

FEELING THE HEAT

THE DECLINE OF STOP SMOKING SERVICES IN ENGLAND

FINDINGS FROM A SURVEY OF LOCAL AUTHORITY TOBACCO CONTROL LEADS

CONDUCTED BY ACTION ON SMOKING AND HEALTH
COMMISSIONED BY CANCER RESEARCH UK



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Feeling the Heat: The Decline of Stop Smoking Services in England

Findings from a survey of local authority tobacco control leads

Cancer Research UK and Action on Smoking and Health

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About Cancer Research UK

Cancer Research UK is the world's largest independent cancer charity dedicated to saving lives through research. It supports research into all aspects of cancer, achieved through the work of over 4,000 scientists, doctors and nurses. We receive no funding from the Government for our research and we are dependent on fundraising with the public. Cancer Research UK wants to accelerate progress so that three in four people survive their cancer for 10 years or more by 2034.

About Action on Smoking and Health

Action on Smoking and Health (ASH) is a campaigning health charity that works to eliminate the harm caused by tobacco. It was established in 1972 by the Royal College of Physicians. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK. It has also received project funding from the Department of Health to support tobacco control.



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Summary

Budgets and political priorities

Budgets for stop smoking services were cut in half (50%) of local authorities in 2017. They increased in 4% of local authorities.

These changes follow budget cuts in 59% of local authorities in 2016 and cuts in 39% of local authorities in 2015.

In 2017, budgets for stop smoking services were cut in 50% of local authorities in England. This follows cuts in 59% of local authorities in 2016 and in 39% of local authorities in 2015.

Budgets for smoking cessation medications were cut in 34% of local authorities that paid some or all of these costs (they increased in 6%). Nine in ten local authorities contribute to the cost of smoking cessation medications.

One third of local authorities no longer have a budget for wider tobacco control work.

The reduction in the public health grant and the wider cuts to local authorities were the primary drivers of the cuts to budgets for stop smoking services, smoking cessation medications and wider tobacco control work.

Tobacco control was perceived to be a high priority or above average priority in 57% of local authorities and a low or below average priority in 16% of local authorities. Budgets for stop smoking services were cut in 75% of local authorities where the priority for tobacco control was low and in 50% of local authorities where it was high.

Services for smokers

Three quarters (74%) of local authorities commissioned a specialist stop smoking service in 2017 but only 61% commissioned a universal specialist service.

A specialist stop smoking service open to all smokers is now provided by only 61% of local authorities in England.

Specialist stop smoking services have been replaced by integrated lifestyle services in 17% of local authorities. In some of these services (9% of all local authorities), specialist stop smoking advisers are available. In others (8%), advice on smoking cessation is fully integrated into a broader intervention exploring personal health needs.

Nine percent of local authorities commissioned stop smoking support solely through primary care (pharmacists and GPs).

One local authority reported no current stop smoking services of any kind for smokers.

In 75% of local authorities, stop smoking services support the use of e-cigarettes by smokers in their attempts to quit. The remainder 'neither support nor discourage' the use of e-cigarettes. Support for the use of e-cigarettes is lower in primary care providers (50%).

Restrictions on the prescription of Varenicline and NRT by GPs are emerging in some areas. More work is needed to quantify and characterise these restrictions.



Recommendations

As a matter of urgency, the government should reverse the decline in funding for local stop smoking and tobacco control services by implementing a sustainable funding solution based on the polluter pays principle. This could be achieved by the introduction of a levy on tobacco company profits to cover the costs of providing the services that support people to quit smoking.

Local authorities should work with clinical commissioning groups and NHS trusts to ensure that all smokers engaging with the health system consistently have access to the treatment and behavioural support they need to quit. Sustainability and Transformation Plans offer a vehicle for promoting such strategic collaborative approaches.

Local authorities and their partners should develop and implement clear strategies to tackle local inequalities in smoking, addressing the needs of highly addicted and disadvantaged smokers who are likely to need high quality treatment to give them the best chance of quitting.

