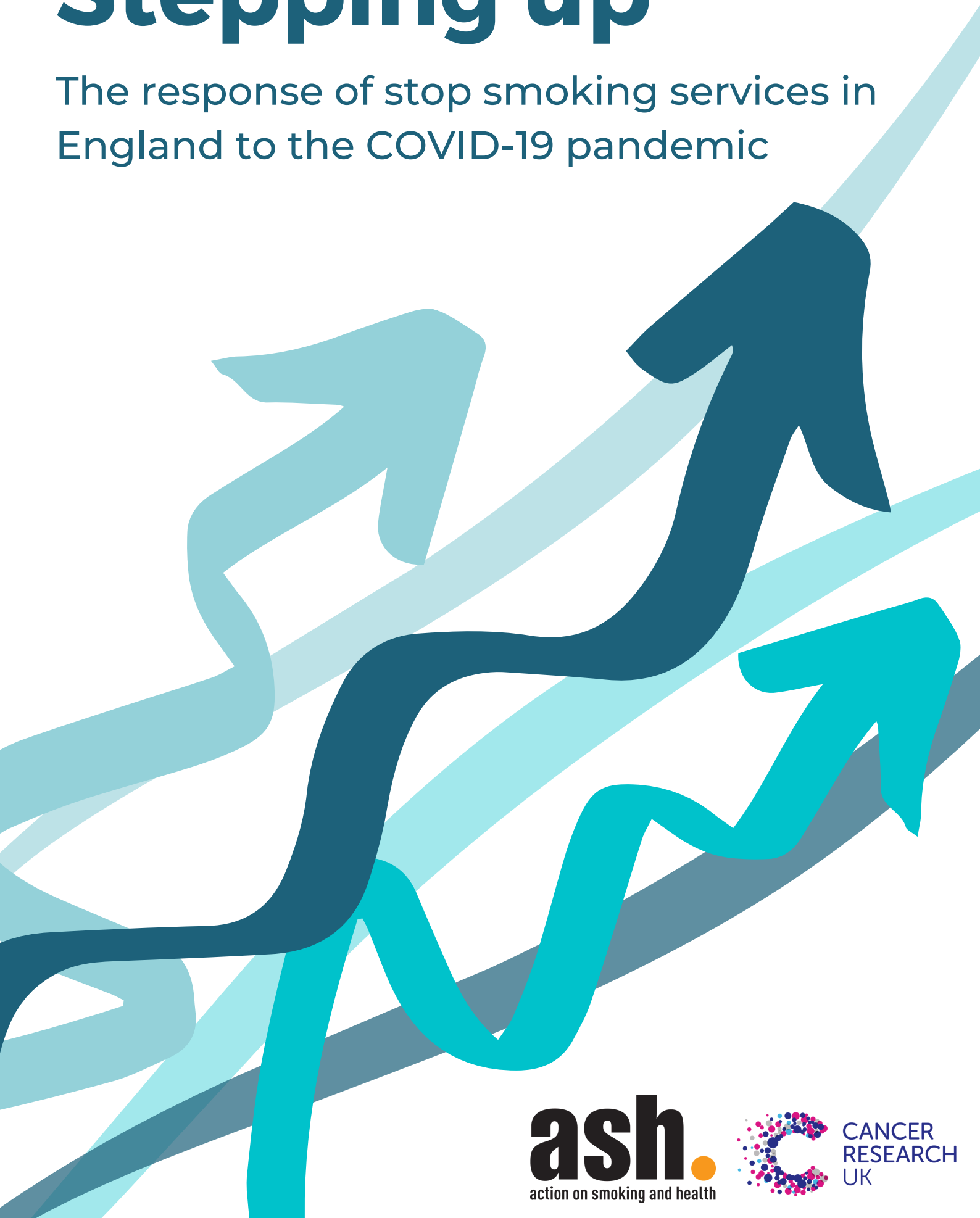
Stepping up

The response of stop smoking services in England to the COVID-19 pandemic



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action on smoking and health

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1. Summary and recommendations

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- The COVID-19 pandemic forced local authorities to reconfigure their stop smoking services at an unprecedented speed. They adapted quickly and many found that smokers welcomed remote methods of engagement such as telephone consultations.
- The impact of the pandemic on the NHS meant that NHS providers of stop smoking support could no longer offer the same level support. Many specialist stop smoking services and lifestyle services were able to pick up the demand that could not be met in primary care.
- Four in five local authorities (82%) undertook communication specifically about smoking and the pandemic, assisted by the #QuitforCovid campaign and resources.

Summary of findings

In 2020/21, a specialist stop smoking service was commissioned by 77% of surveyed local authorities in England, compared to 69% in 2019. A universal specialist service was commissioned by 62% of surveyed local authorities. Where a specialist service was not commissioned, stop smoking support was provided by a lifestyle service or through primary care only.

All surveyed local authorities had commissioned face-to-face behavioural support for 2020/21 and all but one abandoned this method following lockdown in March 2020. At the time of the survey, in August and September 2020, only 18% were offering face-to-face support. Almost all services (98%) offered telephone support during lockdown. Video conferencing was the greatest innovation, commissioned by 29% of local authorities but used by 58% during lockdown and 60% at the time of the survey. These remote methods of delivering behavioural support were reported to be widely welcomed by clients as they were more flexible and accessible than face-to-face appointments.

The impact of the pandemic on the NHS meant that many NHS providers of stop smoking support, especially GPs and pharmacists, could no longer offer the same level of support. Referrals to stop smoking services from primary and secondary care also fell during and after lockdown. Services had to rely on (or rapidly develop) alternative referral pathways, including self-referral. Many specialist stop smoking services and lifestyle services were able to pick up the demand that could not be met in primary care.

Stop smoking services found new ways of ensuring that their clients could obtain nicotine replacement therapy (NRT), other medications and e-cigarettes. These included emailing vouchers and letters to pharmacists and GPs, posting products to clients, using online pharmacies, and delivering direct to clients' homes. Although direct delivery was usually an emergency measure, the other methods are likely to be retained by many services in the long term.

In three fifths of surveyed local authorities (59%), stop smoking services made special provisions for vulnerable groups in response to the COVID-19 pandemic. Remote methods of delivering advice and medications were used to reach vulnerable individuals such as pregnant women, homeless people, or individuals who were shielding from COVID-19. Some stop smoking services sought to target communications with vulnerable individuals through GP lists, local community organisations, or through the mechanisms created by local authorities to reach people affected by COVID-19 restrictions.

Almost all surveyed local authorities (98%) had undertaken public communication in the previous 12 months to encourage smokers to quit or increase footfall to stop smoking services. Social media was the most common method used. Four in five local authorities (82%) undertook communication specifically about smoking and the pandemic, assisted by the #QuitforCovid campaign and resources.

