	10 (7%)	3 (30%)	3 (30%)	2 (20%)
Specialist service (pregnant women only)	3 (2%)	1 (33%)	2 (67%)	0
Integrated lifestyle service	22 (15%)	-	10 (45%)	8 (36%)
Service from GPs and/ or pharmacists	11 (7%)	-	-	4 (36%)
Telephone helpline	2 (1%)	-	-	0
No service	2 (1%)	-	-	-

Local authorities that had retained or recommissioned a specialist stop smoking service or an integrated lifestyle service were better positioned to maintain their service through the COVID-19 pandemic than those that relied solely on NHS primary care providers. GPs and pharmacists had many new demands to meet due to COVID-19 so could provide little or no stop smoking support or even referrals.

- 25% of local authorities with a specialist service reported that the impact of COVID-19 had been negative overall (38% reported a positive impact)
- 33% of local authorities with an integrated lifestyle service and no specialist service reported that the impact of COVID-19 had been negative overall (39% reported a positive impact)
- 88% of local authorities that offered support in primary care only reported that the impact of COVID-19 had been negative overall (none reported a positive impact)

Loss of capacity in primary care was cited by 23 survey respondents in their descriptions of the lasting effects of the pandemic:

“Challenges in re-engaging primary care in undertaking stop smoking work which has led to patients being wrongly referred back to specialist team who now have a waiting list.” — County Unitary Authority

“The community pharmacy element of the service has seen negative impacts due to the pandemic reducing capacity of pharmacy to provide the intervention. We are currently supporting pharmacies to remobilise but this may be an ongoing challenge for the foreseeable future.”
— London borough

The individuals who provide advice

The 2021 survey sought to gain a fuller picture of the individuals who provide advice to smokers in each local authority area. Respondents were asked *Who delivers stop smoking support (behavioural support or brief advice) within the services your local authority commissions, provides or supports (e.g. through training)?* Table 6 describes their responses.

Table 6 is not a comprehensive account of the support available to smokers. It is, and can only be, a local authority perspective, and so excludes NHS services which local authorities do not contribute to or support. Nonetheless it shows the diversity of providers offering stop smoking support and the importance of local authorities' relationships with professionals and providers who can reach into the heart of local communities and engage with smokers in a range of traditional and non-traditional settings.

Despite the loss of capacity in primary care described in the last section, Table 6 reveals that pharmacists, GPs, and their staff remain key providers of local stop smoking support.

Dedicated stop smoking advisers provided behavioural support in all but two of the local authorities that reported having a universal or restricted specialist stop smoking services (the two exceptions relied on lifestyle advisers/health trainers to provide behavioural support) and in three quarters (72%) of the local authorities with an integrated lifestyle service but no specialist service. None of the local authorities that provided support in primary care only reported using dedicated stop smoking advisers.

Table 6. Professionals who provide stop smoking behavioural support or brief advice within services that local authorities commission, provide or support (e.g. through training), 2021 (n=126)

	Behavioural support	Brief advice
Dedicated stop smoking advisers	108 (85.7%)	69 (54.8%)
Pharmacists and other pharmacy staff	77 (61.1%)	81 (64.3%)
GPs, nurses and other practice staff	56 (44.4%)	82 (65.1%)
Lifestyle advisers/health trainers	41 (32.5%)	61 (48.4%)
Midwives	38 (30.2%)	92 (73.0%)
Mental health service staff	20 (15.9%)	65 (51.6%)
Drug and alcohol staff	18 (14.3%)	74 (58.7%)
Acute hospital staff	15 (11.9%)	66 (52.4%)

Health visitors	11 (8.7%)	78 (61.9%)
School nurses	10 (7.9%)	50 (39.7%)
Vape shop staff	9 (7.1%)	23 (18.3%)
Workplace stop smoking advisers	9 (7.1%)	24 (19.0%)
Prison staff	7 (5.6%)	13 (10.3%)
Voluntary and community organisation staff	6 (4.8%)	32 (25.4%)
Housing association and LA housing staff	1 (0.8%)	25 (19.8%)
Firefighters	0	27 (21.4%)

Providing NRT, medications and e-cigarettes

The COVID-19 pandemic challenged stop smoking services to innovate in their methods of providing NRT and medications. The lack of face-to-face consultations meant that medications had to be mailed or delivered to clients, and letters and vouchers for pharmacists had to be mailed or emailed.

By the time of this survey, in August 2021, face-to-face consultations had been widely restarted and 77% of local authorities were once again providing clients with medications during these consultations, either directly or by giving a voucher or letter for the pharmacy or GP. However, a variety of other methods were also being used (Table 7), in part because remote consultations continued to be used alongside face-to-face consultations in many local authorities.

