

CUTTING DOWN: THE REALITY OF BUDGET CUTS TO LOCAL TOBACCO CONTROL

A SURVEY OF TOBACCO CONTROL LEADS
IN LOCAL AUTHORITIES IN ENGLAND



A REPORT BY ACTION ON SMOKING AND HEALTH
COMMISSIONED BY CANCER RESEARCH UK

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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 and this is achieved through the work of over 4,000 scientists, doctors and nurses. In 2015/16, we spent £432 million on research in institutes, hospitals and universities across the UK. We receive no funding from the Government for our research and 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 1971 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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Executive Summary

This report presents the results of the third annual survey of tobacco control leads in local authorities in England, conducted in June 2016. There are 129 local authorities in the sample, 85% of all the local authorities in England with public health responsibilities

Budgets have been cut in a majority of local authorities

- Smoking cessation budgets have been cut in 59% of local authorities this year.
- Budgets for wider tobacco control work, including trading standards enforcement, campaigns and tackling the illicit trade, have been cut in 45% of local authorities this year.

Cuts are primarily the result of national policy decisions

- The 2015 in-year cut in the national public health grant and the wider cost pressures on local authority budgets were most often cited, by a majority of respondents, as the reasons for smoking cessation and tobacco control budget cuts.

Political commitment to tobacco control offers limited protection when budgets are under pressure

- There has been little change in the level priority given to tobacco control in local authorities over the three years of the survey, though the extremes have increased: a high priority is reported in 27% of local authorities and a low priority in 11%.
- Smoking cessation budgets were cut in 40% of local authorities where priority is high, and in 100% of local authorities where priority is low. Everywhere else, around two thirds of local authorities report cuts to smoking cessation budgets.
- Active opposition to tobacco control from the leader, lead member for health and well-being or chief executive is relatively rare, reported in 6% of local authorities.

Specialist smoking cessation services are under threat

- Specialist smoking cessation services are currently provided by 75% of upper-tier local authorities in England.
- In one in five local authorities (20%), the specialist service has been replaced by an integrated 'lifestyle' service of some kind. Without a specialist component, these services are known to be less effective in helping smokers quit.
- In one in twenty local authorities (5%) there is no longer a smoking cessation service beyond that offered by GPs and pharmacists.

More smoking cessation services are now targeted on those in greatest need

- There is increasing emphasis on targeting smoking cessation services on priority groups. This change is principally driven by a strategic interest in tackling inequalities, though in some areas this goes hand-in-hand with budget cuts and the loss of a universal service.
- In the great majority of local authorities, there is some form of service provided for pregnant women and people with mental health conditions.

Tobacco control alliances continue to play an important role in delivering change locally

- Three quarters of local authorities (76%) are members of a tobacco control alliance.
- Tobacco control alliances are perceived to be important to the delivery of local tobacco control/smoking cessation outcomes in 86% of local authorities that are members of one.

Some parts of the NHS are more engaged in tobacco control than others

- Overall, 88% of tobacco control leads report productive relationships with maternity services and 70% report productive relationships with mental health services but only 52% report productive relationships with acute services.
- Relationships with GPs and clinical commissioning groups are not as strong as their potential contributions to tobacco control warrant and are seen to be unproductive in a minority of local authorities.
- Relationships with the NHS are strengthened by shared strategy and priorities, good personal relationships, effective communication, political leadership and strong partnerships.

Recommendations

1. The decline of smoking cessation services in England must be stopped and reversed. Given the ongoing cost pressures on local authorities, a new approach to funding these services, and wider tobacco control work, is needed. Our preferred mechanism is for the government to require the tobacco industry to fund measures to reduce smoking prevalence through a levy or user fee, in line with the principle established by the soft drinks industry levy
2. The opportunities to tackle smoking within the NHS must be maximised. Clinical commissioning groups and NHS trusts should work closely with local authorities to ensure that smokers who engage with the NHS for any reason always have an offer of specialist support to quit.
3. Local smoking cessation services should meet NICE guidelines and standards. This principle is being slowly eroded as local authorities struggle to make savings in their public health budgets. Yet it is these guidelines and standards that provide assurance that public investment, however reduced, delivers real outcomes for smokers.
4. Commissioners and tobacco control alliances should prioritise tackling inequalities. The high rates of smoking in more disadvantaged groups, such as people with mental health conditions and people with routine and manual occupations, provide a powerful focus for stronger partnerships between local authorities and the NHS. As population prevalence continues to decline, high rates of smoking in these groups will exacerbate overall health inequalities.
5. The evidence remains the starting point for all tobacco control work. Using tools such as the *The CLear model*¹ and the *Tobacco joint strategic needs assessment support pack*², local authorities should ensure that they are taking a comprehensive and evidence-based approach to reduce local smoking prevalence.

¹ Public Health England: *The CLear model, Excellence in tobacco control*, 2014

² Public Health England: *Tobacco joint strategic needs assessment support pack* (<http://www.nta.nhs.uk/healthcare-JSNA.aspx>)

Introduction

This report presents the results of the third annual survey of tobacco control leads in upper-tier local authorities in England. The survey was first conducted in 2014 to assess the impact on tobacco control of the transition of public health from the NHS to local authorities³. The subsequent studies in 2015⁴ and 2016 have sought to describe the ongoing opportunities and challenges encountered by tobacco control professionals in the local government setting.

The 2015 survey was conducted just after the in-year cut in the national public health grant was announced, but before respondents knew what the impact of this cut would be on smoking cessation services and wider tobacco control work. A year later, this impact is abundantly clear in the results of the 2016 survey.