At the time of the survey in August and September 2020, demand for stop smoking services was reported to be higher than before lockdown in 21% of surveyed local authorities and lower in 38%. Demand had fluctuated across the year and was dependent on many factors including the profile of commissioned services and whether this included a specialist service, loss of capacity in the NHS, the decline in referrals from the NHS, the prohibition of carbon monoxide (CO) monitoring, adaptability and innovation within stop smoking services, and increases in smokers' motivation to quit. Some respondents reported a higher level of need among those who did contact their services.

Tobacco control alliances (established cross-sector partnerships) had been adversely affected by the pandemic in two thirds of the 61% of local authorities that had an alliance, principally due to cancelled meetings and loss of capacity. Nonetheless many respondents reported that the challenges of responding to COVID-19 had generated valuable new relationships with stakeholders within and beyond their local authority.

Most local authorities (94%) were engaged in some form of wider tobacco control work including 86% who were tackling illegal tobacco and 81% enforcing legislation. The size and scope of local authorities' commitment to wider tobacco control varied greatly. Some local authorities had struggled to maintain this work in the face of shrinking resources and capacity, exacerbated by the challenges of the COVID-19 pandemic, while others had fully-fledged programmes of work. Such programmes were typically supported by strategy (enabled by leadership and accountability), committed resources, and effective partnerships, often extending to larger geographies.

Spending on stop smoking services by local authorities in England fell by 7.8% between 2018/19 and 2019/20 from £77.3m to £71.3m. Over the same period, spending on wider tobacco control increased by 28.9% from £10.0m to £12.9m. Between 2013/14 and 2019/20, total local authority expenditure on stop smoking services and wider tobacco control fell by 43.3%.

Despite the financial constraints faced by local authorities due to the pandemic, no stop smoking services suffered an in-year cut in funding and 14% benefited from an increase in financial resources. Extra costs arose from setting up home working, posting medication or e-cigarettes to clients, making special provisions for vulnerable groups, additional public communication, and increases in demand for specialist and lifestyle services.

Recommendations

1. Government should invest in public health and deliver new investment in tobacco control by implementing a 'polluter pays' Smokefree 2030 Fund. This charge on the tobacco industry could raise at least £300 million a year which has been estimated to be the amount needed to fund the recurring costs of stop smoking services and tobacco control at national, regional and local levels.[1]

2. Government should implement the measures set out in the Smokefree Action Coalition's Roadmap to a Smokefree 2030.[2] These include further reducing the affordability of tobacco, renewing the Government's strategy to control the illicit trade in tobacco, and consulting on new measures such as a requirement for retailers to have a licence to sell tobacco. This would ensure that national policy fully supports local action in delivering the Smokefree 2030 ambition in England.

3. Local authorities should consider how lessons from the innovation this year can be best applied in the future to meet the needs of all smokers in the most effective way. In particular, remote support may need to be complemented by face-to-face services for populations that are unable or unwilling to access remote support. It is likely that many services will continue to be remote through 2021; this provides an opportunity to evaluate these methods before determining the profile of longer-term service models that meet the needs of all smokers.

4. As pressure on the NHS eases, local authorities should explore ways to strengthen links with NHS partners, ensuring that primary care referral pathways that have been interrupted during COVID-19 are restored. The roll-out of the NHS Long Term Plan in 2021 will create new opportunities to address tobacco dependence in acute, mental health and maternity settings.

5. Local authorities should ensure comprehensive tobacco control strategies are in place,[3] revised as appropriate to take account of lessons from the COVID-19 pandemic.

6. Given the contribution that tobacco control makes to tackling health inequalities and improving the economic wellbeing of local communities, local authorities should ensure that comprehensive tobacco control strategies are a core part of COVID-19 recovery plans.

7. Local authorities should build on their communications successes in 2020. Social marketing activity is most effective at regional level and opportunities to collaborate on a larger footprint should be grasped. Local communications strategies should be developed to take advantage of revitalised relationships with local stakeholders and maximise the opportunities of social media and local media partners.

2. Introduction

This report presents findings from the seventh annual survey of tobacco control leads in English local authorities. It was commissioned by Cancer Research UK (CRUK) and conducted by Action on Smoking and Health (ASH). Previous surveys have tracked the development of local stop smoking services and local authorities' wider tobacco control work since responsibility for public health was transferred from the NHS to local government in 2013. Over this period there has been considerable diversification in stop smoking services, with some local authorities integrating stop smoking support into broader lifestyle advice services, and others shifting stop smoking advice entirely to primary care providers.[4]

Repeated cuts in the government's public health grant, and wider government cuts to local authority spending, have taken their toll on local stop smoking services and tobacco control activity. However, the local authority setting has also created opportunities to build new working relationships both within local authorities and across the wider local community.

The 2020 survey had a new focus: the impact of the COVID-19 pandemic on local stop smoking services and tobacco control work. Commissioners and providers of stop smoking services had to move fast to adjust to the constraints of the pandemic and the national lockdown imposed by government in March 2020. Specific guidance for stop smoking service providers was issued by the National Centre for Smoking Cessation and Training on the 18th March which recommended that all face-to-face advice and carbon monoxide (CO) monitoring should cease immediately.[5]

Respondents to the survey described in detail how they coped with these restrictions and the wider impacts of the pandemic on the NHS and public attitudes. Many were innovative and resourceful, developing new approaches to delivering their services that not only met the immediate challenge but also offered the prospect of longer-term improvements. Nonetheless the constraints were considerable and some local authorities were much better placed to cope with the challenges of the pandemic than others.

3. Methods and respondents

The survey was conducted online and included questions with closed 'tick-box' answers and questions with open free-text answers. Questions explored commissioning intentions for 2020/21 and subsequent changes in services due to lockdown and the ongoing impact of the COVID-19 pandemic.

The survey was open online in August and September 2020. Local tobacco control leads were emailed by ASH and invited to complete the survey. Non-respondents were initially followed up by email, then by telephone, and encouraged to participate.

Complete responses were received from 106 individuals who provided data on 111 local authorities, 74% of the 151 local authorities in England with responsibility for public health. This compares to response rates of 84% in 2019 and 71% in 2018.

Of the 106 respondents, 92 (87%) identified as a tobacco control lead, or a commissioner of tobacco control/smoking cessation services, or both. Of the remaining 14 respondents, four were stop smoking service managers, three were public health specialists and two were consultants in public health with responsibility for tobacco. There was one Addictive Behaviours Lead, one Specialist Stop Smoking Practitioner, one Manager of a Health Check Team and one Quality Assurance Officer.