Table 7. Methods of providing NRT and stop smoking medications (n=121)

	Local authorities
Direct supply during face-to-face consultation	62 (51%)
Vouchers/letters emailed to pharmacy or GP	61 (50%)
Vouchers/letters given during consultation	53 (44%)
Post	42 (35%)
Vouchers/letters posted to pharmacy or GP	30 (25%)
Home delivery	22 (18%)
Online pharmacy	6 (5%)
Nothing offered – users must obtain independently	5 (4%)

There has been a small improvement in the medications offered over the last two years. In 2021, 76% of surveyed local authorities offered a full course of dual NRT, compared to 65% in 2019. Overall, 88% of surveyed local authorities offered smokers a full 12-week course of varenicline (Champix) in 2021, the same rate as in 2019 (though in practice Champix has been suspended from the market since June 2021).²

Provision of e-cigarettes has increased significantly over the last two years. In 2019, only 11% of surveyed local authorities offered e-cigarettes to some or all smokers accessing stop smoking service. In 2021, 50 (40%) of surveyed local authorities offered e-cigarettes to some or all smokers and a further 19 (15%) had plans to do so.

Respondents described their services' current offer of e-cigarettes in their own words. Their approaches were diverse and included:

- offering e-cigarettes alongside stop smoking medications/NRT
- giving smokers vaping starter kits
- giving incentives for local vape shops and training vape shop staff
- targeted provision for pregnant women and other high need groups

The following examples illustrate each of these approaches:

"Our lifestyle service offers e-cigs/e-liquids as part of the standard service offer." — London borough

"The integrated lifestyle service stop smoking team provides a free vaping starter kit and starter liquids. Service users supply their own replacement parts (coils etc) and liquids on an ongoing basis."
— City Council

"We have two vape shops that have Level 2 advisors on site. We do not provide or finance the devices, the patients choose what they want."
— Urban Unitary Authority

"The specialist service offers E-burns to clients if they've had multiple failed quit attempts in the past and have used NRT/Champix with little success. We are also planning a pilot to offer E-burns to residents who smoke and live in support accommodation. There may also be an opportunity to offer E-burns to rough sleepers with substance misuse needs, as part of the PHE rough sleeper funding bid/initiative."
— London borough

Fifteen local authorities described their provision of e-cigarettes as still in a pilot phase.

Tobacco control work and alliances

Most local authorities were still engaged in tobacco control work beyond the provision of stop smoking services. The most common activities were tackling illegal tobacco supplies, conducting communications and campaigns about smoking, and enforcing legislation such as age of sale, point of sale and smokefree legislation (Table 8).

Table 8. Wider tobacco control work undertaken by local authorities, 2019-2021

	2021 (n=126)	2020 (n=108)	2019 (n=117)
Tackling illegal tobacco	108 (86%)	86%	91%
Communications and campaigns	107 (85%)	72%	88%
Enforcing legislation (age of sale, point of sale, smokefree)	103 (82%)	81%	87%
Smokefree public spaces	70 (56%)	63%	62%
Smokefree homes	49 (39%)	44%	44%
Regional support/action	49 (39%)	44%	48%
Research	17 (13%)	11%	21%
None of the above	5 (4%)	6%	3%

Table 8 describes a decline in the proportion of local authorities undertaking wider tobacco control work since 2019, prior to the COVID-19 pandemic. There has also been a decline in the volume of work undertaken within some local authorities. This was cited as one of the lasting effects of the pandemic by 22 survey respondents:

“Sub-regional alliance has not met due to officers being drawn to support the COVID-19 response. Contract performance meetings reduced. Campaigns significantly reduced e.g. ‘dog days’ with Trading Standards.” — Metropolitan borough

“Tobacco Control work such as awareness days and smokefree play park events ceased. Tobacco Control alliance ceased meetings due to priority of Covid response however these are looking to recommence soon.” — County Unitary Authority

“Tobacco control activity has been minimal due to Covid priority within local authority especially in public health and regulatory services. This continues.” — City Council

Nine respondents specifically identified problems related to their local alliances as one of the long term effects of the pandemic. Overall, 68 (54%) still had some form of local tobacco control alliance or partnership, down from 61% in 2020 and 74% in 2015. Even here, however, the experience was mixed. A respondent from a county council described how the local tobacco control alliance had flourished during the pandemic:

“Smokefree Alliance activity and interest has been high. Good engagement, particularly within healthcare, which has now been helped further by long term plan funding. Attendance at Alliance meetings has been excellent – I suspect virtual communication is easier with our large geography. Working across ICS patch has improved significantly. Engagement with the Alliance strategy has been good. People seem to be valuing the importance of smoking and its impact on physical health during the pandemic.” — County Council

The number of local authorities with a local tobacco control alliance varied by region (Table 9). All the surveyed local authorities in the North East of England reported having an alliance compared to only 36% in both London and the West Midlands.