When budgets tighten and time is short, it can be difficult to make time to complete surveys. ASH and Cancer Research UK would therefore like to thank all the respondents for their contributions to this study this year and in the two preceding years in which the survey was conducted.

Methods

The aim of the study was to assess the current health of tobacco control within upper-tier local authorities in England. The questionnaire was based on the 2015 survey questionnaire with some amendments to address issues of current interest. A core set of questions has been retained across the three surveys in order to track changes to budgets and political priorities.

The survey went online through Survey Monkey in June 2016 and was open for two months. Tobacco control leads in England were emailed about the survey and subsequently telephoned to maximise the response rate. Respondents were told that all their responses would remain anonymous.

The sampling frame was all the local authorities in England with public health responsibilities ('upper-tier' local authorities). However, some of these local authorities share their tobacco control teams. In these cases, special versions of the survey were prepared that allowed respondents to answer questions separately for each of the authorities they represented, where appropriate.

A total of 120 people responded including seven who did not complete the entire survey but provided enough data to warrant inclusion in the final dataset (all respondents answered the questions on budgets). Five respondents answered for two local authorities and two respondents answered for three local authorities, bringing the final sample of local authorities to 129, 85% of all upper-tier local authorities. This compares to response rates of 83% in 2015 and 80% in 2014.

Of the 120 respondents, 103 described themselves as either the tobacco control lead or commissioner for smoking cessation/tobacco control. Five were managers of smoking cessation services. Of the remaining 12, who ticked 'other', six described themselves as public health specialists with responsibility for tobacco.

Analysis was conducted using SPSS and correlations were explored using the chi squared test of goodness of fit with statistically significant differences reported for $p < 0.05$.

³ Anderson W and Asquith H. *Taking a Reading: The impact of public health transition on tobacco control and smoking cessation services in England*. Cancer Research UK and Action on Smoking and Health, 2015

⁴ 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, January 2016

Budgets and political priorities

- Three fifths (59%) of upper-tier local authorities in England have cut their smoking cessation budgets this year.
- Budgets for smoking cessation medications and for other tobacco control work have also been widely cut.
- These changes are primarily due to the cost pressures arising from the cut in the national public health grant and from wider cuts to local authority budgets.
- On average, local authorities spend £14.78 per smoker per year on smoking cessation and tobacco control.
- The number of local authorities where tobacco control is perceived to be a high priority has increased from 17% to 27%. Tobacco control is perceived to be a low priority in 11% of local authorities.
- Smoking cessation budgets were cut in 40% of the local authorities where tobacco control is perceived to be a high priority. In the local authorities where tobacco control is perceived to be a low priority, 100% of smoking cessation budgets have been cut.
- Regionally, smoking cessation budgets have been cut most often in the East Midlands and East of England and least often in the Northeast and Yorkshire & Humber.

Changes to budgets

Respondents were asked to identify changes to the following three local authority budgets between 2015/16 and 2016/17:

- smoking cessation (excluding medication costs and wider tobacco control)
- smoking cessation medications
- wider tobacco control work

Smoking cessation budgets – typically the biggest of the three – have suffered the widest and the deepest cuts (Figure 1). Three fifths (59%) of local authorities have cut their smoking cessation budgets this year and nearly half (48%) have cut these budgets by more than 5%. These changes compound the cuts of the last two years (Figure 2).

Figure 1. Changes to local authority smoking cessation budgets 2015/16 – 2016/17 (excluding medications and wider tobacco control work)

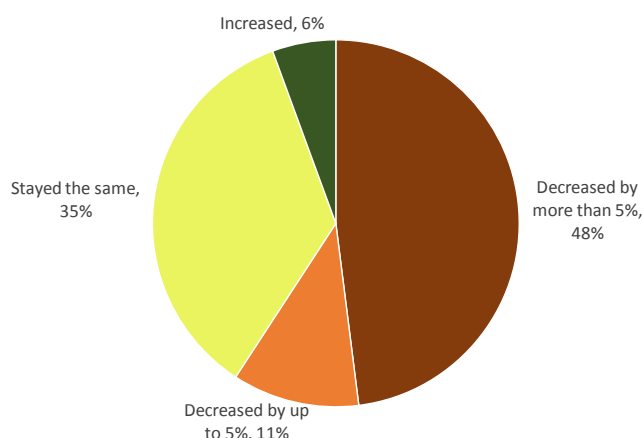
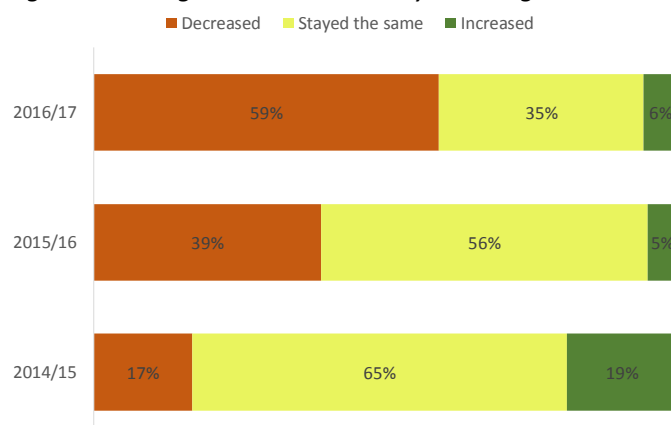