Respondents were asked if they had responsibility for any areas of work other than tobacco control and smoking cessation. Ninety per cent said they did (n=95). The following areas of work were reported:

- healthy lifestyle services (21%)
- NHS health checks (19%)
- COVID-19 response (13%)
- drugs (13%) and alcohol (21%) services
- healthy weight services (18%)

Other areas of work identified were workplace health, sexual health, falls, food poverty, community development, and parks. Other strategic responsibilities identified were general public health responsibility, primary care contracts and voluntary sector commissioning.

All quantitative data was analysed using SPSS Version 23. Data from open questions was subject to content analysis.

4. Stop smoking services commissioned for 2020/21

Respondents to the survey were asked to identify the range of stop smoking support their local authority had commissioned, or planned to provide, in 2020/21 prior to any changes due to the COVID-19 pandemic.

Over three quarters of surveyed local authorities (77%) commissioned a specialist stop smoking service in 2020/21 (Table 1). This is a significant increase from previous years: the proportion of local authorities commissioning a specialist stop smoking service was 69% in 2019 and 65% in 2018. There was a corresponding decrease in the proportion of local authorities commissioning a lifestyle service only or support in primary care only (Table 2).

Among the 85 local authorities that commissioned a specialist stop smoking service, 69 commissioned a universal service (62% of all surveyed local authorities). Of the 16 that restricted access to their specialist service, 12 provided a universal offer via another means such as an integrated lifestyle service, primary care or a telephone helpline. Of the four that did not, two had broad eligibility criteria including people with long-term conditions and people with mental health conditions. The remaining two only provided a service to pregnant women.

Specialist stop smoking advisers were employed in the great majority of surveyed local authorities (83%). Advisers in primary care – pharmacists and GPs – were also widely commissioned to provide stop smoking advice (Table 3).

Table 1. Services for smokers commissioned or provided by local authorities in 2020 prior to any changes due to COVID-19

	local authorities (n=111)
Specialist stop smoking service	85 (77%)
Integrated lifestyle service	47 (42%)
Stop smoking support in primary care	68 (61%)
Stop smoking support in maternity care	66 (59%)
Stop smoking support in secondary care	37 (33%)
Stop smoking support in mental health services	28 (25%)
Telephone helpline	43 (39%)

Table 2. Principal service for smokers commissioned or provided by local authorities: 2020 vs. 2019 and 2018

	2020 (n=111)	2019 (n=127)	2018 (n=107)
Specialist stop smoking service	85 (77%)	69%	65%
Integrated lifestyle service (no specialist service)	19 (17%)	20%	22%
Stop smoking support in primary care only	6 (5%)	9%	9%
Community-based model of support	1 (1%)	0	0
Telephone helpline only	0	2%	3%

Table 3. Advisers delivering stop smoking advice and support in local authority-commissioned services in 2020 prior to any changes due to COVID-19

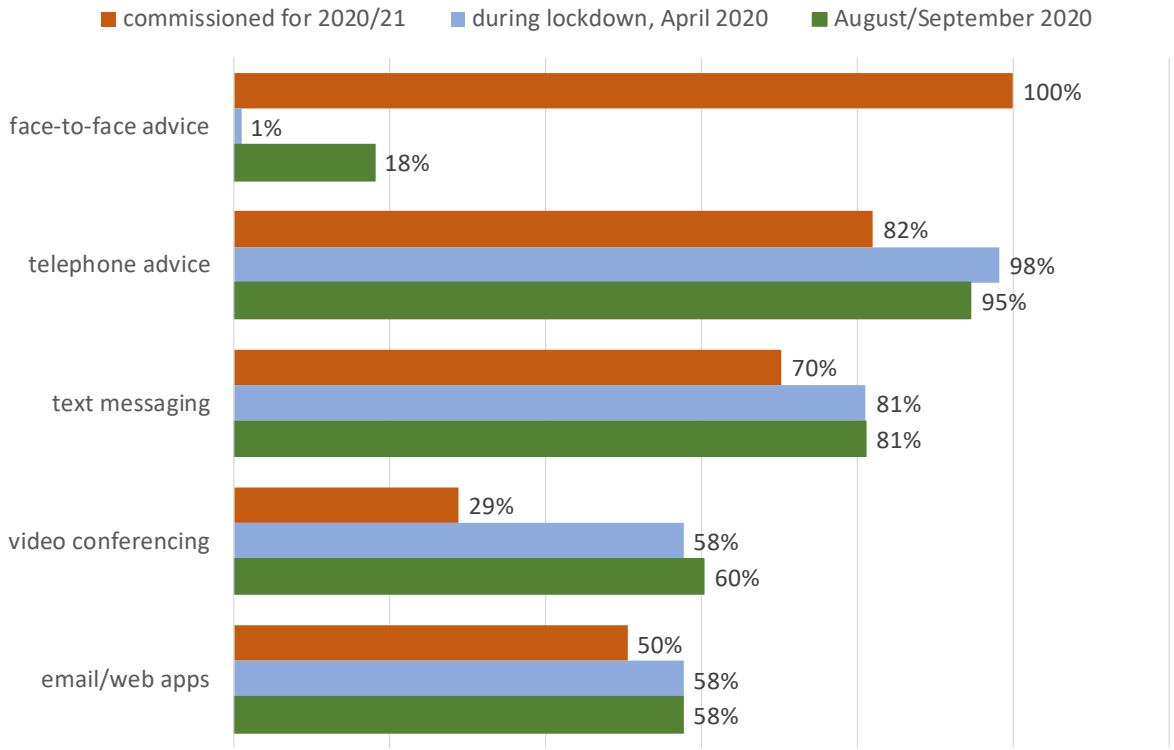
	local authorities (n=111)
Specialist stop smoking advisers	92 (83%)
Pharmacists	67 (60%)
GPs	52 (47%)
Lifestyle advisers/ health trainers	45 (41%)
Nurses	39 (35%)
Midwives	39 (35%)
Vape shops	11 (10%)

5. Delivering behavioural support in a pandemic

The March lockdown forced stop smoking services to radically change their approach to providing advice to smokers. In every surveyed local authority, face-to-face advice had been commissioned or planned for 2020/21 but this was abandoned by all but one during lockdown (Figure 1). By the time of the survey, in August and September 2020, only 18% were offering face-to-face advice.

Telephone advice was the most widely used method both during lockdown and at the time of the survey. Video conferencing was the biggest innovation: only 29% of local authorities had commissioned this method but three fifths used it during lockdown (58%) and at the time of the survey (60%).