Table 9. Local authorities with a tobacco control alliance by region (n=126)

Region	Surveyed local authorities responding	With a local tobacco control alliance
North East	10	10 (100%)
East Midlands	7	5 (71%)
Yorkshire and Humber	13	9 (69%)
East of England	11	7 (64%)
South East	16	10 (62%)
North West	17	8 (47%)
South West	13	5 (38%)
West Midlands	11	4 (36%)
London	28	10 (36%)

Integrated care systems

At the time of the survey in August 2021, 79 surveyed local authorities (63%) were engaging with their integrated care system (ICS) to address smoking. This compares to 105 (83%) that were engaging with their PHE region* to address smoking.

Respondents were asked if their ICS had made any commitments on tobacco control. In nearly half of all surveyed local authorities (47%), the respondent did not know if any such commitments had been made. Two fifths (42%) reported that the ICS had made such commitments, and 12% reported that the ICS had not.

Respondents who were aware of ICS commitments on tobacco control were asked to describe them in their own words. The majority of these descriptions focused on the NHS Long Term Plan and/or the delivery of tobacco dependency treatment services in NHS trusts. Five respondents specifically mentioned inequalities.

“In process - we have several working groups focusing on tobacco dependency and have worked across our ICS patch to develop our first business case and proposal around working with NHS trusts to achieve the ambitions set out in NHS LTP around tobacco dependency.”

— Urban/Rural Unitary Authority

“Identified as inequalities priority. Linked to LTP delivery.”

— Urban Unitary Authority

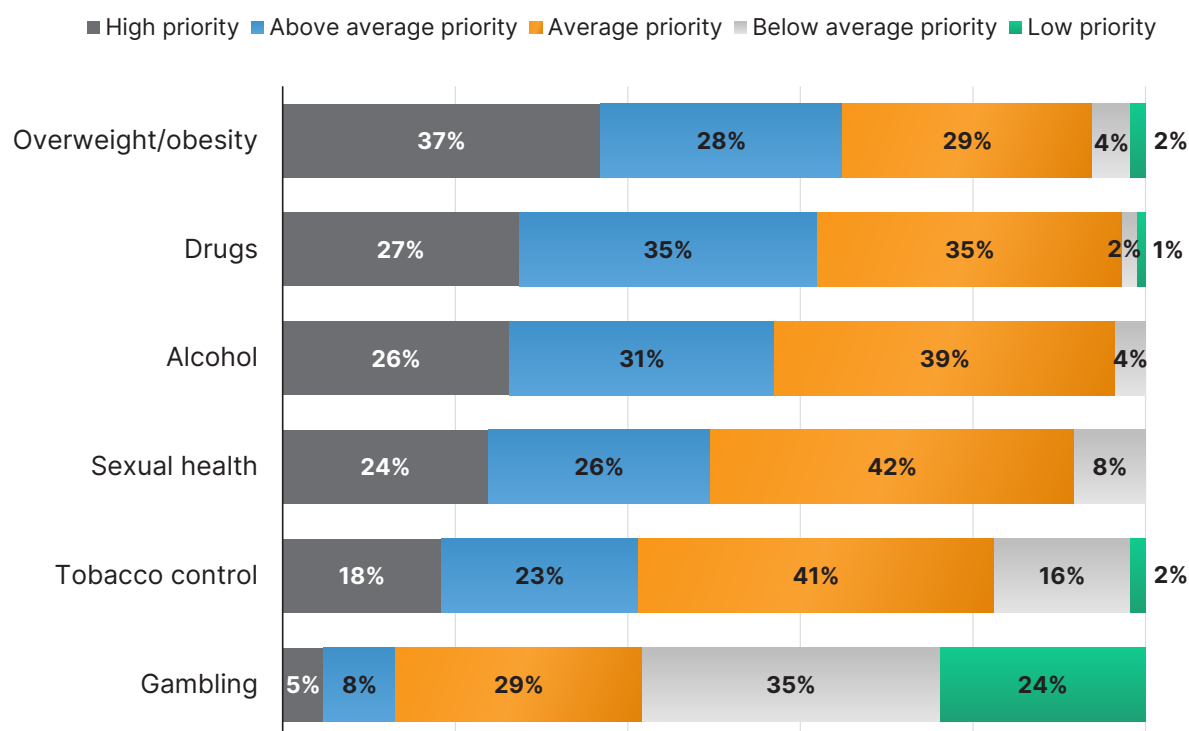
* Public Health England regions became regions of the Office of Health Improvement and Disparities on October 1st 2021.

The priority given to tobacco control

Tobacco control is one of several behavioural public health issues for which local authorities have responsibility. To assess its relative status, survey respondents were asked to indicate their perceptions of the priority given to six public health issues including tobacco control within their local authorities (Figure 3). Each assessment was on an independent scale from 'high priority' to 'low priority'.

Tobacco control was identified as being a high priority or an above average priority in 41% of surveyed local authorities and a low or below average priority in 18% of local authorities. It was rated as a high priority or an above average priority less often than overweight/obesity (65%), drugs (62%), alcohol (57%) and sexual health (50%). Only gambling was rated as a high priority or an above average priority less often (13%).