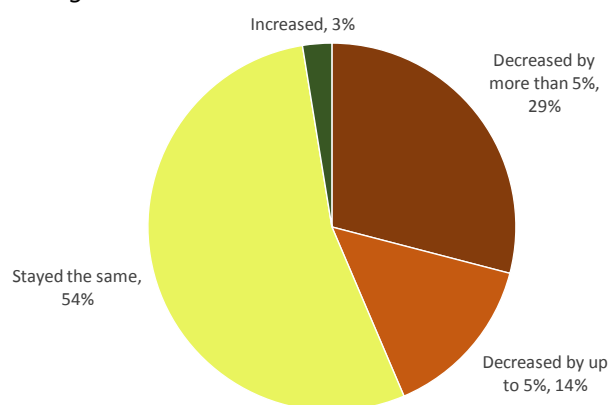
Figure 2. Changes to local authority smoking cessation budgets year-on-year, 2014/15 – 2016/17



Local budgets for smoking cessation medications are not always the sole responsibility of local authorities. Clinical commissioning groups, NHS trusts and GPs may also contribute. In our sample, 91% of local authorities contributed to the medications budget including 51% who were the sole funders.

Among those local authorities that contribute to the local smoking cessation medications budget, 44% have cut their budget this year including 29% that have made cuts of more than 5% (Figure 3). The pattern is similar among the local authorities that are sole funders of smoking cessation medications with 44% cutting these budgets this year (but no budget increases).

Figure 3 Changes to local authority smoking cessation medication budgets 2015/16 – 2016/17 (among local authorities that contribute to the smoking cessation budget)



Budgets for wider tobacco control work are relatively small compared to smoking cessation budgets. Nonetheless they are vital to local efforts to reduce smoking prevalence. Tobacco control budgets were cut in 45% of local authorities this year, including 29% where the cut was greater than 5% (Figure 4). As with smoking cessation budgets, these budget reductions compound the cuts experienced in the previous two years (Figure 5).

Figure 4. Changes to local authority tobacco control budgets (excluding smoking cessation) 2015/16 – 2016/17

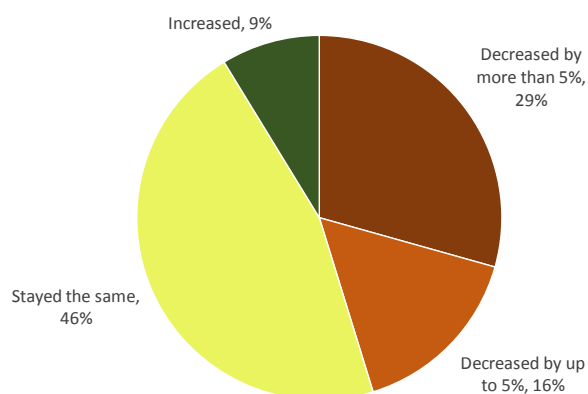
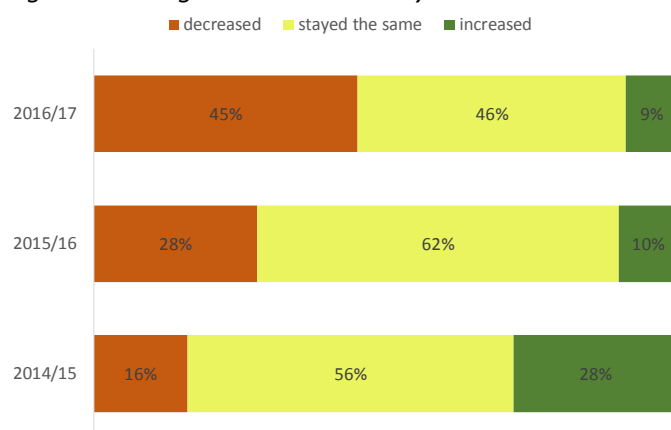
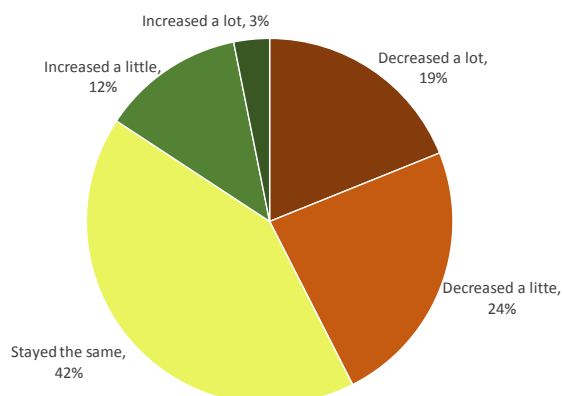


Figure 5. Changes to local authority tobacco control budgets year-on-year, 2014/15 – 2016/17



These budget cuts inevitably impact on the staff time available for smoking cessation and tobacco control within local authorities. In 43% of local authorities, the total staff time dedicated to smoking cessation and tobacco control had decreased in the 12 months prior to the survey, whereas staff times increased in 15% (Figure 6).

Figure 6. Changes to the total staff time dedicated to smoking cessation and tobacco control in the 12 months prior to the survey.



Reasons for budget cuts

Respondents described in their own words the reasons for the cuts to their budgets. Overwhelmingly, the reduction in the national public health grant and the wider cost pressures on local authorities were cited as the drivers of the budget reductions. One or both of these cost pressures were specifically identified by:

- 78% of the respondents whose smoking cessation budgets had been cut
- 53% of the respondents whose medications budgets had been cut
- 75% of the respondents whose wider tobacco control budgets had been cut

As this was an open free-text question, these results will under-represent the impact of these cost pressures on local authority tobacco control budgets, as not all respondents answered the question in this manner. For example, some respondents accounted for cuts in their budgets by describing changes in service delivery such as decommissioning services, implementing a new approach to delivery (such as a lifestyle service) or diminished targets. These changes in service provision, which are often but not necessarily responses to cost pressures, are examined in the next section.