Figure 1. Methods used by stop smoking services to provide advice: commissioned for 2020/21, used during lockdown, and used at the time of the survey



The speed with which services had to adapt was unprecedented. Specialist and lifestyle services, with their dedicated advice functions, were well-placed to make the change, though the challenges were considerable:

> *Quarter 1 saw the full implementation of an entirely remote service offer due to the effects of the Covid 19 pandemic. This difficult time was supported by the coaches and managers who tirelessly worked to be able to offer support to people using telephone and video support.*

> *Putting remote working arrangements in place, plus the number of staff shielding and self-isolating whilst working from home, had a strain on service delivery but this was quickly resolved.*

Most respondents were positive about the telephone and online services that they had developed or expanded. These approaches were more flexible than face-to-face advice and reported feedback from service users was encouraging:

> *Alternative engagement methods other than face to face delivery have proved successful and service users have retained engagement. There are benefits for service users of not needing to travel for an appointment.*

> *There has been positive feedback from service users re use of remote/telephone support and they have liked this more informal/less clinical approach.*

> *Remote working has enabled the provider to offer a wider range of appointments and times to patients. They have also been able to respond more quickly to referrals and in some instances have been able to book patients in for their first session on the same day as the referral.*

Given the benefits of telephone and online support for clients and professionals alike, the shift to these methods is likely to be retained by many stop smoking services. Several respondents described such plans:

> *Our transition to telephone support has been widely praised and incredibly popular with our service users. I can't see us returning to our normal face to face clinics in the same way, and it is likely we will stick with telephone support for the foreseeable future.*

> *The service will offer telephone consultations as well as face to face in the future, giving clients choice of how to access the service especially those who struggle to attend due to work commitments or being housebound.*

> *We can't provide face to face support for those that want it but found that virtual support has been successful overall. We will look to increase this which will add capacity to the service.*

As in the last of these examples, some respondents expressed regret at the loss of face-to-face advice as this was the preferred form of engagement for some clients. Furthermore, service models that relied on engaging smokers in community venues had to be abandoned. The flexibility of telephone and online consultations undoubtedly removed some of the obstacles to accessing stop smoking services, but these methods also had the potential to exclude some clients:

> *There is concern that the new model of delivery will be excluding parts of communities who do not have access to IT or who are not comfortable with this medium, or have specific needs which prevents them from using it (hearing, language etc).*

> *The digital offer means it is harder to engage/reach certain groups e.g. BAME/areas of deprivation.*

The following case study balances the local pros and cons of this universal shift in practice:

> *As we are a small team, we only offer a couple of clinics which are not convenient for a lot of people due to geography and times. Virtual support allows more flexibility. It has also pushed us to develop other ways of providing pharmacotherapy i.e. via electronic vouchers and direct supply. However, remote*

working can be difficult for team members to feel connected and with more people coming through our service and less through primary care there could be a greater disparity on our pharmacotherapy budget and less on CCG budget who fund pharmacotherapy through quit attempts in surgeries. Also, we are unable to CO monitor service users and it is unclear as to the true number of quitters.

6. Pressure on NHS providers

The lockdown in March and the ongoing demands of the pandemic affected the capacity of many services to deliver stop smoking support, especially those that were based in the NHS. Capacity within primary and secondary care fell dramatically in many areas, as did referrals from NHS providers to specialist and lifestyle services.

Although survey respondents were not specifically asked about changes in NHS capacity or referrals, many described these problems in their free-text answers to questions about the impact of COVID-19. A decline in capacity in primary or secondary care, or a decline in referrals, was reported in free-text answers by two thirds (67%) of surveyed local authorities.

NHS providers in primary and secondary care were dealing with a complex range of challenges including rapidly revised priorities, changes in demand, and new infection control restrictions. In contrast, specialist stop smoking services and lifestyle services retained their focus on smoking and so were better able to adapt, sometimes picking up the demand that could no longer be met in primary care. This, however, depended on referrals still coming through. Services that had diverse referral pathways, especially opportunities for self-referral, tended to fare better than those that relied on the NHS for referrals.

The following examples illustrate the diversity of local experience, firstly in relation to capacity in the NHS:

> *GPs were focusing on other things, vape shops were closed, and pharmacists were prioritising other work.*
>
> *GPs and pharmacies did not have the capacity to continue to deliver support which has left the core service needing to meet the full demand instead of the 40% previously. This service now has a waiting list and needs to increase its capacity.*
>
> *Activity in GPs and pharmacies significantly reduced, with only a handful offering stop smoking advice virtually. The healthy lifestyle service and associated specialist service were therefore the primary provider of stop smoking support.*

Secondly, in relation to referrals:

> *Referrals from secondary and primary care decreased with a resulting decrease in smokers accessing the service.*
>
> *Initially there was a reduction in referrals (both self-referrals and from health care practitioners). Self-referrals have returned if not increased, however the referrals from health care practitioners have dropped and is an area of concern which we are looking into.*
>
> *COVID-19 has reduced the number of referrals coming into the system as people are having fewer contacts with health professionals in primary and secondary care. This highlighted further the need we had already identified to strengthen access to our service for smokers through alternative referrals routes, greater targeted messaging, and the ability to self-refer.*

The prohibition on CO monitoring further diminished referrals, especially in secondary and maternity care where patients and health professionals still met face-to-face. Several respondents highlighted the importance of CO monitoring in identifying and referring pregnant women who smoke:

> *Engagement has reduced due to not being able to provide a presence particularly in maternity services and acute. Not being able to perform CO monitoring appears to have impacted on engagement with pregnant smokers.*

> *There was an impact on pregnant women: not being able to see them face-to-face and midwives not being able to take their CO levels. The service remained an opt-out service but we were not able to validate their CO levels to confirm smoking status.*

7. The provision of NRT, medications and e-cigarettes

NRT and medications

Stop smoking services had to innovate to maintain supplies of NRT and prescription medications to smokers during and after lockdown. Many services had relied on giving their clients NRT at the end of a face-to-face consultation. Others gave their clients vouchers for NRT or letters of recommendation. The sudden loss of face-to-face contact meant that these direct approaches were no longer viable.