A consistent approach to e-cigarettes should be pursued by all providers in line with the evidence base and the recommendations of NICE and Public Health England. Primary care providers should take a more positive approach to supporting those smokers who want to quit using an e-cigarette.

Introduction

This report presents the findings from the fourth annual survey of tobacco leads in English local authorities with responsibility for public health. Funded by Cancer Research UK and conducted by Action on Smoking and Health, these surveys have tracked key indicators of the health of stop smoking services and wider tobacco control functions in the local government setting. Full reports are available of the surveys conducted in 2014¹, 2015² and 2016³.

Public health teams moved to local authorities as part of the NHS reorganisation in 2013. The rationale for the change focused on local authorities' links with their communities, which potentially offer diverse opportunities to promote the health of these communities.

Unfortunately, however, the change coincided with the beginning of a major austerity programme within local

government, driven by central government cuts. It has been these constraints, rather than the new opportunities of the local government setting, that have dominated the findings of the surveys over the last four years. Nonetheless, in many areas stop smoking services have proved to be resilient and adaptable. The findings in this report highlight both the ongoing challenges faced by tobacco control professionals in local authorities and the diversity of their responses to these challenges.

1. Anderson W and Asquith H. *Taking a Reading: The impact of public health transition on tobacco control and stop smoking services in England*. Cancer Research UK and Action on Smoking and Health, 2014.

2. Anderson W and Cheeseman H. *Reading between the lines: Results of a survey of tobacco control leads in local authorities in England*. Cancer Research UK and Action on Smoking and Health, 2016.

3. Action on Smoking and Health. *Cutting Down: The reality of budget cuts to local tobacco control*. Cancer Research UK and Action on Smoking and Health, 2016.

Methods

The survey was designed to be completed by tobacco control leads in English local authorities. There are 152 local authorities in England with responsibility for public health: 57 unitary authorities, 27 non-metropolitan counties, 36 metropolitan boroughs and 32 London boroughs.

The survey was conducted online using Survey Monkey. Tobacco control leads were contacted by email and invited to complete the survey. Non-respondents were followed

up by telephone. The survey was open online from July to September 2017. Responses were received from 117 local authorities, a response rate of 77%.

Respondents identified principally as tobacco control leads or commissioners of tobacco control/stop smoking services (Table 1). Fifty-two respondents (44%) identified as both.

Analysis was conducted using SPSS and Excel.

Table 1. Respondents' roles

Tobacco control lead	79 (68%)
Commissioner of tobacco control/stop smoking services	77 (66%)
Consultant in public health with responsibility for tobacco	7 (6%)
Stop smoking service manager	11 (9%)

Budgets and political priorities

Changes in budgets

In every year since this survey was first conducted in 2014, a simple measure has been used to monitor the financial health of tobacco control activity in local authorities: whether local budgets for stop smoking services, medications and wider tobacco control work increased, decreased or stayed the same compared to the previous year.