Figure 3. Level of perceived priority given by local authority to key public health responsibilities



The priority given to tobacco control has fallen over the last five years. In 2016, when this question was last asked within the annual ASH/CRUK survey of tobacco control leads, tobacco control was perceived to be a high or above average priority in 55% of local authorities and a low or below average priority in 19% of local authorities.

The number of local authorities where the priority given to tobacco control was perceived to be high or above average varied by region (Table 10). It was most often reported to be high or above average priority in the North East, and least often in the South West.

Table 10. Local authorities where the priority of tobacco control was perceived to be high or above average (n=114)

Region	Surveyed local authorities responding	Priority of tobacco control perceived to be high or above average
North East	8	7 (88%)
Yorkshire and Humber	12	7 (58%)
North West	16	8 (50%)
South East	14	6 (43%)
East Midlands	7	2 (29%)
London	24	8 (33%)
East of England	10	3 (30%)
West Midlands	10	3 (30%)
South West	13	3 (23%)

Respondents were asked to describe in their own words the factors that affected the level of priority given to tobacco control within their local authority. The principal positive factors they identified were leadership and advocacy, both within the organisation and beyond it; strong partnerships; and a clear case of local need. These are all identified in the following account:

“Strong and long standing Tobacco Alliance, in which the chief executive and director of public health have been well invested: a forum for discussion and to bring items to the attention of a broad range of people. Dedicated tobacco control lead in public health team, with leadership support. Good engagement across many sectors on the topic. Passionate individuals in the county. Good use of and appreciation of evidence and data.” — County Council

Ambitious strategy and goals were also identified, though not as frequently as the leadership and partnerships required to deliver them:

“The presence of an ambitious goal and strategy, a new director of public health and consultant, a shift from a focus on four week quits to wider tobacco control, an active and supportive Alliance Chair.” — County Council

The NHS Long Term plan was only mentioned by two respondents, also in the context of leadership, partnerships and strategy:

“Tobacco control has had a slightly lower priority over the last 18 months, but with the NHS Long Term Plan tobacco use prevention workstream there is a renewed focus on tobacco control. This means the local authority is driving conversations with local partners and planning to restart a Tobacco Control Alliance and publish a tobacco control strategy.” — City Council

The principal negative factors identified by respondents were the COVID-19 pandemic, budget cuts, and the loss of capacity arising from both of these factors. Several respondents expressed hope that the loss of capacity due to the pandemic would be recovered in time:

“Capacity of colleagues during the pandemic has definitely effected priorities of work in tobacco but also other areas. A number of our senior colleagues and public health consultants have been pulled in so many other directions. It has been a challenge to do much of the planning and strategy work, we have had to focus on just keeping business as usual going. We are starting to see this really shift now as we are moving out of the worst of the pandemic.” — County Council

Reduced budgets were the most commonly cited negative factor affecting the priority given to tobacco control. In some cases, loss of funding was due to COVID-19 but many respondents also identified the longer-term constraints on public health funding as the heart of the problem:

“Limited funding only supports commissioned smoke cessation services with very limited additional funds for projects, campaigns and other tobacco control work.” — County Council

The following response links the local lack of capacity with the need for leadership, engagement and partnership:

“The main issue is capacity to drive tobacco control as a priority. For a city this size we need more senior leadership / funding / staff not just to develop and deliver a comprehensive plan, but to engage with partners and develop an effective tobacco alliance. We have one manager who oversees all aspects of healthy living and one public health specialist who is new in post and is not from a tobacco control background.”
— City Council

A few respondents expressed hope that the pandemic would in time have a positive effect on priorities, thanks to the raised profile of public health and the new emphasis on tackling health inequalities:

“In the past council leaders have backed away from bolder stances on Tobacco Control (such as Smokefree Town Centres, which had a majority public support), although I feel that attitudes to this are now changing, following the councils strong response to the pandemic, and the greater emphasis and involvement of Public Health that the council has had.”
—London borough

“Everything has dropped down the priority list due to the pandemic but I am hoping that the renewed interest in health inequalities that has come from this may be a good hook to highlight tobacco control.”
— Urban Unitary Authority

Some of the factors described here as affecting the level of priority given to tobacco control may alternatively be the product of this political commitment. For example, local authorities where the priority given to tobacco control was perceived to be high or above average were twice as likely to have a local tobacco control alliance as the local authorities where the priority was low or below average.

Addressing inequalities

In order to explore current practice in tackling smoking-related inequalities, survey respondents were asked if their local authorities were currently undertaking any work with the following communities with higher smoking-related needs or services targeting at these communities:

- social housing providers
- debt and financial services
- deprived communities and routine & manual workers
- pregnant women
- people with mental health conditions
- Black and Minority Ethnic communities
- LGBTQ+ communities
- people with acute or long-term conditions

Where a local authority was undertaking specific work, respondents were asked to describe this work in their own words. Other groups mentioned by respondents as targets of their inequalities work were:

- users of drug and alcohol services
- older people
- young people
- looked after children and care leavers
- homeless people/ users of homeless hostels/ people in temporary accommodation
- carers

Table 11 describes the number of local authorities undertaking specific smoking cessation/ tobacco control work with each of the groups identified in the survey.