A simple solution was to email pharmacies and GPs. Some local authorities were already used to doing this; others were quick to adopt it:

> *Normally vouchers/GP letters are issued direct to clients for them to take to surgery or chemist. Now we have to email letters to GP surgeries and vouchers for NRT are emailed to selected pharmacies.*

There were, however, problems at pharmacies due to high demand, delays, shortages and queues. Access to GPs also become more difficult. For vulnerable clients who were shielding, even getting out of the house to a pharmacy or GP could be a problem. Consequently, some local authorities posted medications to clients' homes or used online pharmacies to facilitate this:

> *Our stop smoking specialist service was supplying NRT directly to clients pre-COVID and they changed to postal NRT during COVID. This works very well. There have been some GP-related difficulties with patients getting their Champix prescriptions.*

> *We had difficulties with pharmacies as they were in such high demand. Our services therefore built a relationship with an on line pharmacy who posted out NRT to patients. Champix was requested from GP.*

> *As we wanted to support the reduced movement of people, ie. not attending the pharmacy to get their NRT, we implemented an electronic 'prescription' service via PharmOutcomes, which replaced our paper voucher model. And staff from a local housing provider, who were not required in their substantive posts, delivered the NRT to the quitter's home. The delivery bit has now finished but we retained the eNRT offer.*

Direct in-person delivery of medications to clients' homes was reported by 30% of the surveyed local authorities. This was often a short-term emergency measure targeting clients who were shielding or who were otherwise vulnerable:

> *In early days some advisors personally delivered NRT to clients at home - complying with rules.*

> *Individuals who were shielding or self-isolating could access support from the local support helpline which included delivery of prescribed stop smoking products (NRT/Varenicline).*

We introduced a delivery service of NRT to pregnant women due to the limitations of accessing pharmacies.

Many of the changes introduced to cope with lockdown were successful: the shift to online communication with pharmacies and GPs has been widely retained and some services continued to use the post to supply vouchers or medications at the time of the survey.

E-cigarettes

Lockdown closed vape shops and forced users of e-cigarettes and vapes to order online, if they were able to. Although most local authority stop smoking services were not involved in the provision of e-cigarettes, those that were either suspended their service or made arrangements for postal or direct delivery to clients.

In twelve of the surveyed local authorities, special provisions for the supply of e-cigarettes to vulnerable individuals during lockdown were described by respondents. In nine of these, this included arranging supplies for smokers who were homeless or in temporary accommodation. At the time of the survey, after the lifting of lockdown, all but one of these local authorities continued to sustain part or all of these special provisions.

The vape retailers who have a service level agreement with the specialist stop smoking service adapted to send out vapes and liquids by post to patients homes.

A small stock pile of e-cigs/liquids was kept at the compassionate community hub for anyone who really needed them - these would be posted. Pregnant women are able to access e-cigs as part of our Health in Pregnancy service and a postal system was set up specifically for this group, which has been incredibly well used - alongside ongoing support to stop smoking from the HIPs team over the phone.

We previously have not provided any e-cigarettes and liquids prior to COVID-19. In response to the pandemic we started a vape pilot project to provide those with experience or at risk of homelessness with vape starter kits and liquid for 12 weeks, alongside behavioural support. This was to enable better adherence to social distancing, protect shielding individuals and reduce evictions due to breaking of smokefree rules in accommodation.

8. Reaching out to vulnerable groups

In three fifths of surveyed local authorities (59%), stop smoking services made special provisions for vulnerable groups in response to the COVID-19 pandemic. This often involved giving these groups greater priority, or simply more time, within newly adapted telephone or online advice services. As described above, special provisions were also made by some services to ensure that NRT, medications and e-cigarettes reached vulnerable individuals such as pregnant women, homeless people, or individuals were shielding from COVID-19.

Many stop smoking services seized the opportunity to reach out more actively to vulnerable groups. This was done in a variety of ways, for example by asking NHS partners to identify vulnerable individuals among their smokers, or by engaging with local organisations working with vulnerable groups:

> *A request was made for GPs to run clinical searches on all smokers prioritising vulnerable groups to refer into service.*
>
> *We have established a new project with the LMC whereby vulnerable patients (those with a Long Term Conditions and those within IMD Quintiles 1&2) are directly contacted via text and asked to engage directly with the specialist smoking cessation service.*
>
> *We started working with homeless charities to assist homeless and vulnerable people access the service.*

The systems and services created by local authorities to address the needs of those most vulnerable to COVID-19 also provided a new route into accessing vulnerable smokers:

> *A sticker was put on all food deliveries and government deliveries to encourage people to make a quit attempt. GPs sent out COVID texts to encourage people to engage and we received a large number of referrals.*
>
> *The county Welfare service was set up at the start of lock down to support vulnerable individuals. The service created a direct route into stop smoking services so that patients could be picked up quickly. With the core team delivering clinics by telephone and meds being posted direct to home, risks of COVID were eliminated. People with other vulnerabilities identified during clinic (e.g. domestic violence, loneliness/depression/anxiety), were referred to appropriate services.*

COVID-19 highlighted the vulnerability of all smokers to serious respiratory illness. This gave stop smoking services a platform to communicate anew with their smoking population, and to target those who were doubly vulnerable, many of whom were now more willing to engage:

> *We ran a comprehensive Covid comms campaign that included the #QuitForCovid messaging and targeting vulnerable people. We also worked with partners to ensure these messages reached vulnerable service users such as substance misuse clients.*
>
> *COVID has encouraged more vulnerable individuals to engage. We have seen positive outcomes with this group.*

At the time of the survey, 78% of the local authorities that made special provisions for vulnerable groups in response to COVID-19 had retained some or all of these provisions.

9. Public communication about smoking and COVID-19

Public communication about smoking can serve both to encourage local smokers to quit and to increase footfall into stop smoking services. In all but two of the surveyed local authorities (98%), some public communication had been undertaken in the previous 12 months in pursuit of one or both of these goals. Table 4 describes the methods used, with social media and other internet-based communication being reported most often.

The COVID-19 pandemic gave a new impetus to local authorities' efforts to communicate with smokers about the risks of smoking and the benefits of quitting. Overall, 82% of local authorities undertook some form of public communication specifically about smoking and COVID-19. They were assisted in this by the resources produced and shared by the national #QuitforCovid campaign, which were used by 86% of surveyed local authorities (

Table ***5***).

The messaging of the #QuitforCovid campaign evolved over the course of the pandemic as the evidence grew. The initial focus on poorer outcomes for smokers from COVID-19 shifted to a broader message about the importance of staying healthy, avoiding smoking-related diseases, and protecting the NHS.