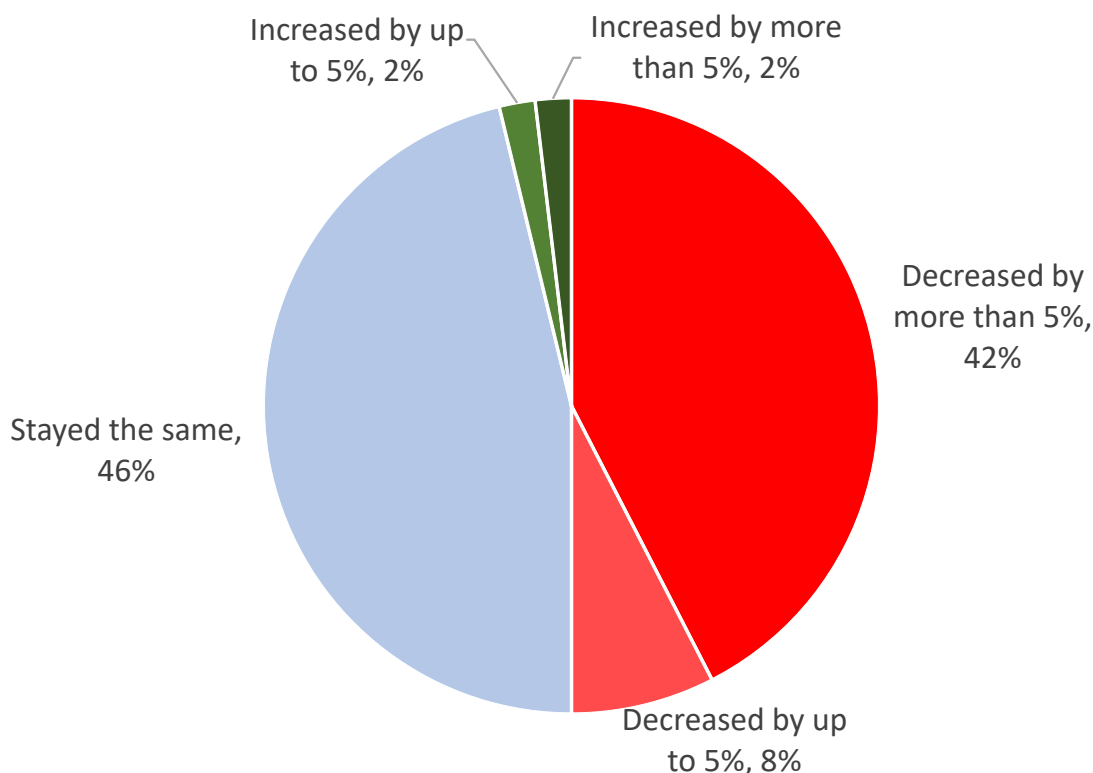
One of the consequences of the changes in local stop smoking and tobacco control services, described in detail below, is that this measure can no longer be applied universally. In particular, where specialist stop smoking services have been decommissioned and replaced with an integrated 'lifestyle' service, there may no longer be an identifiable budget for stop smoking service. Furthermore, many local authorities no longer have budgets for

wider tobacco control work, a reality that is misrepresented by a finding that such budgets have 'stayed the same'.

Of the 117 respondents to the 2017 survey, seven reported that a specific budget for stop smoking services could no longer be identified due to a shift to an integrated lifestyle approach, and one respondent reported a nil budget across all smoking cessation and tobacco control work. A further three respondents did not have access to budget data and so did not know how their budgets for stop smoking services had changed.

Of the remaining 106 respondents, exactly half reported a decrease in their budgets for stop smoking services this year (Figure 1). For most of these respondents (45/53) this decrease had been greater than 5%. In 49 local authorities (46%) budgets for stop smoking services had stayed the same,

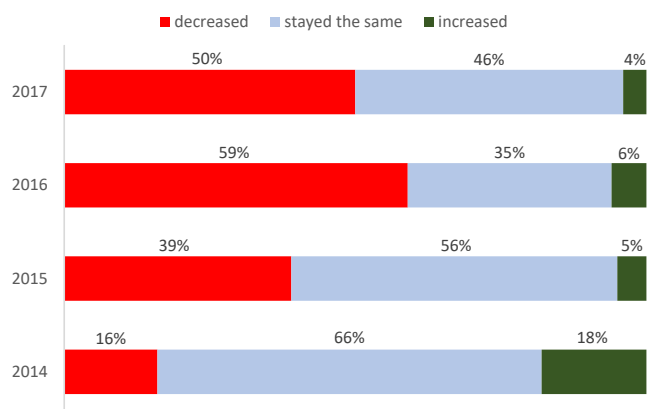
Figure 1. Changes in local authority budgets for stop smoking services 2016/17 to 2017/18 (excluding integrated and nil budgets)



with increased budgets reported by four respondents (4%).

Figure 2 compares this year's reported changes in budgets for stop smoking services with the results from the three previous years. Each year is a snapshot with a slightly different sample but every sample has been large enough to be representative.