Table 11. Local authorities undertaking specific smoking cessation/tobacco control work with high need populations and targeted services (n varies as 'don't know' responses excluded)

Population/service	Local authorities
Housing associations	48 (43%)
Debt/financial services	23 (21%)
Deprived/routine & manual communities	101 (91%)
Pregnant and post-partum women	115 (97%)
People with mental health conditions	88 (77%)
BME communities	50 (44%)
LGBTQ communities	23 (21%)
People with acute or long-term conditions	79 (69%)

Many respondents made clear that addressing inequalities was at the heart of their approach and overall service design. For example:

“Our specialist stop smoking provider has KPIs specific to reaching smokers in high prevalence groups (mental health, BME, routine & manual, pregnant), and has been working with community partners to reach those groups, with good success. We are working with regional partners to implement comprehensive pathways for smokers with long-term or acute conditions and pregnant women.” — London borough

“Our services moved into an Integrated Community Network model based in the highest smoking prevalence area in the borough. This approach offers an opportunity to work closer with primary, voluntary and social care services, including social prescribers, who all members of the borough’s ICN+ network. We feel we can improve the reach in communities with highest need using this approach.” — London borough

“We have a Smoke Free Alliance with key stakeholders in the community to be able to tackle inequalities and reach our priority groups/populations. We are conducting assessments (CLeaR) at a local level to identify the needs and fill the gaps in policy and practice. We also work on an engagement plan tailored to each priority group to increase awareness and referrals in the service but also to collect service users’ experiences with our specialist service.” — London borough

Social housing

Among surveyed local authorities, 43% reported that they were undertaking tobacco control/smoking cessation work with housing associations or other social housing providers. This included:

- supporting the development of smokefree policies
- promoting stop smoking services and encouraging referrals
- training housing officers or housing association staff in very brief advice
- targeted provision of e-cigarettes
- including information on stop smoking services and smokefree homes in tenancy packs and in local communications
- engaging with tenants in rent arrears
- running local information events
- including housing professionals in local tobacco control alliances
- exploring the scope for smokefree tenancies
- delivery of stop smoking services on site in estates

“We have worked closely with one housing association to support their implementation of a voluntary No Smoking Policy with their tenants. This work is underpinned by provision of physical and electronic smokefree homes resources, brief intervention training for staff and signposting where required to the specialist smoking cessation service for staff and tenants.” — City Council

“Working with Social Housing providers to identify tenants who are smokers and are in arrears with rent payments, to engage and offer E-cig Starter kits to help with financial management support.” — Urban Unitary Authority

“Smokefree homes campaign, exploring smokefree tenancies and signposting to stop smoking services. Possibility of delivering stop smoking clinics in housing complexes.” — County Council

“Very brief advice training has been offered to all housing officers and stop smoking resources have been given to be used with all communications with smokers.” — Urban Unitary Authority

Debt and financial services

Among surveyed local authorities, 21% were undertaking tobacco control/smoking cessation work with debt or financial advice services. This included:

- training debt advisers to provide brief advice and referrals
- including smoking status in debt assessments
- encouraging referrals to stop smoking services by debt and financial advice services
- inclusion of tobacco control/smoking cessation in the local authority’s poverty strategy

“We have a homes and money team and they support residents, they have all been trained on smoking cessation and they explore this as part of their financial assessment.” — London borough

“Very brief advice and Make Every Contact Count training has been offered for specific community services that support targeted populations with issues such as financial debt.”
— Urban Unitary Authority

“Attempting to establish smoking status as standardised question in debt assessments with direct referral to smoking cessation services; support to include e-cigarettes.” — City Council

Deprived communities and routine/manual workers

Among surveyed local authorities, 91% were undertaking tobacco control/smoking cessation work with deprived communities or routine/manual workers, including those who were doing specific work with social housing providers or debt advice services.

Deprived communities and routine/manual workers were central to the commissioning and priorities of many stop smoking services. Some respondents reported that the entire service was directed to these communities, while others described more specific targets. For example:

“All of our smoking cessation work is targeted to individuals from deprived communities and routine/manual workers.” — London borough

“The core work of the stop smoking service is to work with vulnerable populations/groups and routine and manual workers.”
— Metropolitan borough

“Service targets to have 70% of service users from areas within the top 2 quintiles of deprivation.” — London borough

“Routine and manual workers are one of our priority groups for the service and as a KPI we have to have half of our service users working in routine and manual occupations.” — London borough

In addition to the work described above with social housing providers and debt services, the following work with deprived communities and routine & manual workers was identified by respondents:

- targeted support in deprived wards/ high prevalence areas
- targeted provision of e-cigarettes
- community engagement in deprived areas in partnership with community organisations
- workplace interventions and integration of smoking cessation in workplace health programmes
- work with local providers to improve referral pathways
- integration with wider work with deprived communities including COVID-19 recovery initiatives and food banks
- targeted communication and promotion of services

“Clinics set up in deprived areas; clinics set up in routine and manual workplaces.” — County Council

“We offer a workplace vaping intervention with routine & manual workplaces. The project gives smokers the chance to switch to e-cigarettes whilst also getting a £30 vaping vouchers when they quit.”
— County Unitary Authority

“To target routine & manual workers, we are collaborating with our business engagement teams including local town centre teams, licensing and environmental health to raise awareness of services available and offer businesses workshops for staff around smoking cessation as part of their health and wellbeing initiatives.”
— Urban Unitary Authority

“Focussed work through community engagement with community organisations.” — City Council

Pregnant and post-partum women

All but four surveyed local authorities (97%) were undertaking or supporting work with pregnant or post-partum women including 25% that ran a stop smoking incentive scheme for pregnant women. Their work included:

- partnership with maternity services in NHS trusts
- standard screening, CO-testing and advice at booking
- training midwives, maternity ward staff and health visitors to provide consistent stop smoking advice and referrals
- targeted specialist stop smoking support for pregnant women, post-partum women and their significant others
- providing advice to women in their homes on quitting, smokefree homes and smokefree cars
- targeted provision of e-cigarettes
- use of digital apps to widen engagement with pregnant smokers
- targeted communications
- inclusion of maternity services and professionals on tobacco control alliances
- supporting delivery of NHS Long-Term Plan commitment to provide tobacco dependency treatment in maternity wards
- support for midwife champions

“Maternity staff are all trained to deliver brief advice and referral as part of mandatory training. NHS Long-Term Plan ambitions being explored through maternity services, initially using CLear deep dive as a gap analysis exercise. Training has been provided to health visitors to provide brief advice and referral to post-partum women.” — City Council

“As part of the NHSE Early Implementer programme: offer of vapes, digital CO monitors, more enhanced intervention, looking at specialist midwife clinical support in trusts, updating web content, booking forms, recording and sharing data, training etc.” — County Unitary Authority

“All women are screened at booking and given CO readings and very brief advice. All Baby Intervention team members will become trained advisors and complete CO checks with all women on home visits and raise awareness about smokefree homes and cars.” — London borough

“We are working jointly with other boroughs to implement a BabyClear approach for pregnant women, with training of all midwives, CO monitoring at booking and at 36 weeks, and coordination of the work by midwife champions. This work was suspended during Covid but has now restarted.” — London borough

People with mental health conditions

Among surveyed local authorities, 77% were undertaking or supporting tobacco control/smoking cessation work with people with mental health conditions. This included:

- building and strengthening partnerships with mental health trusts
- training mental health trust staff to deliver behavioural support and brief advice
- improving referral pathways
- providing specialist stop smoking support within mental health services
- providing tailored, enhanced or more flexible stop smoking support to people with mental health conditions
- targeting communications to reach people with mental health conditions
- supporting mental health trusts to go smokefree including enabling e-cigarette use
- engagement with community mental health organisations
- supporting delivery of NHS Long-Term Plan commitment to provide tobacco dependency treatment in mental health and hospital services

“We work closely with the mental health trust and have a specialist mental health advisor to provide continuity of care to all mental health patients. This also helps us build relationships and work more closely with providers.” — County Council

“We are collaborating with local organisations such as Mind to run sessions with staff on the local stop smoking services available, myth busting, and education on the importance of having healthy conversations with all clients that smoke. We are planning to make use of the mental health trust’s service-user forums to inform the work that we do and how we promote our services to this cohort.” — Urban Unitary Authority

“People with mental health conditions are offered a more flexible ‘harm reduction/cut down to quit’ service rather than a ‘12 week quit’ programme.” — City Council

“The tobacco lead has been working with counterparts across the county to support the mental health trust to develop and implement its smokefree policy in line with NICE guidance. The tobacco lead has also been supporting the trust’s application process for NHS Long-Term Plan tobacco dependency funding for inpatients. Pre-Covid, our commissioned stop smoking service had clinics in the trust and a pathway created to move clients into the community.” — County Council

Black and Minority Ethnic communities

Among surveyed local authorities, 44% were undertaking tobacco control/smoking cessation work with Black and Minority Ethnic communities. This included:

- targeted promotion of services, in local languages where necessary
- targeted communications about shisha and oral tobacco
- working with community organisations and champions
- running information and advice sessions in community settings
- dedicated stop smoking advisers and outreach workers
- developing digital apps for specific communities
- increasing language skills within the stop smoking service
- using social prescribing within primary care
- targeted work to detect illegal tobacco
- integration of smoking cessation in other plans (e.g. asylum-seeker support plans)
- building on the lessons of COVID-19 to better reach communities