Some local authority messaging about the risks of COVID-19 and smoking was targeted specifically at smokers. For example, a highly-targeted method reported by several respondents was sending SMS texts from GPs to the smokers among their patients. The following example describes significant local outcomes from this method:

> *We have proactively reached out to our GP Practices and asked them to send text messages to all their registered smokers asking them to refer themselves for quit support because of the COVID-19 pandemic. Calls and referrals have doubled during Q1 as a result of these texts.*

More often, messages about smoking were integrated into the broader communications that local authorities undertook to inform their populace about the risks of COVID-19 and the behaviour change required to control the pandemic. This context of urgent public health messaging helped to give messages about quitting smoking a new authority. The following are some examples of how local authorities made the most of this opportunity:

> *Public health used various publications including bulletins, social media and print to cascade weekly updates about Covid, including information on smoking and covid19.*

> *There were numerous regular communications through our Council's comms team to highlight the benefits of stopping smoking to Covid outcomes and directing smokers to our service.*

> *We have used the #QuitForCOVID campaign locally on websites and social media. We have also recruited a councillor to document their quit journey, which has provided plenty of content.*

One respondent described remarkable outcomes from the local authority's #QuitforCOVID campaign which combined targeted messaging with broader public communications about COVID-19:

> *We delivered a comprehensive QuitforCovid campaign from March to July which focused on the importance of quitting to be as healthy as possible right now at a time when we are all worried about our health. Getting behind the national campaign has included developing local social media messaging, direct e-mails to staff, news updates, press releases, blogs, text messages via GP practices, radio adverts and TV adverts as well as QuitforCovid stickers and leaflets being developed to be placed on food parcels and via Foodbanks as part of the city response. The campaign has seen significant engagement and success at a population level, reaching over 480,000 people and generating 3,000 engagements.*

Although public communication about smoking was reported to be almost universal among surveyed local authorities, only half (48%) had a strategy in place to communicate with their whole population of smokers at the time of the survey.

Table 4. Methods of public communication used to encourage smokers to quit and/or increase footfall to stop smoking services in the past 12 months

	local authorities (n=111)
Social media promotion	102 (92%)
Promotion on websites	96 (86%)
Council newsletters	80 (72%)
Posters/leaflets	80 (72%)
Local press releases	74 (67%)
Text messages to identified smokers	66 (59%)
Digital advertising	42 (38%)
Radio advertising	25 (23%)
Print/newspaper advertising	18 (16%)
Email to identified smokers	18 (16%)
TV advertising	10 (9%)
None of the above	2 (2%)

Table 5. #QuitforCOVID resources used by surveyed local authorities

	local authorities (n=111)
Suggested social media messages/tweets	89 (80%)
Social media images	79 (71%)
Logo assets pack	44 (40%)
FAQs	42 (38%)
E-banners	40 (36%)
E-posters	35 (32%)
Word templates	27 (24%)
QuitCast	12 (11%)

10. Changes in demand for stop smoking services

Respondents were asked if demand for stop smoking advice at the time of the survey (August/September 2020) had changed compared to demand before lockdown in March 2020 (demand in the summer months is usually higher than in March). Their responses were mixed with demand reported as higher in 21% of surveyed local authorities and lower in 38% (Figure 2).

The simple picture presented by Figure 2 disguises a complex reality. Most services saw an immediate fall in demand following lockdown but recovered in different ways. As described in the previous sections, there were many factors in play including:

- the profile of commissioned services and whether this included a dedicated advice service;
- loss of capacity to deliver stop smoking support, especially among NHS providers;
- the decline in referrals from the NHS;
- the prohibition of CO monitoring;
- adaptability and innovation within stop smoking services including the introduction of more flexible methods of delivering advice and new initiatives to reach vulnerable individuals;
- the increase in smokers' motivation to quit, widely stimulated by #QuitforCovid campaign initiatives.

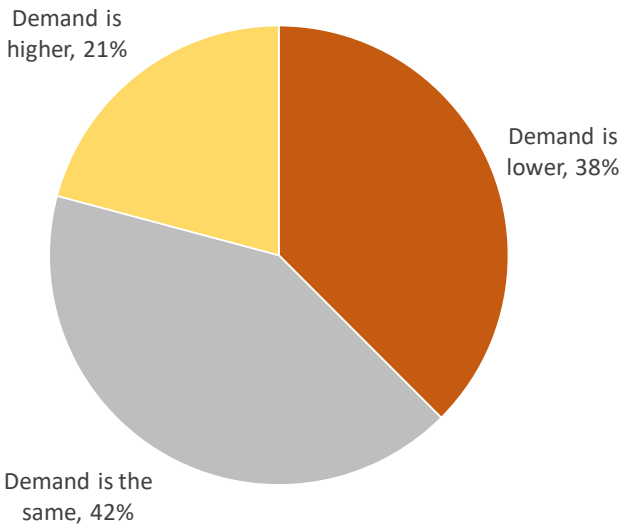
Overall, stop smoking services that adapted quickly, implemented new methods, and were not reliant on the NHS for referrals stood a good chance of recovering well from lockdown and even increasing demand. Resourcefulness and innovation did not, however, always translate into increased footfall. In addition to the complex practical, institutional and financial obstacles faced by stop smoking service providers, some respondents reported that the profile of those using the service also changed. Clients may have been more motivated to quit but some also had higher needs:

> *Due to the challenging time participants have been experiencing due to the lockdown situation, their needs from the service were greater. They had more worries and concerns. Normal support networks had been taken away and many therefore needed weekly rather than fortnightly appointments.*

> *A positive change has been the service adapting to the needs of vulnerable clients, but this means that the clients being supported generally have higher needs than previously.*

> *It is very difficult to say whether demand has changed. Our clinics are full and have remained full throughout the last 6 months, however capacity of those clinics has become smaller as staff have been redeployed elsewhere. Referrals into the service have reduced, particularly from GPs surgeries, yet we sense that of those clients we are working with, many more are from the demographics that we sometimes find hard to engage.*

Figure 2. Change in demand for stop smoking advice and support: March – August/September 2020



11. Relationships and alliances

Respondents to the survey were asked to describe how their relationships with local stakeholders had changed as a result of the COVID-19 pandemic. Their responses were as likely to be positive as negative. For although the pandemic had put many services under pressure and diverted attention and resources to tackling the pandemic, the raised profile of respiratory disease and the opportunities for rapid innovation gave a new impetus to many relationships.

The following example describes the core problem that most respondents faced:

> *NHS partners in particular, and partners across the wider public and private sectors, have been impacted by COVID-19, placing greater pressure on them and making it more difficult for them to find time and resources to work on non-COVID-19 issues.*

Despite this difficult context, many opportunities were seized to build or strengthen relationships with local stakeholders:

> *We have a closer working relationship with retailers, pharmacies, CCG, Maternity and Mental health services as a result of lockdown requirements and the need to discuss new ways of working.*
>
> *We established new partners and contacts via a local respiratory group established in response to COVID 1.*
>
> *More joined-up working with other services such as CAB, MIND, welfare support due to working alongside these colleagues in the compassionate communities hub.*
>
> *As part of the borough's Covid response we've had a better working relationship with all our partners including developing a new relationship with a local bike shop to begin an E-cig pilot.*
>
> *We have worked with our local GP Federation on a project to send out text messages, this has led to closer links with NHS colleagues.*

The following two examples capture the tension between these constraints and opportunities. Both describe projects with housing providers: the former postponed by the pandemic, the latter stimulated by it.