Figure 2. Changes in local authority budgets for stop smoking services 2014-2017

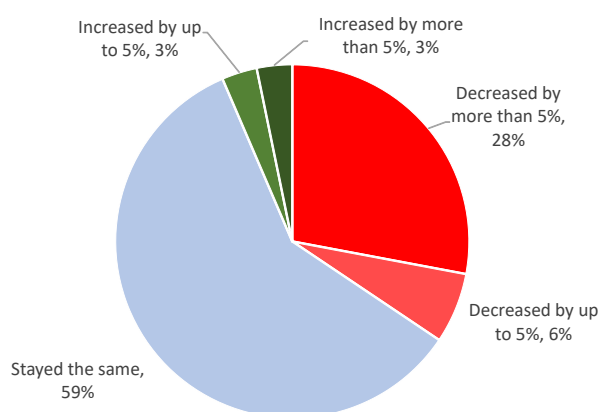


Budgets for smoking cessation medications were held by 103 local authorities in the sample (90%). Fifty local authorities (44%) met all of these costs (Table 2), while 53 local authorities shared medication costs with clinical commissioning groups (n=29), GPs (n=19) or NHS trusts (n=20).

In those local authorities with budgets for smoking cessation medications, where respondents also had knowledge of changes to these budgets (n=93), budgets had stayed the same in 55 (59%), declined in 32 (34%) and increased in 6 (6%) (Figure 3).

Information on wider tobacco control budgets was provided by 79 respondents. A third of these budgets (n=26, 33%)

Figure 3. Changes in smoking cessation medication budgets 2016/17 to 2017/18 (in local authorities paying some or all of these costs)



were nil budgets. In the remaining 53 local authorities, budgets had remained the same in 30 cases, declined in 18 and increased in 5.

Reported budgets ranged from £0 to £1.77 million for stop smoking services (mean £436,500), £0 to £836,000 for smoking cessation medications (mean £274,100) and £0 to £160,000 for wider tobacco control work (mean £33,600).

Reasons for budget changes

In those local authorities where budgets had declined, the principal reasons respondents gave for the cuts were the reduction in the public health grant and the wider pressures on local government budgets. One or both of these reasons was specifically identified by 26 of the 44 respondents who gave a reason for a budget cut in response to an open question (a further eight respondents cited unspecific cost pressures). Although all local authorities have had to absorb the

Table 2. Organisations funding smoking cessation medications, 2017. Percentages are of all local authorities in the sample where data was available (n=114)

	Paying some or all medication costs	Paying all medication costs
Local authority	103 (90%)	103 (90%)
Clinical Commissioning Group	38 (33%)	9 (8%)
NHS Trusts	22 (19%)	1 (1%)
GPs	20 (18%)	0

cuts to the public health grant, the wider cuts to local authority budgets were cited just as often:

“The local authority needs to make significant amount of savings as part of the wider savings proposal. Public health is not immune to these cuts. Tobacco budget is not ring fenced and it is not one of the mandated function to deliver.”

A fall in demand for stop smoking support was cited as a reason for budget cuts by six respondents. This was described by the following respondent as part of a more complex shift in the smoking epidemic and the response of public services to it:

“Cuts are due to changes in the commissioning landscape, introduction of e-cigarettes, decreasing prevalence and low uptake rates and targets.”

However, this complexity cuts both ways. In one of the few local authorities where stop smoking service budgets had increased, the following reason was given for the uplift:

“Targeting routine and manual workers and those who are heavy smokers is more expensive per quit. Numbers using NRT and pharmacotherapy have increased and wider tobacco control work is also dedicated to supporting smoking cessation in pregnancy.”

Similarly, in a local authority where the stop smoking services budget had stayed the same, an uplift had been agreed for a previously nil tobacco control budget in recognition of the increasing difficulty of attracting smokers to the stop smoking service:

“We had no budget for tobacco control in 16/17, however in 17/18 we have made the case for a small budget to deliver a campaign to increase the number of referrals into the stop smoking service, and do some focused work around smoking in pregnancy.”