“Engagement work and public health messaging with the local community on niche tobacco products such as shisha and oral tobacco. Dedicated stop smoking advisor who provides advice and support to those using oral tobacco products.” — City Council

“The smoking cessation service has employed several part time workers who speak English as a second language but who can communicate fluently in a number of other languages such as Arabic, Bengali, Polish, and Romanian.” — City Council

“Using community champions; targeted work with community leaders; offer of brief intervention training to community leaders/staff in BAME organisations. Targeted intelligence-led operations to detect illegal tobacco. PR material in different languages in relation to illegal tobacco.” — City Council

“We are working with our in-house Community Connections Forum to raise awareness of local support available to local inter-faith, inter-ethnic influencers and hope to offer in-reach support considering how successful this model of delivery has been through the COVID-19 pandemic with promoting testing/vaccinations.” — Urban Unitary Authority

LGBTQ+ communities

Among surveyed local authorities, 21% were undertaking tobacco control/smoking cessation work with LGBTQ+ communities. This included:

- having a presence at local events such as Pride
- partnership with community organisations
- outreach to local groups
- targeted communications

“We make sure we have a presence at local LGBTQ+ events such as Pride (a stall with resources as well as our stop smoking advisor having a roaming presence and conducting CO monitoring, VBA interactions and signing people up for support). We are beginning discussions with a local youth LGBTQ+ support group to think about potential collaborative approaches to raise awareness around the benefits of quitting smoking and to offer stop smoking support.” — Urban Unitary Authority

“The council has commissioned a health and wellbeing outreach bus which will provide advice on a range of health behaviours. It will target a range of communities and events including LGBT specific events and provide stop smoking brief advice and information.” — London borough

“The specialist smoking cessation team have recently started working with the local authority Equalities lead to build connections with the LGBTQ community.” — City Council

People with acute or long-term conditions

Among surveyed local authorities, 69% were undertaking tobacco control/smoking cessation work with people with acute or long-term conditions. This included:

- partnerships and clear referral pathways across the NHS: in primary, acute and community care
- provision of specialist stop smoking support in primary and secondary care
- training clinical professionals in brief advice
- specific campaigns such as ‘Stop before the Op’
- screening and referral through Targeted Lung Health Checks
- supporting delivery of NHS Long-Term Plan commitment to provide tobacco dependency treatment in hospital services

“This is part of the local authority plan and also the NHS Long Term Plan which is our focus at the moment. We are currently reviewing pathways in order to improve referrals and to understand how/if we can make this easier through systems and provide feedback.” — County Council

“We have funded a full-time post across two acute trusts to provide clinical training, stop smoking behavioural support and work with clinical leads to coordinate the stop smoking work. Our specialist stop smoking provider provides a clinic for inpatients and outpatients, working collaboratively with the respiratory team.” — London borough

“The local stop smoking service is targeted to this group and very brief advice training is provided to clinicians who serve those populations.”
— County Council

“Smoking cessation information and support provided to those with respiratory issues via lung health checks.” — Metropolitan borough

Targets, plans and specific work

In the analysis above, attention is drawn to the more active and engaged forms of work with the communities identified. The examples cited illustrate the breadth of the work currently being undertaken. For some respondents, however, a ‘Yes’ to these questions simply reflected a commitment to target these groups. This commitment might be expressed in the content of local tobacco control strategy or in the specification of the service for the commissioned provider.

In some cases, respondents noted that their work was still in the planning stage. This was especially notable for the findings for social housing providers and debt and financial services, which are services rather than target groups:

- Of the 43% of local authorities that reported they were undertaking tobacco control/smoking cessation work with housing associations or other social housing providers, 44% described this work as wholly in the development or planning stage.
- Of the 21% of local authorities that reported they were undertaking tobacco control/smoking cessation work with debt or financial advice services, 26% described this work as wholly in the development or planning stage.

In contrast:

- Of the 91% of local authorities that reported they were undertaking tobacco control/smoking cessation work with deprived communities or routine/manual workers (including work with social housing providers and debt services), only 5% described this work as wholly in the development or planning stage.

Respondents’ accounts of their current actions to address inequalities encompassed a wide range of approaches. These included:

- improving the accessibility of the existing service for target groups including exploring and enhancing referral pathways
- improving the service offer to higher-need individuals including the provision of e-cigarettes
- employing or training specialised workers who can better meet the specific needs of individuals engaging with the service
- training frontline workers in other organisations to provide advice, support and referrals

- outreach and direct engagement with communities in their own settings or localities including partnerships with community organisations
- tailoring communications to target communities
- integrating tobacco control in wider local authority strategies that engage with local communities and address inequalities
- supporting the development of policy and practice in the NHS and within community organisations

Discussion

This study draws attention to the diversity of the impacts of the COVID-19 pandemic on stop smoking services and wider tobacco control work in English local authorities. There have been many negative impacts including the redeployment of people and resources away from tobacco control, the loss of capacity in primary care, and the decline in tobacco control work beyond stop smoking services. Yet survey respondents also reported many positive impacts, chief of which has been the development of new methods of remote support which, when combined with reinstated face-to-face support, potentially offer a more flexible service to local smokers than the services that preceded the pandemic.