Other reasons given for budget cuts were:

- reduced demand, cited by 7% of those whose smoking cessation budgets had been cut and 23% of those whose medication budgets had been cut
- underspend in the previous year, cited by 5% of those whose smoking cessation budgets had been cut and 11% of those whose medication budgets had been cut
- withdrawal of funding for regional tobacco control agencies, cited 9% of those whose wider tobacco control budgets had been cut

2016/17 budgets

Respondents were asked to give details of their 2016/17 budgets including, where possible, their budgets for smoking cessation, medications, and wider tobacco control. Many were unable or unwilling to do so, or provided incomplete data. Overall, 72 (56%) provided either a total budget figure or comprehensive disaggregated data which allowed calculation of the total budget.

The average spend per local authority on smoking cessation and tobacco control was £716,109 with a range from £0 to £2,560,000. Overall, these budgets were divided 92% to smoking cessation services and medications and 8% to wider tobacco control work.

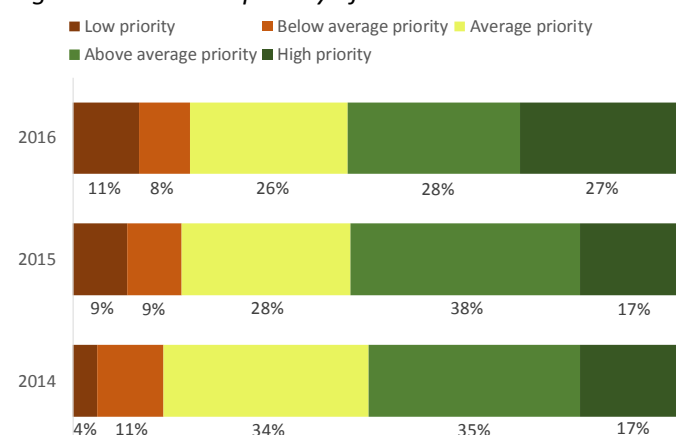
Spending per smoker in the local population provides a better measure of the variability between local authorities. The average annual spend per smoker was £14.78 with a range from £0 to £29.48. Local authorities with higher smoking prevalence spend more per head of population, but not more per smoker, than local authorities with lower smoking prevalence.

Political support for tobacco control

In the majority of local authorities (55%), tobacco control is perceived by respondents to be an above average or high priority (Figure 7). This is unchanged from last year, though there has been a shift within this group such that tobacco control is now perceived to be a high priority within over a quarter (27%) of local authorities.

Over the last three years, the proportion of local authorities where tobacco control is perceived to be a low priority has grown, with one in nine local authorities (11%) now perceived to be in this position.

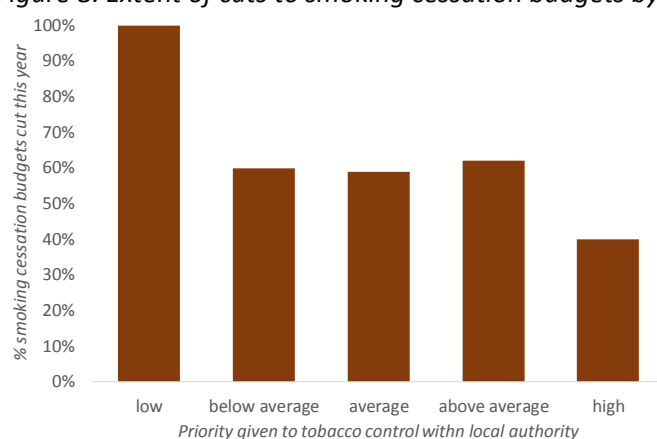
Figure 7. Perceived priority of tobacco control within the local authority 2014-2016



In every local authority where tobacco control is perceived to be a low priority, smoking cessation budgets have been cut this year. In the local authorities where tobacco control is perceived to be a high priority, 40% of smoking cessation budgets have been cut. In between these extremes, in the authorities where tobacco control was perceived to be below average, average or above average priority, around three fifths of smoking cessation budgets had been cut (Figure 8).

The overall level of spending on smoking cessation and tobacco control is higher in local authorities where tobacco control is perceived to be an above average or high priority: £16.18 per smoker compared to £13.65 where priority is average and £13.20 where priority is below average or low. However these differences are not statistically significant.

Figure 8. Extent of cuts to smoking cessation budgets by priority given to tobacco control, 2016

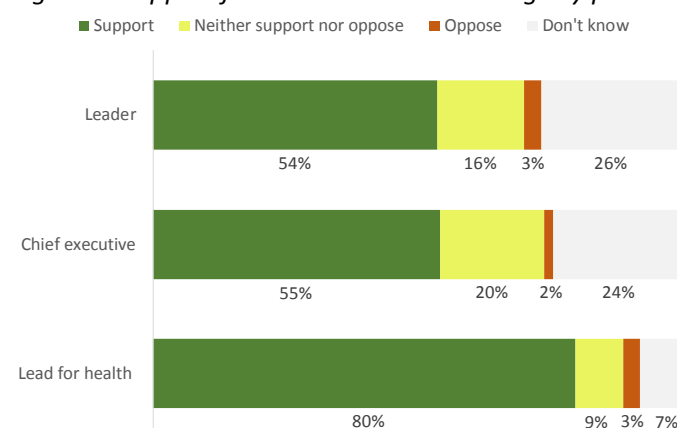


Respondents also described the level of support for tobacco control expressed by the leader, chief executive and lead member for health and well-being in their local authority (Figure 9). These results are almost identical to those reported in 2015.

