Smoking and social housing

Supporting residents, addressing inequalities

May 2022

Housing LIN
Connecting people, ideas and resources

ash.
action on smoking and health

Contents

Forewords.... 3
Summary and recommendations.... 5
    How this report was developed.... 6
Introduction.... 8
Why act: How smoking harms social housing residents.... 9
    Smoking rates in social housing.... 9
    Smoking, health, and health inequalities.... 11
The benefits of tobacco control for social landlords.... 14
Next steps: supporting social housing residents to go smokefree.... 16
    Recommendations for social landlords.... 16
    The role of local government health teams and partners in the NHS.... 21
    National action to support local delivery.... 22
    Conclusion.... 24
References.... 25

Forewords

Jeanelle De Gruchy

Deputy Chief Medical Officer for England,
Joint lead for the Office for Health Improvement and Disparities (OHID)

At the start of this century, when I turned my focus from medicine to public health, smoking rates in England had flatlined for a decade, and 27% of adults and 19% of children under 16 smoked, the same as when records began in 1982. Around 150,000 people a year were killed by smoking in the UK, equivalent to a jumbo jet crashing every day with no survivors.

Terrible though the lethal toll of tobacco was at that time, glimmers of hope were emerging. The government had recognised that smoking was not a 'lifestyle choice' but a serious addiction and the first national tobacco control plan, *Smoking Kills* had been published. Since then, the UK has become a world leader in tobacco control, with Stop Smoking Services free at point of delivery, prohibition of smoking in enclosed public places and a ban on all tobacco advertising. Most recently the introduction of plain standardised packaging with large graphic health warnings has turned cigarette packs from a promotional tool into a motivation to quit.

Population-wide interventions have been matched by significant declines in smoking rates among adults and children. 5% of children under 16 now smoke – this is too many but great progress has been made from 19% two decades ago. The decline in adult smoking rates has been less rapid, now at 14.4%, but this is nearly half what it was in 2000. Now the proportion of adults who smoke is less than the proportion of children who smoked in the year 2000.

But the decline in average smoking rates masks growing inequalities. The differential in smoking rates between the most and least disadvantaged communities is larger than it was two decades ago. Indeed housing tenure is now the strongest predictor of smoking, with one in three people in social housing current smokers, compared to around one in ten people who own their home.

It often used to be said that disadvantaged smokers were 'hard to reach', but as this report points out that is simply not the case. I am passionate about a place-based approach to public health and this provides us with major opportunity but also a challenge. We know that smokers living in social housing are just as likely to want to stop smoking, and try just as often, they also tend to be more heavily addicted and be in a more pro-smoking environment therefore find it harder to succeed.

Ensuring effective, easily accessible and sympathetic stop smoking support is provided for those living in social housing will require local government public health teams and the NHS to work collaboratively. However, as this report demonstrates social housing providers also have a critical role to play, and I would add that OHID does too. If we work together, we have a

huge opportunity to radically reduce health inequalities and improve the health, wellbeing, and employment opportunities of people living in social housing. OHID is committed to working with colleagues in social housing, local government, and the NHS to ensure that this opportunity is seized.

Martyn Hale

Director of Care and Support, Citizen Housing

Supporting residents to quit smoking is something that Citizen recognises has many benefits. As a social landlord, we see it as part of our responsibility to support the physical and mental wellbeing of our residents. We do so not only by providing high-quality, well-built, and maintained homes but our 'Tenant Support and Wellbeing Programme' provides a wide range of advice and support from mental health and wellbeing support to managing debt or workplace issues.

We're already involved in supporting the health and wellbeing of our residents, however, the consideration is how we position smoking cessation and get the message right. We don't want to be, or appear, 'overbearing'; but this is not about telling people want to do, it's about raising awareness and offering our residents' opportunities to take control of their own health. This report highlights that this isn't something 'extra' that social landlords need to do; many of us are already providing health and wellbeing programmes that smoking cessation activities could neatly sit within. What this report gives us is fresh evidence of why this is important and how other social landlords have achieved successful results that we can replicate. At Citizen we look forward to learning from their examples.

This report couldn't be timelier; the COVID-19 pandemic has highlighted the stark health inequalities present in our society. This report also demonstrates the smoking-related inequalities that drive and exacerbate wider health inequalities. We see addressing smoking cessation as part of our COVID-recovery and redressing this imbalance for some of our tenants.

Lastly, this report comes at a time when many of our residents are very concerned about the cost-of-living crisis. The evidence indicates that, on average, people who smoke and live in social housing lose around an eighth of their total disposable income to smoking costs. Therefore, any support that we can give to help our residents to maximise their incomes and relieve some of these concerns is crucial.

Martyn Hale

Summary and recommendations

This joint report by Action on Smoking and Health (ASH) and the Housing Learning and Improvement Network (LIN) outlines the case for reducing rates of smoking in the social housing sector and the action needed to achieve this.

The report is the product of collaboration between the public health and social housing sectors and aims to equip both sectors with the information required to progress action on smoking and improve the support available to people who smoke and live in social housing. The report also identifies improvements that could be made at a national level which would better support local action on this important issue.

Key points

- The smoking rate among social housing residents is one of the highest in England – around 1 in 3 people in social housing smoke, compared to around 1 in 10 people who own their home and 1 in 7 in the general adult population.[1 2]
- Higher rates of smoking mean people living in social housing are disproportionately affected by the substantial health and economic inequalities caused by smoking.
- The gap in smoking rates between people living in social housing and people living in other types of housing has worsened in recent years, exacerbating inequalities.[5]
- Action on smoking is a valuable addition to social landlords' existing health and wellbeing activities. Supporting residents who smoke to stop and access existing professional support delivers substantial benefits to them and social landlords.
- Successful collaboration between social landlords and public health teams is already underway in England, providing replicable models and lessons for action in other areas.
- However, practice remains inconsistent and greater support and leadership is needed by central government, including additional resource.
- Successfully delivering on this agenda would radically improve the lives of social housing residents whilst delivering on shared ambitions for social landlords, central and local government, and the NHS.