The challenges of attracting smokers to stop smoking services was also cited as a reason for a shift in commissioning towards an integrated lifestyle approach.

Political priorities

Despite the ongoing cuts to budgets for stop smoking services and wider tobacco control, a majority of respondents perceive tobacco control to be a high (26%) or above average (31%) priority in their local authority. Sixteen per cent of respondents perceive tobacco control to be a below average (12%) or low (4%) priority, with 31% reporting an average priority.

Active opposition to tobacco control is rare: three respondents reported opposition from the leader of the council but no-one reported opposition from their chief executive or lead member for health and wellbeing. The great majority of respondents (91%) said their lead member for health and wellbeing supported tobacco control. The remainder (9%) said this key stakeholder neither supported nor opposed tobacco control.

Cuts to budgets for stop smoking services were most common in local authorities where the priority for tobacco control was perceived to be low (75%) or below average (79%). However, half of the local authorities where tobacco control was perceived to be a high priority had also cut their budgets for stop smoking services.

Nil budgets for wider tobacco control work were also most common among local authorities where tobacco control was perceived to be a low or below average priority (62%), compared to 41% of local authorities where the priority for tobacco control was perceived to be average and 18% of local authorities where this priority was perceived to be above average or high.

Services for smokers

The outcome of the widespread decommissioning and recommissioning of stop smoking services since public health teams moved to local government in 2013 is a complex map of services for smokers across England. In many places, specialist stop smoking services continue to engage hundreds of smokers in quitting programmes every month. In others, services are substantially diminished or gone.

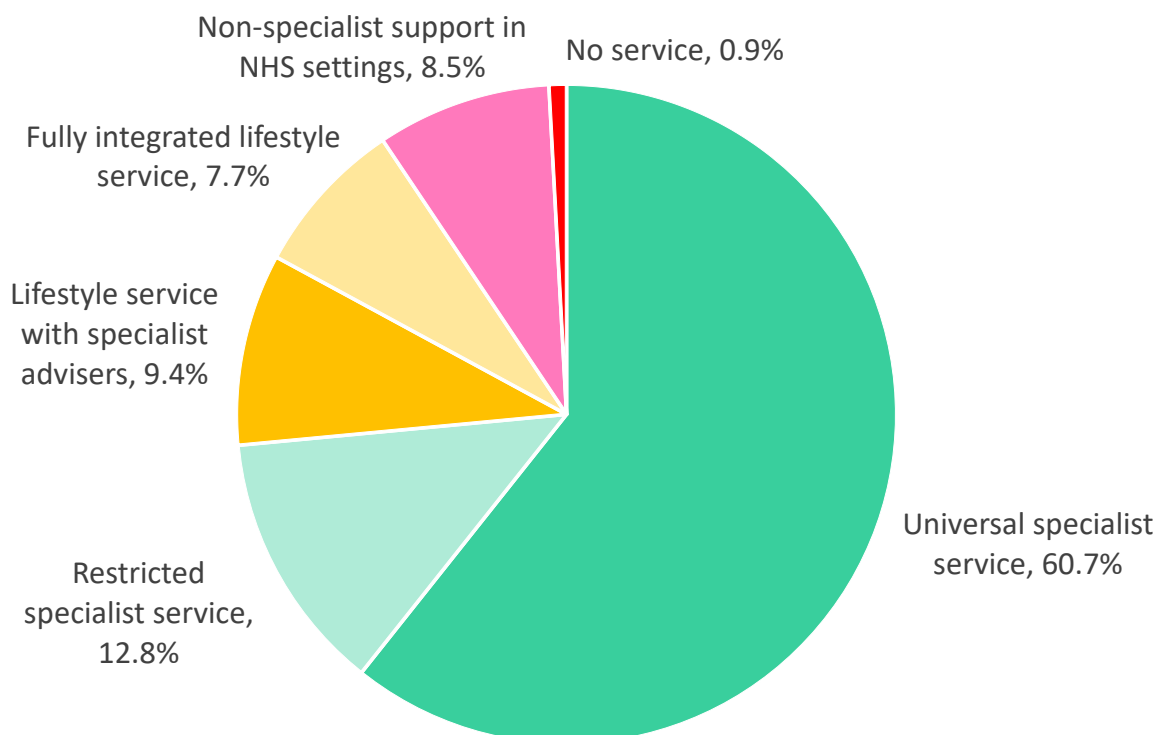
Three broad approaches to commissioning stop smoking services can be distinguished:

- specialist services (universal and restricted)
- integrated lifestyle services
- support from within primary care only

These are not mutually exclusive: many local authorities that commission specialist services or integrated lifestyle services also commission support from GPs and pharmacists. If, however, these categories are used to describe the primary offer to smokers by local authorities, they can be applied exclusively (Figure 4).

In Figure 4 integrated lifestyle services are divided between those services that retain specialist stop smoking advisers and those services that pursue a fully integrated model in which advisers address smoking as part of a wider discussion about health and wellbeing. In addition, some integrated lifestyle services function as a gateway to established specialist services. These services are all included within the 'universal specialist services' slice of the pie chart.

Figure 4. Primary offer to smokers in local authorities in England, 2017



Specialist stop smoking services

The majority of local authorities in England still commission a specialist stop smoking service, though not always a universal one.

At the time of the survey (July - September 2017), 86 local authorities (74%) had some form of specialist stop smoking service in place. Specialist services take many forms but, in line with NICE guidance, they typically include a team of specialist advisers offering smokers a programme of one-to-one or group support with access to pharmacotherapy. Specialist services may also support the work of non-specialist advisers in the wider health economy, as in the following example:

“A broad range of stop smoking support is available to help smokers to quit or reduce the harm from tobacco. They include a specialist service providing one to one and group support in community settings, intermediate behavioural support and treatment provided through community pharmacists and specific community providers such as health trainers. Services are promoted through communications support. The specialist service provides 50% of time direct delivery and 50% mentoring and supporting other providers especially the pharmacists.”

The 86 local authorities commissioning a specialist service include 14 local authorities where the stop smoking service is accessed through a lifestyle service of some kind, for example through an initial consultation with a generic health adviser or through the completion of an online health needs assessment. In these cases, the service received by smokers is likely to be comparable to other established specialist services:

“Specialist service within wider integrated wellbeing service, evidence based (NCSCT guidance compliant), open and repeat access, based on medication (12 week course free of charge to service users) and specialist

behavioural support. Includes 1 day per week in-reach to local hospital”

Many specialist stop smoking services now target those most in need. Target groups identified by respondents included pregnant women, people within the routine and manual socio-economic group, people with mental health conditions, people with long term conditions, heavy smokers and smokers who are unlikely to quit through other means, people living in deprived areas, young people and students, homeless people, LGBT people, gypsies and travellers, and people from ethnic minorities. The first three of these target groups were most often identified.

Local authorities may combine such a targeted approach with a universal offer, as in the following examples:

“Flexible, comprehensive smoking cessation support including NRT and/or medication as appropriate, available to all smokers with a particular focus on routine and manual workers, pregnancy and mental health.”

“Universal service that offers evidence-based level 3 support including both behavioural support and pharmacotherapy. Including an outreach service that targets routine and manual workers and BAME.”

However, for 15 of the 86 local authorities who commission a specialist stop smoking service, targeting involves the restriction of the service to specific groups. Most respondents who described restricted specialist services identified a range of target groups but two reported that their service was only available to pregnant women.

Overall, at the time of the survey, 71 local authorities (61%) still offered a universal specialist stop smoking service.

Specialist services remain the most common approach to local stop smoking service provision but the shift away from this model is on-going. Four respondents reported that their specialist services would be gone within 12 months: two replaced

by a lifestyle service and two replaced by provision in primary care only. At the same time, however, two local authorities that have decommissioned their specialist services are planning to reintroduce them. Overall, this will leave 84 local authorities (72%) offering a specialist service and 69 (59%) offering a universal specialist service.