Active support from the lead member for health and wellbeing is forthcoming in the great majority of local authorities (87% if 'don't know' responses are excluded). A lack of active support from the lead member for health and wellbeing was associated with a higher rate of smoking cessation budget cuts. This association was not found for the other two roles.

Few respondents identified active opposition to tobacco control. There were only seven local authorities (6%) where opposition from one or more of these key political stakeholders was reported.

Figure 9. Support for tobacco control among key political stakeholders in local authorities



Regional differences

Table 1 describes regional variations in the priority given to tobacco control, the extent of cuts to smoking cessation and tobacco control budgets, and the smoking cessation/tobacco control spend per smoker. The number of local authorities in each region is low so percentages should be compared with caution.

The Northeast and Yorkshire & Humber emerge as the regions where tobacco control was most often given high priority and where budget cuts were least often reported. In contrast, tobacco control was least often given high priority in the East Midlands and London and cuts, at least to smoking cessation budgets, were more common here.

Table 1. Political priorities, spend per smoker and budget cuts by region

Region	No. local authorities in sample	% local authorities where:			Average spend per smoker (where data is available)
		Priority for tobacco control is high/above average	Smoking cessation budget was cut	Tobacco control budget was cut	
North West	19	47%	56%	42%	£13.05
North East	10	90%	30%	40%	£15.78
Yorkshire & Humber	12	78%	42%	45%	£16.87
West Midlands	11	55%	60%	9%	£21.67
East Midlands	8	38%	88%	62%	£15.45
East of England	11	64%	70%	27%	£15.04
Southwest	14	50%	57%	86%	£12.67
Southeast	13	54%	54%	31%	£15.97
London	31	44%	70%	52%	£11.11
ENGLAND	129	55%	59%	45%	£14.78

Changes to services

- Specialist smoking cessation services are currently provided by 75% of upper-tier local authorities in England.
- Although specialist services are being sustained and developed in many areas, contraction is common in those local authorities where the smoking cessation budget has been cut.
- In one in five local authorities (20%), the specialist service has been replaced by an integrated 'lifestyle' service of some kind.
- In around one in twenty local authorities (5%) there is no longer a smoking cessation service beyond that offered by GPs and pharmacists.
- Some local authorities are increasingly targeting their specialist services. Most but not all local authorities provide some form of targeted service for pregnant women and people with mental health conditions.
- There are no specialist smoking cessation services available to inpatients in 14% of local authorities.
- Cuts to wider tobacco control budgets have led to reductions in enforcement work, campaigns, youth work and, in the southwest, the closure of a regional tobacco control office.
- New work on tackling illicit tobacco was reported in 10% of local authorities.

Smoking cessation services

Specialist smoking cessation services are no longer universally available to smokers in England. Although they are still offered by the majority of local authorities, a shift away from this approach is taking place.

Respondents were asked to identify which approach – or approaches – to smoking cessation were delivered locally. Table 2 describes the results. Three quarters (75%) of local authorities still have some form of specialist service. However, one in five local authorities (20%) only offer smoking cessation support as part of a wider lifestyle service. In a few areas, smoking cessation support is limited to what GPs and pharmacies offer.

Table 2. Approaches to delivery of smoking cessation services (percentages are of all local authorities in the sample)

<i>Approach</i>	<i>Total</i>	<i>Lifestyle approach without specialist service</i>	<i>Lifestyle approach In addition to specialist service</i>
Specialist service	96 (75%)		
Service integrated into a wider lifestyle offer	41 (32%)	25 (20%)	16 (12%)
NHS community provision ONLY	5 (4%)		
No service	n=1		

Respondents were also asked to describe, in their own words, any significant changes that their smoking cessation services had undergone in the previous year, and any changes that were planned for the remainder of the year. Four broad approaches to the ongoing delivery of smoking cessation services can be distinguished:

- maintenance of existing provision
- contraction of services, including complete decommissioning in some cases

- integration of smoking cessation services into a broader lifestyle offer
- targeting services on groups in greatest need

‘No change’ was the most common response overall, given by around half of those whose budgets had stayed the same or increased and by about a fifth of those whose budgets had been cut. However, some form of contraction of service was the most common response among the respondents whose budgets had been cut. This has taken many forms including:

- Reducing quit targets
- Removing some providers, such as GPs or pharmacies
- Cutting outreach work
- Cutting medication budgets and shifting medication costs to the client
- Prioritising online support over face-to-face support
- Decommissioning specialist services altogether

The decommissioning of specialist smoking cessation services may – or may not – go hand-in-hand with recommissioning:

The local authority has cut the Stop Smoking Budget. In 2017-18, there will be NO stop smoking service commissioned by Public Health.

Specialist NHS stop smoking support will no longer be available; stop smoking support will continue from primary care practices and community pharmacies and provision is being planned from volunteers.

Decommissioning Stop Smoking Service at the end of this financial year and preparing to recommission a behaviour change service.

Stop Smoking Service was decommissioned due to significant budget pressures; two alternative services focusing on specific target groups (pregnant women and people with severe and enduring mental ill health) are currently being developed.