The uneven impact of COVID-19 across surveyed local authorities is striking, with 36% reporting a positive impact overall and 30% reporting a negative impact overall. In part this reflects differences in how services were configured and supported within local authorities prior to the pandemic. Those local authorities that had a dedicated stop smoking service, whether as a stand-alone specialist service or as a component of a lifestyle service, fared better than authorities that had commissioned support predominantly in primary care, which was to be overwhelmed by the demands of the pandemic. More generally, services that had maintained substantial capacity despite years of cuts to public health budgets were well placed to innovate and adapt, while those services that had been pared back to a minimum were more likely to buckle and contract as new demands were made on public health capacity.

The NHS remains a key partner in efforts to reduce smoking. Survey respondents acknowledged the role not only of GPs and pharmacists in providing stop smoking support but also that of midwives, health visitors, and the staff of acute and mental health trusts. Although the pandemic has slowed down the roll-out of the NHS Long Term plan,³ the commitment within it to creating new tobacco dependence treatment services in hospital settings is likely to play an increasingly important role in the collective effort to reach smokers with high health needs. It is of some concern that nearly half of respondents to the survey did not know if their integrated care system had made any commitments on tobacco control. Among those that did, the majority cited the role of the Long Term Plan in defining these commitments.

The coming year is likely to see demand for services stimulated by the roll-out of tobacco dependency treatment services through the NHS Long Term Plan and the expansion of Targeted Lung Health Checks. These new programmes are to be welcomed but local government services have little capacity to expand after years of funding cuts. This lack of capacity may affect the outcomes of these NHS programmes and reduce the likelihood that more smokers will be supported to stop.

This demand stimulation will come at a time of uncertainty as the recurring shocks of the pandemic continue to place pressures on the whole health and care system. While many local authorities were resourceful in adapting stop smoking services and their tobacco control work in 2020 and 2021, some local authorities have clearly struggled. It is unreasonable in the current environment to expect local authorities to continue to adapt to ongoing resource pressures without further support from national Government.

All services remain vulnerable to cuts in public health funding. Between 2013/14 and 2020/21 net expenditure by local authorities in England on stop smoking services declined by 45% from to £129.6m to £71.2m. Expenditure on wider tobacco control fell by 48% from £18.9m to £9.9m.⁴ Over this period the priority given to tobacco control within local authorities also fell: tobacco control was perceived to be a high or above average priority in 55% of surveyed local authorities in 2016, but in only 41% of local authorities in 2021. These two measures are linked, for cuts to funding were the most commonly cited factor affecting the level of priority given to tobacco control. Prior to the pandemic, in 2019, three quarters of surveyed local authorities (74%) said pressure on budgets was a threat to local tobacco control, including ongoing cuts to local authority budgets, cuts to the public health grant, and uncertainty about the future of the grant.⁵

The Government's commitment in the 2021 Spending Review, to maintain the Public Health Grant in real terms,⁶ did nothing to reverse the 24% real-term per capita cut the Grant has seen since 2015/16, which will require an additional £1.4bn a year investment in 2021/22 price terms by 2024/25 to restore historical levels of funding, according to The Health Foundation.⁷ Despite local authorities' best efforts, these cuts have consistently translated into substantial cuts to local government tobacco control work, which is why it is so important local councils have increased and sustainable funding for dedicated smoking cessation services.

The importance and urgency of the work of tobacco control professionals has not diminished. The inequalities that define the remaining population of smokers in England present huge challenges which will not be met on shoestring budgets. This report has described many of the innovative approaches that local authorities are taking to tackle these inequalities and reach smokers in deprived and disadvantaged populations, including much wider provision of e-cigarettes. These approaches need to be universal, properly resourced, and complemented by ambitious national interventions if the 2030 smokefree goal is to be achieved in England across all population groups. The sustainability of local authority tobacco control is vital to the mission of tackling inequalities given local authorities' reach into local communities, engagement with community groups, and convening role through local tobacco alliances.

The recommendations made in the APPG on Smoking and Health's report, *Delivering a Smokefree 2030*,⁸ would provide the funding and national regulatory framework to enable local authorities to play their full role in tackling smoking. The publication of a new national tobacco control plan for England provides the perfect opportunity to implement them. **The proposed Smokefree Fund would raise the necessary funding for comprehensive tobacco control activity across England, without allowing the tobacco industry to interfere with how it is spent. This fund is much needed to guarantee security for local authorities' tobacco control work, achieve the 2030 smokefree ambition, and level up health outcomes to address disparities across the country.**

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