Integrated lifestyle services

As described above, there were 14 local authorities (12%) where lifestyle services were commissioned but did not replace specialist stop smoking services, instead providing either a referral gateway to specialist services or a complementary service for those smokers who do not qualify for a targeted specialist service. In addition, there were 20 local authorities (17%) commissioning lifestyle services that did not refer smokers to specialist services but incorporated the offer within the service. These were all universal services.

It is in the nature of such lifestyle services that stop smoking advice is offered as part of a broader intervention exploring other aspects of health behaviours. However this does not necessarily mean that smokers who approach such a service with a motivation to quit cannot receive focused stop smoking support. Eleven local authorities (9%) commissioned a lifestyle service where smokers can speak to a dedicated stop smoking adviser at some point in their engagement with the service.

"[The lifestyle service] can support patients to quit smoking for up to a year offering 1-2-1 friendly, tailored support and advice with specialist advisors. It also provides an express service for those who just want to quit. Free stop smoking medicine is available. There is also free text or phone support."

This leaves nine local authorities (8%) where the lifestyle service commissioned has no specialist stop smoking component or advisers. Advice is given by generic health advisers whose brief is to address

all aspects of each individual's health behaviour, though they may still be trained to offer focused advice on quitting where this is requested.

GP and pharmacy services

Overall, 65 local authorities (57%) commissioned GPs to provide stop smoking support and 79 (69%) commissioned pharmacies to provide this support. In some cases, this service is subcontracted through a specialist service.

Ten local authorities (9%) commissioned stop smoking support solely through primary care. All of these local authorities commissioned pharmacies to provide this support; 8 commissioned GPs as well.

Although some local authorities have decommissioned specialist services to leave stop smoking services in primary care only, elsewhere it has been primary care provision that has been lost to protect specialist services:

"We had engagement of all our GP practices and 14 local pharmacies but these were decommissioned from 1 April 2017 due to mandatory cost savings - Public Health responsibilities that were not mandated (such as smoking cessation) took the biggest hit."

Other services

Respondents described a variety of other service providers and settings including voluntary organisations, maternity services, drug and alcohol services, NHS trusts and prisons. The national helpline and the London Smoking Cessation Transformation Project were also mentioned.

Overall, 19 respondents (17%) reported that their local authorities commission stop smoking services in hospitals. This is likely to under-represent the extent of stop smoking services in secondary care as NHS funders may also be involved.

Support for e-cigarettes

Most stop smoking services now support smokers who want to use e-cigarettes as part of their approach to quitting. Overall, 75% of respondents said that local stop smoking services supported this approach with the remaining 25% reporting that services ‘neither support nor discourage’ the use of e-cigarettes. No-one reported that e-cigarette use was discouraged.

The following examples illustrate the extent to which e-cigarettes are now integrated into both the practice and the values of many stop smoking services:

“All commissioned services allow for the provision of a structured evidence based 4 week quit attempt as part of the 12 week treatment programme that includes setting a quit date and support for behavioural change in conjunction with an electronic cigarette. E-cigarettes are not currently available on prescription but can be purchased by the client to support their quit attempt.”

“The service is e-cig-friendly, plus licensed meds. Person-centred, diverse. It’s a stop smoking service not a stop nicotine service.”

Support for e-cigarettes use was lower in those areas dependent solely on stop smoking provision in primary care: exactly half of respondents in these areas said that e-cigarette use was supported compared to 67% of respondents in areas where lifestyle services were commissioned and 80% of respondents in areas where specialist services were commissioned.

Prescribing

Table 3 describes prescribing practice for key smoking cessation medications in both specialist stop smoking services and lifestyle services. In most, but not all, of these services, Varenicline and dual form NRT are directly available to smokers. Where they are not, users of the service may have to seek help from their GPs, as in the following example:

“The support offered is the NCSCCT standard treatment programme. Smokers are offered up to 12 weeks NRT support. Smokers who want to use an e-cigarette to quit are also offered NRT and behavioural support as part of the treatment. If a smokers want to use Varenicline or Bupropion they are sent a letter of recommendation to their GP.”