As the latter two examples illustrate, the creation of integrated ‘lifestyle’ services and the targeting of specialist services may be specific responses to cost pressures. But this was not universally so. Both approaches were also reported by those whose budgets had stayed the same this year, and an emphasis on targeting was reported by two respondents whose budgets had increased. Again, there is a diversity of possibilities within these approaches.

Given the brevity of respondents’ descriptions, it is impossible to tell how much commonality there is between different ‘integrated’ or ‘lifestyle’ services, including how often the existing offer to smokers is being retained:

Smoking Service is now part of a wider integrated wellness service.

The service is part of an integrated lifestyle service. Advisors are now also trained to support people with other lifestyle support needs including weight management. Their approach to supporting people to stop smoking has not changed though and is still based on NICE guidance.

Our new health and wellbeing service was launched and support for people to stop smoking is part of the brief for that service.

The targeting of specialist services typically reflects a strategic shift away from four-week quit targets towards a new or renewed priority on addressing inequalities:

Focus of the service has been on more targeted work - pregnancy, mental health, routine/manual, specific wards with high deprivation - replacing main focus on number of 4-week quits.

Our service provider is doing more targeted work in areas of deprivation and with specific groups such as routine/manual workers, parents, pregnant women, etc.

More targeted approach towards the most deprived wards to focus on reducing health inequalities.

Targeted work with priority groups is an established approach to smoking cessation, albeit traditionally part of, rather than instead of, a universal specialist service. In a separate closed-response question, respondents were asked to identify the extent of their work with eight priority groups. Table 3 describes the results. In the great majority of local authorities, there is some form of service provided for pregnant women and people with mental health conditions.

These various approaches to delivering smoking cessation support are not mutually exclusive, although targeting requires the retention of some form of specialist service whereas lifestyle approaches may jettison the specialist component. They may even be combined, as in the following case:

We have recently procured a healthy lifestyle service which will provide level 2 stop smoking support to anyone who needs it. On top of this, we have a separate specialist service commissioned to work only with high risk or high prevalence groups, including pregnancy, routine and manual workers, mental health etc. We continue to provide level 2 services in GPs and Pharmacies, but no longer have any community providers.

A variety of other service changes were also identified by respondents such as new harm reduction services, including becoming 'e-cigarette friendly', a shift to outcome-based service contracts, the use of online self-help services and self-help kits, and the development of a more personalised service.

Table 3. Local authorities undertaking targeted work to address smoking prevalence

<i>Population</i>	<i>Comprehensive programme of work</i>	<i>Some work undertaken</i>	<i>No work undertaken</i>
Pregnant women	62 (51%)	53 (43%)	7 (6%)
People with mental health conditions	32 (26%)	67 (55%)	23 (19%)
Young people	32 (26%)	55 (45%)	35 (29%)
People with routine/manual occupations	23 (19%)	75 (61%)	24 (20%)
People on low incomes	19 (16%)	67 (55%)	36 (29%)
People with long-term conditions	12 (10%)	72 (59%)	38 (31%)
BME groups	11 (9%)	46 (38%)	65 (53%)
LGBT groups	3 (2%)	18 (15%)	101 (83%)

Inpatient access to smoking cessation services

Respondents were asked to identify which local agencies funded inpatient specialist smoking cessation services in the area (Table 4). Two thirds of local authorities fund some or all of local inpatient smoking cessation services. However, in one in seven local authorities (14%), there are no specialist services for smokers in hospital.

Table 4. Funders of inpatient specialist smoking cessation services (percentages are of all local authorities in the sample)

<i>Funder</i>	<i>Total</i>	<i>Sole funder</i>
No-one (no services)	16 (14%)	
Local authority	75 (67%)	63 (57%)
NHS trusts	28 (25%)	18 (16%)
Clinical commissioning group	5 (5%)	2 (2%)
GPs	1 (1%)	0

Wider tobacco control work

Respondents were asked to describe, in their own words, any significant changes that their tobacco control services had undergone in the previous year. As with the comparable question for smoking cessation services, the most common response was 'no change', given by the majority of those whose budgets had stayed the same and 15% of those whose budgets had been cut.

Across the 44% of local authorities where tobacco control budgets had been cut, most respondents described some form of contraction in this work. These changes included:

- less enforcement work
- fewer campaigns
- less youth work
- withdrawal of regional funding (in the southwest)
- less staff time dedicated to tobacco control
- closure or suspension of the local Tobacco Control Alliance

Of the new initiatives reported, the most common was an increase in work on illicit tobacco (including a new partnership in London to tackle the illicit trade), identified in 10% of local authorities including a few where tobacco control budgets had been cut.

Other new initiatives reported included:

- completion of a CLeaR review
- the creation of a local tobacco control strategy
- starting or restarting a Tobacco Control Alliance
- local research to inform action to reduce smoking inequalities
- promotion of smokefree homes, play areas and communities
- prevention programmes with young people including ASSIST
- exploring the use of e-cigarettes to reduce smoking prevalence

The following detailed responses illustrate the ongoing commitment to wider tobacco control in many local authorities in England:

We have set up a tobacco control network consisting of local health and support organisations who collaborate to deliver aspects of our Smoke Free Action Plan. The action plan was created from a needs analysis and workshop with the network and is underpinned by NICE guidance and Clear assessment principles. We have prioritised key themes so that action can be taken to reach our goal population smoking prevalence. The new Public Health Practitioner post supports the delivery of this work.