> *Fewer meetings, less capacity in public health team to engage widely as focus on managing outbreak. New activities planned with housing agencies postponed.*
>
> *Greater relationship with housing authorities in the drive to promote smokefree homes, especially as smokers may be smoking more in the home than they did previously.*

The pressure on established relationships was felt within tobacco control alliances, many of which did not meet because of more pressing demands. Three fifths of the surveyed local authorities (61%) had a tobacco control alliance or partnership at the time of the survey. In over two-thirds of these local authorities, the pandemic had reduced the activity

of the alliance, principally because of cancelled meetings, postponed projects or a loss of capacity across members of the partnership.

Once again, the picture across the country was mixed. In some areas, alliances were sustained or invigorated:

> *We held an Alliance meeting online which was very well attended and lively! The partnership specifically does not seem to have been affected, although partners obviously have been.*

> *We are currently in the process of re-vamping the partnership and updating our tobacco control plan. Covid-19 has increased attention on smoking cessation and tobacco control.*

Whatever specific problems established alliances may have faced, the on-going strategic importance of partnerships – formal or otherwise – was clear in respondents' accounts of their wider tobacco control work.

12. Wider tobacco control work

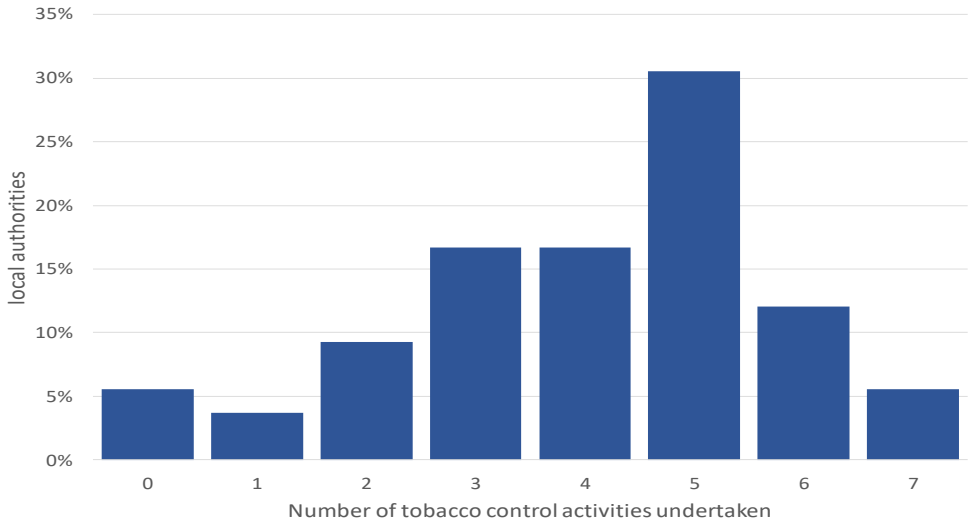
The range of wider tobacco control work that was funded or undertaken by surveyed local authorities is described in Table 6. The most common activities were tackling illegal tobacco and enforcing legislation such as age of sale, point of sale and smokefree legislation. These are both long-standing local authority responsibilities.

The extent of tobacco control work undertaken by local authorities is highly variable (Figure 3). Six local authorities reported doing all of the activities listed in Table 6. A further six reported doing none of them. On average, those local authorities that had a tobacco control alliance had undertaken more of the tobacco control activities listed in Table 6, an average of 4.7, than those that did not (3.1).

Table 6. Wider tobacco control work undertaken by surveyed local authorities

	local authorities (n=108)
Tackling illegal tobacco	93 (86%)
Enforcing legislation	88 (81%)
Communications and campaigns	78 (72%)
Smokefree public spaces	68 (63%)
Smokefree homes	48 (44%)
Regional support/action	48 (44%)
Research	12 (11%)
None of the above	6 (6%)

Figure 3. Number of wider tobacco control activities undertaken by local authorities



This diversity was also evident in respondents' descriptions of their wider tobacco control work. Some local authorities have struggled to sustain this work in the face of shrinking resources and capacity, exacerbated by the challenges of the COVID-19 pandemic:

> *The strain across the entire system, not just health and social care, is obvious. There are particular concerns over capacity for regulation and enforcement given the role of those officers in managing compliance with COVID regs.*

The focus has been on ensuring provision of support for stop smoking and less on alliance work: illegal tobacco visits have stopped and smokefree play park events cancelled.

Yet despite such constraints most respondents could point to substantial on-going activity, typically sustained by partnerships with stakeholders both within and beyond the local authority:

Mostly undertaken by council departments in terms of illicit tobacco and point of sale. Smokefree homes and public spaces are done through attachment to the smoking in pregnancy service.

The county has a large population so the wider tobacco work is tackled through different groups to ensure local diversity is taken into account. This requires working closely with different sectors. Many of these groups work well, some more than others.

Engagement in regional work to tackle illegal tobacco including funding joint enforcement role. Smokefree homes work as part of the integrated approach. Work with community groups to address the issues of young people smoking shisha.

Some respondents gave detailed accounts of extensive, established programmes of tobacco control work. Common characteristics of these approaches were:

- strategy, enabled by leadership and accountability
- committed resources
- effective partnerships, often extending to larger geographies

Each of the following examples illustrate these three characteristics:

A focused and committed agenda, trying to put the needs of our most vulnerable communities at the heart of what we do. We have a health improvement specialist in the team who works 3 days a week on tobacco control supporting delivery of our tobacco control strategy. We are part of the SW illegal tobacco work and work closely with trading standards on enforcing legislation. The research work relates to the evaluation of our e-cigarette in maternity project.

We are one of seven local authorities in the region that commissions our regional office, Fresh, which coordinates and leads much of our wider tobacco control work. Locally we operate a number of tobacco-related workstreams with partners, such as smoking in pregnancy, smoking and mental health, and partnership with public protection (Trading Standards). We commission an Integrated Wellbeing Service to deliver on local implementation of elements of the regional strategy such as smoke-free homes and campaign support.

We have a sustained annual budget and plan of action that is revised annually and reported on quarterly through our Tobacco Control Board. The plan is based on the government's ambitions as stated in their Tobacco Control Plan for England. Safer Communities co-ordinate the delivery of tobacco control for the Council. Partners include public health, Trading Standards, the Fire Service, the stop smoking service provider and the communications officer. Wider partnership networks and sub

group meetings are used to inform and foster support for local initiatives and campaigns, such as Stoptober.