All respondents were asked about current prescribing practice by GPs in their area. Excluding those who did not know, 88% of respondents reported that GPs prescribed NRT and 90% reported that GPs prescribed Varenicline. In the ten local authorities where stop smoking support was only provided through primary care, two respondents did not know whether NRT and Varenicline were prescribed by GPs and two reported that NRT was not prescribed including one who also reported that Varenicline was not prescribed.

These findings on GP prescribing should, however, be treated with caution as local authority tobacco control leads may not always have full knowledge of the prescribing practice of their local GPs. More work is needed to quantify and characterise prescribing restrictions, where they exist.

Table 3. Prescribing practice by primary service offer (specialist vs. lifestyle) ‘Don’t know’ responses excluded

	Varenicline (Champix)	Bupropion (Zyban)	NRT		No meds available
			Dual form	Single form ONLY	
Specialist services (n=81)	75 (93%)	65 (80%)	76 (94%)	4 (5%)	1 (1%)
Lifestyle services (n=18)	15 (83%)	14 (78%)	18 (100%)	0	0

Discussion

This was the fourth annual survey of tobacco control leads in English local authorities. The first was first conducted in 2014, the year after public health teams moved to local government. Tobacco control professionals have faced significant challenges in the subsequent years, the biggest of which has been the financial pressures of a shrinking public health grant and tightening local authority budgets.

Specialist stop smoking services have been credited with reducing the inequalities in smoking prevalence. Now, more than ever, this expertise is needed.

This year, half of local authorities with public health responsibilities cut their budgets for stop smoking services. Last year, three fifths did so. In 2015, two fifths of these budgets were cut. The cumulative impact of these cuts is inescapable: services for smokers have greatly diminished since the NHS gave up control of them in 2013. Then, smokers throughout England could access a universal specialist stop smoking service. Now, this is true in only three fifths of English local authorities.

As in previous years⁴, stop smoking services have suffered most in local authorities where tobacco control is a low priority but, even in those local authorities where the priority given to tobacco control is perceived to be high, half of stop smoking budgets were cut this year. The stark epidemiological fact that smoking remains the leading cause of preventable deaths in every local authority in England has not been enough to protect these services.

Smoking prevalence remains particularly

high in disadvantaged groups including people in the routine and manual socio-economic group, people with mental health conditions and people experiencing multiple forms of deprivation, such as homeless people. Many stop smoking services target such high prevalence groups, though the concurrent loss of a universal offer in some areas suggests that such targeting may be a response not only to local epidemiology but also to financial constraints.

Specialist stop smoking services have a good record of treating people from disadvantaged groups and have been credited with reducing the inequalities in smoking prevalence^{5,6}. Now, more than ever, this expertise in reaching disadvantaged smokers is needed⁷. However, the shift away from specialist stop smoking services to integrated lifestyle services and services provided solely in primary care risks losing this focus on inequalities. Typically, such services make an offer to the general population and may not have the capacity or skills to reach out to those groups where smoking prevalence remains high.

Commissioners face a challenge: retaining a universal service for all smokers is highly desirable but this should not involve the loss of a commitment to tackling the inequalities that lie at the heart of the epidemic, a commitment that costs more per head to deliver than a simple open door policy.

4. Anderson WJ, Cheeseman H and Butterworth G. Political priorities and public health services in English local authorities: the case of tobacco control and stop smoking services. *Journal of Public Health*, 20th October 2017 doi.org/10.1093/pubmed/fox143.

5. National Centre for Smoking Cessation and Training: *Stop Smoking Services and Health Inequalities*, NCSC, 2013.

6. Bauld L, Judge K, Platt S: Assessing the impact of stop smoking services on reducing health inequalities in England: observational study, *Tobacco Control* 2007, 16: 400-404.

7. Department of Health: *Towards a Smokefree Generation – A Tobacco Plan for England*, 2017.