More focused work around illicit tobacco and its link to the public health outcomes. More locally developed behaviour change campaigns targeting priority groups: deprived/high prevalence populations (including LGBT, lone parents, BME groups), pregnant women in deprived areas, and children and young people.

We are using proceeds of crime money to fund prevention work, for example we are piloting theatre performances in primary schools and will be running an illegal tobacco roadshow in September.

Alliances and relationships

- Three quarters of local authorities (76%) are members of a tobacco control alliance.
- Tobacco control alliances are perceived to be important to the delivery of local tobacco control/smoking cessation outcomes in the great majority of local authorities (86%) that are members of one.
- The most productive stakeholder relationships are with trading standard officers and NHS maternity services. The least productive are with parks and recreation services, housing services and adult social care services.
- Relationships with GPs and clinical commissioning groups are perceived to be productive in around two thirds of local authorities.
- Relationships with the NHS are strengthened by shared strategy and priorities, good personal relationships, effective communication, political leadership and strong partnerships.
- The most frequently cited factor that inhibits relationships with the NHS is a lack of time and resources.

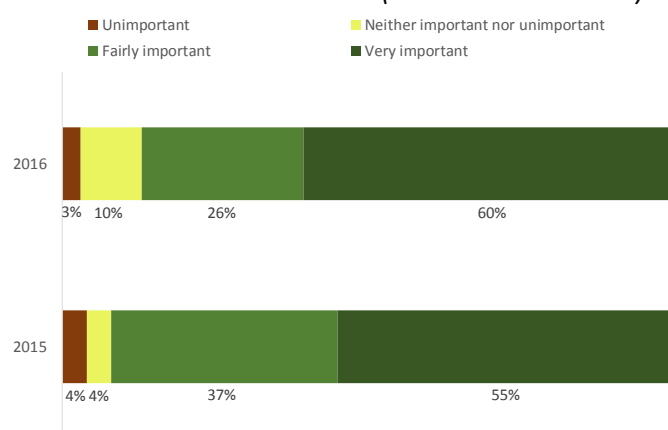
Tobacco control alliances

Tobacco control alliances remain integral to the delivery of smoking cessation services and wider tobacco control work in the majority of local authorities. Three quarters of local authorities (76%) are members of a tobacco control alliance. Although this figure is unchanged since the 2015 survey, a few alliances have disbanded this year while elsewhere others have been created or restarted.

Where an alliance existed, respondents were asked to identify how important they felt their tobacco control alliance was to the delivery of local tobacco control/smoking cessation outcomes. Overall, the alliance was perceived to be fairly or very important in 86% of local authorities. This is a slight decline on the 92% reporting this level of importance in 2015 (Figure 10).

There were no statistically significant differences in the prevalence of budget cuts between those local authorities that were part of tobacco control alliances and those that were not. There was, however, a relationship with perceived political priority: respondents from local authorities that are part of a tobacco control alliance were twice as likely to report a high local priority given to tobacco control as respondents from local authorities that are not part of a tobacco control alliance.

Figure 10. Importance of tobacco control alliance to the delivery of local tobacco control/smoking cessation outcomes 2015-2016 (where alliance exists)



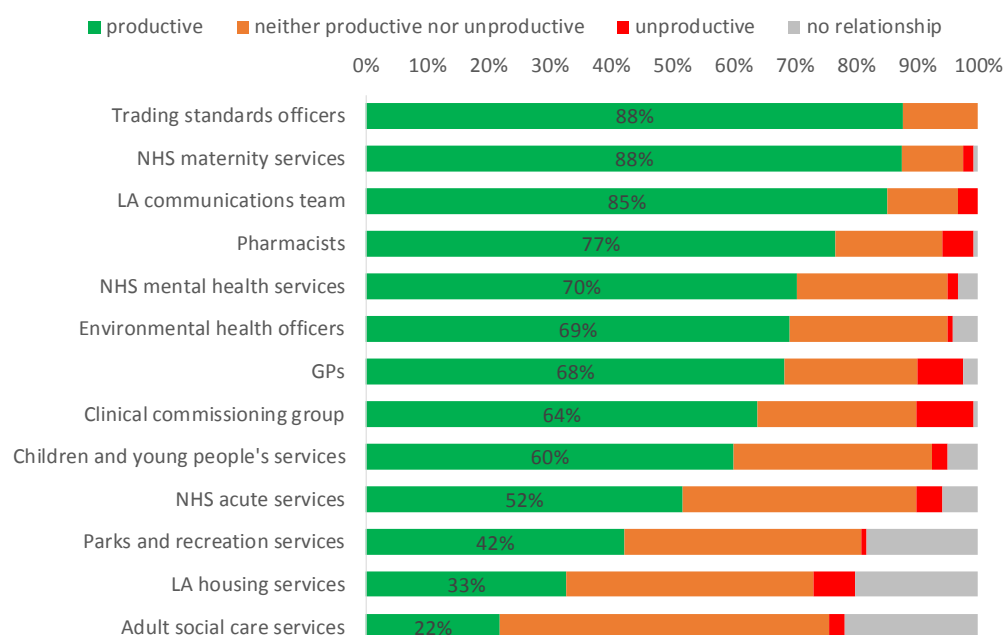
Stakeholder relationships

Respondents were also asked to state, for a range of local partners, whether they perceived their relationships with these partners to be productive or unproductive. Figure 11 illustrates the results.

Relationships with trading standards officers, NHS maternity services and local authority communications teams were most often perceived by respondents to be productive. The relationships least often reported to be productive were with local authority departments beyond those with an established role in tobacco control: parks and recreation services, housing services and adults social care services.