Some respondents reported new commitment to tobacco control within their local authorities. As in the previous examples, strategy, resources and partnerships all feature:

There has been very little done over the last five years. We have recently established a new multi-agency partnership group and are in the process of developing an action plan. Our Wellbeing board has just signed the Local Government Declaration.

A significant lift in the budget has been made available. Tobacco control now has a strategy behind it and an action plan needs to be worked up. We are taking an approach where the environment which people live, work and play is conducive to children not starting, supporting adults to quit and stay quit, and for all residents not to be exposed to second hand smoke. Engaging partners/stakeholders though an Alliance, with strong political leadership and system wide leadership, through signing up to the Declaration and Pledge.

13. Annual and in-year changes in spending

Data from the Ministry of Communities and Local Government indicate a 7.8% decrease in spending on stop smoking services by local authorities in England between 2018/19 and 2019/20, from £77.3m to £71.3m.[6] Over the same period, spending on wider tobacco increased by 28.9% from £10.0m to £12.9m. Between 2013/14 and 2019/20, total local authority expenditure on stop smoking services and wider tobacco control fell by 43.3% (Table 7).

Table 7. Spending by English local authorities on stop smoking services and wider tobacco control 2013/14 – 2019/20 (Ministry of Communities and Local Government)

	stop smoking services	wider tobacco control	total
2013/14	£129.6m	£18.9m	£148.5m
2014/15	£121.2m	£14.7m	£135.9m
2015/16	£111.2m	£13.6m	£124.8m
2016/17	£89.3m	£9.8m	£99.1m
2017/18	£85.2m	£9.7m	£94.9m
2018/19	£77.3m	£10.0m	£87.3m
2019/20	£71.3m	£12.9m	£84.2m
% change 2013/14 - 2019/20	-45.0%	-31.7%	-43.3%

The demands of the COVID-19 pandemic did not adversely affect 2020/21 budgets for stop smoking services and wider tobacco control. None of the surveyed local authorities reported an in-year cut in funding for stop smoking services and in 15 local authorities (14%) stop smoking services received additional in-year financial support. This additional funding was used:

- to cover the set-up costs for home working
- to cover postage costs for medications
- to increase capacity of stop smoking advisers
- to provide e-cigarettes to homeless clients
- to support the #QuitforCOVID campaign and regional (Fresh) social marketing campaigns

Two respondents described the extra funding as being a precursor to more specialised, targeted stop smoking services:

> *COVID-19 has fast tracked plans for a new stop smoking services that will specifically target high prevalence groups. This will start by scaling up the pharmacy service which will now happen in year with the additional funding for this made available earlier than expected.*
>
> *The budget for the service has increased as the service will be commissioned as a stand-alone service form the 1st January 2021. Currently it is integrated with weight management and physical activity.*

14. Conclusion

COVID has had a positive impact as it has brought smoking cessation into the spotlight and accelerated progress around our new service including increasing interest from councillors.

The COVID-19 pandemic forced local authorities to reconfigure their stop smoking services at an unprecedented speed. Innovations that might otherwise have taken months to agree were put in place in days. Overall, respondents to the survey were remarkably positive in their accounts of how they had adapted, and in some cases transformed, their services. These findings are consistent with reports of the wider response of public services to the pandemic, which was characterised by speed and innovation.[7]

There remains, however, great diversity in the resources and commitment given to stop smoking services and tobacco control work across English local authorities. Although no respondents this year reported a complete absence of stop smoking services, two local authorities only offered a service to pregnant women. In contrast, the most inspiring reports came from local authorities which had the means to respond creatively to the pandemic thanks to strong leadership, committed resources and good local relationships.

Commissioning decisions for 2020/21, made before the pandemic, appeared to give renewed priority to specialist stop smoking services, which were commissioned by 77% of surveyed local authorities compare to 65% in 2018 and 69% in 2019. This appears to have been prescient, as specialist stop smoking services were better able to adapt to the challenges of the pandemic than services based with the NHS which had many other demands on their time. Specialist services were in a strong position to rapidly innovate, build new relationships, exploit the opportunities for public communication, and address the needs of vulnerable groups. There are, however, many ways of achieving these goals, just as there are many approaches to commissioning a 'specialist stop smoking service' in the local authority context.[4]

The COVID-19 pandemic propelled respiratory disease to the centre of media and public attention. This offered a clear opportunity to promote quitting which most local authorities seized, supported by the national #QuitforCovid campaign. Although the messaging of the campaign changed as the evidence of the relationship between smoking and COVID-19 developed, it was clear from the outset that everyone should maximise their health and well-being to protect themselves and the NHS from the consequences of COVID-19 infection. Data from the University College London Smoking Toolkit Study indicate that in October 2020 the percentage of smokers who had tried to stop in the last year reached a ten year high (36.3%) and the success rate among those who tried to quit reached an all time high of 22.3%.[8]

Local authority spending on stop smoking services and tobacco control has fallen by 43.3% since 2013, largely due to cuts in the government's public health grant[9]. Yet the COVID-19 pandemic revealed the resilience of many of these services and the determination of those who lead them to adapt to the ever-changing challenges of the smoking epidemic. These strengths must be recognised and valued in the new tobacco control plan for England, promised for July 2021,[10] if the goal of a smokefree England in 2030 is to be achieved.

15. References

[1] ASH & Breathe 2025. ASH and Breathe 2025 response to Advancing our health: prevention in the 2020s. October 2019.
[2] Smokefree Action Coalition. Roadmap to a Smokefree 2030. January 2020.
[3] ASH & Fresh. The End of Smoking, A brief guide for local authority members and officers and their partners on Health and Wellbeing Boards. June, 2019.
[4] ASH & Cancer Research UK. Many Ways Forward: Stop smoking services and tobacco control work in English local authorities. January, 2020.
[5] National Centre for Smoking Cessation and Training (NCSCT). Protecting smokers from COVID-19. March, 2020
[6] Ministry of Housing, Communities and Local Government. Local authority revenue expenditure and financing England: 2019 to 2020 individual local authority data – outturn. October 2020. (2019/20 data for England included imputed data for fourteen local authorities where data was missing).
[7] House of Lords Public Services Committee. A critical juncture for public services: lessons from COVID-19. 1st Report of Session 2019–21, HL Paper 167. November, 2020.
[8] West R, Kale D, Kock L, Brown J. Top-line findings on smoking in England from the Smoking Toolkit Study. November 2020.
[9] ASH & Cancer Research UK. A changing landscape: Stop smoking and services and tobacco control in England. March, 2019.
[10] UK Parliament: Smoking - Question for Department of Health and Social Care, UIN 122663, tabled on 30 November 2020. Available at: https://questions-statements.parliament.uk/written-questions/detail/2020-11-30/122663

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