GPs and clinical commissioning groups are in the centre of Figure 11. Relationships with these key local stakeholders are perceived to be productive in around two thirds of local authorities. They were also most often reported to be unproductive: GPs in 8% of local authorities and clinical commissioning groups in 9% of local authorities. Relationships with NHS acute services were reported to be productive in just over half of local authorities (52%).

Figure 11. Relationships with local stakeholders



Respondents were asked to describe in their own words anything that they felt strengthened and weakened relationships with the NHS. The following factors were identified most often as factors that strengthened relationships with the NHS:

- shared strategy, priorities, goals and interests
- good personal relationships
- effective communication
- political leadership and buy-in
- strong partnerships
- tobacco control champions within the NHS
- resources and time

In many respects, the factors that respondents felt weakened relationships with the NHS were the adverse of the strengthening factors:

- lack of resources and time
- different or conflicting priorities; lack of shared strategy
- failure by others to understand or appreciate the importance of the agenda
- lack of leadership
- poor communication
- obstructive individuals
- lack of partnerships
- bureaucracy and organisational barriers

Discussion

This study is the third annual survey of tobacco control leads in local authorities in England. As each of these surveys has had an exceptionally high response rate, the results can be taken as representative of all the local authorities in England with public health responsibilities.

In 2014, the first year of the survey, the focus of the survey was on the impact of the transition of public health from the NHS to local authorities. For smoking cessation services and tobacco control, this change appeared to have been positive for most – if not all – respondents. In particular, budgets had increased more often than they had decreased and tobacco control was perceived to be an above average or high priority in a majority of local authorities.

In 2015, the results of the survey suggested that the honeymoon was over. Smoking cessation budgets had been cut in 39% of local authorities and wider tobacco control budgets had been cut in 28% of local authorities. The priority given to tobacco control, however, had not changed.

This year, the results of the survey emphatically describe a national picture of decline, with further cuts made to smoking cessation budgets in 59% of local authorities and to tobacco control budgets in 45% of local authorities. Yet at the same time the number of local authorities where tobacco control is perceived to be a high priority has risen to its highest ever level (27%).

The cuts to smoking cessation and tobacco control budgets are not being driven by changing political priorities within local authorities but by the burden of national cost cutting: overwhelmingly they were reported to be the consequence of the in-year cut to the public health grant in 2015 and the wider pressures on local authority budgets. Political support for tobacco control offers limited protection at a time when national policy is driving local budget cuts. Nonetheless, the experience at the extremes is distinctive: 40% of local authorities where tobacco control is perceived to be a high priority cut their smoking cessation budget compared to 100% of local authorities where the priority is perceived to be low.

With no clear strategic lead from government, local authorities are pursuing different strategies in response to the many pressures upon them. In a few local authorities, the response to public health budget cuts has been to decommission specialist smoking cessation services altogether. This is terrible news for smokers in these areas and sets a worrying precedent for the rest of the country. Elsewhere, in 20% of local authorities, smoking cessation services have been replaced by a wider lifestyle offer, typically combining advice on smoking with other issues such as weight management, nutrition and exercise. Although it may be possible to retain an approach to smoking cessation within such a service that meets NICE guidance, the risk is that such changes are a diminution of the offer to smokers and may prove to be ineffective as a result⁵.

An increase in the targeting of smoking cessation services on groups and populations most in need is also evident. Although in some places this is a response to cost pressures, the shift appears to reflect a wider strategic concern with addressing inequalities. This is appropriate at this stage of the epidemic, given the stubbornly high rates of smoking prevalence among disadvantaged groups despite the ongoing decline in population prevalence. However, a greater effort to target and tailor services ought not to be at the cost of the universal service to smokers. For all smokers, specialist smoking cessation services still offer their best chance to quit.

Regional tobacco control functions remain in the north of England only: in the North East, North West and Yorkshire and the Humber. The North East and Yorkshire and the Humber are the two regions where a high priority for tobacco control was most often reported and cuts to smoking cessation budgets were least often reported. Such regional functions are invaluable in running campaigns, tackling illicit tobacco and promoting good practice, but the pressure on tobacco control budgets is putting them at risk, especially in the North West. In the South West, the closure of the regional office is reflected in the cuts to local authorities' tobacco control budgets. Further losses would be highly regrettable, given the achievements of the remaining offices.

Tobacco control alliances continue to play an important part in shaping local efforts to tackle smoking prevalence, as do the many relationships that tobacco control leads have built with partners in the NHS and across their own organisations. Given the importance of tackling inequalities, it is encouraging that relationships with NHS maternity services and mental health services are productive in the great majority of local authorities. However, there is scope for improvement elsewhere: relationships with GPs and clinical commissioning groups are seen as productive in only two thirds of local authorities. These key stakeholders in the health of the local population ought to be supportive of all local efforts to reduce smoking prevalence.

The scale of the cuts reported here casts a long shadow on the future of smoking cessation and tobacco control services in England. Despite this, these services remain at the heart of public health practice in the majority of local authorities. The wealth of activity described by respondents to this survey is striking. As smoking remains the biggest cause of preventable death in every part of England, most local authority politicians and officers alike recognise that this is not the time to walk away from tobacco control, whatever the national and local cost pressures may be.

⁵ Shahab, L. 2016 *Integrated health behaviour services briefing: A review of the evidence* NCSCCT (available from: <http://bit.ly/2eIDFq9>)