Recommendations

Social housing providers

1. Recognise and embed support to help smokers quit, in consultation with residents
2. Establish and build relationships with local authority public health teams
3. Explore options for delivering stop smoking support and aids directly to residents

Local government public health teams and the NHS

1. Engage social housing providers to help support residents who smoke to stop
2. Support the implementation of tobacco control approaches in social housing in consultation with residents
3. Embed social housing-based tobacco control programmes within ICS level prevention and inequalities strategies

Central government

1. Provide funding for targeted programmes supporting people to quit in social housing
2. Set targets for reducing smoking prevalence in social housing

How this report was developed

This report has been produced by ASH and Housing LIN (information about ASH and Housing LIN is available at the end of this report on page 28). ASH and Housing LIN would like to thank the following organisations for supporting the development of this report:

- Bolton at Home
- Chartered Institute of Housing (CIH)
- Citizen Housing
- Clarion Futures of Clarion Housing Group
- Flagship Homes
- Grand Union Housing Group
- Irwell Valley
- Kirklees Council
- National Housing Federation (NHF)
- Nottingham Community Housing
- Peabody Group
- Sanctuary Housing
- The ExtraCare Charitable Trust
- Virgin Care
- Wakefield & District Housing

The report's narrative, findings, and recommendations have been developed with insights from:

- **ASH's 2018 report *Smoking in the home: New solutions for a Smokefree Generation*,**[3] including interviews with 17 professionals across the social housing and public health sectors and 5 focus groups containing 42 social housing residents.
- **A 2021 roundtable held by Housing LIN and ASH with 10 social housing providers,**[4]

conducted to establish a better understanding of social landlords' perspectives on the role they can play in promoting the health and wellbeing of their tenants by reducing tobacco use. The round table explored the opportunities for action and barriers which needed to be addressed.

- **Interviews with 9 social housing providers and key sector professionals,** conducted by Housing LIN in September 2021, using insights gathered during the roundtable event. The interviews explored practical routes to operationalising and embedding tobacco control programmes in social housing.
- **Feedback on the draft report** from the Chartered Institute of Housing, National Housing Federation, Clarion, and Citizen Housing.
- **New research from University College London on smoking in social housing,** evaluating progress toward reducing disparities in smoking prevalence among residents of social housing compared with other housing types. The research was based on a survey of over 100,000 adults in England.
- **ASH's research on the impact of smoking on employment, earnings, poverty and wider socio-economic security,** conducted by Landman Economics, with specific insights gathered on the impact of smoking on social housing residents' finances and economic security.
- **A national survey of local authorities in England on their work with social housing providers**, to explore how far social landlords already collaborate with public health teams on tobacco control programmes, and gather examples of best practice, understanding of key facilitators and opportunities to scale up initiatives across England.

Later in 2022, ASH will publish further findings based on insights from qualitative research with social housing residents and an update on tobacco control projects in England currently undertaken by social housing providers.

Introduction

Smoking is a leading cause of preventable illness and death across the UK. It is also strongly linked with inequality and disadvantage, with differences in smoking rates accounting for half the gap in life expectancy between the most and least disadvantaged in society. However, of all the socioeconomic measures, a person's housing tenure is now the strongest independent predictor of smoking in England,[5] with the highest levels of smoking found among people living in social housing. Rates in social housing are estimated to be between 30%[2] and 33%[5] - almost 3 times higher than among people who own their home and more than double that of the general adult population.[2]

Housing is rightly recognised as a determinant of health. By providing high-quality, well-built and maintained homes, social housing providers are a key partner in protecting and improving the physical and mental health of the population. However, the provision of high-quality, well-built homes is not the only way social housing providers can support their residents.

Social housing providers are increasingly seeking to improve the breadth and depth of support offered to their residents, maximising the social value they deliver. In being connected to where a person lives, they are uniquely placed to support residents in a wide range of areas as part of their housing and asset management; for example, from providing health and wellbeing services to installing smoke detectors or sprinkler systems, and from offering financial advice to supporting career development or addressing worklessness. Our research with social landlords found that many are actively engaged in trying to better support their residents to reduce tobacco use as part of approaches to improving residents' health. However, this activity is ad hoc, often depending on the commitment of individuals, rather than from a widely held organisational or sector-wide understanding that smoking is a leading cause of preventable illness and inequalities for their residents.

Higher rates of smoking mean the enormous burden of preventable death and ill health caused by smoking is disproportionately borne by people living in social housing. Smoking-related inequalities in health also drive and exacerbate wider interconnected inequalities social housing residents experience. For example, on average, people who smoke and live in social housing lose around an eighth of their total disposable income to tobacco.[6] For hundreds of thousands of people, this makes all the difference – an estimated 1 in 7 people living in social housing fall below the poverty line as a direct result of income lost to tobacco.[9]

There is a strong case for a collaborative approach across the NHS, public health and the social housing sector to share expertise and resources to reduce smoking prevalence in social housing. This has the potential to deliver on shared ambitions for all partners, improving the health and wellbeing of local communities whilst maximising social landlords' social value.

However, ensuring action progresses from ad hoc projects, which are frequently short-term and not sustained, to consistent and effective action across England requires greater national support and leadership. The Government has set an ambition to make England smokefree by 2030,[7] defined as smoking prevalence of 5% or less. However, the 2030 ambition can only be achieved across all population groups if significant reductions in smoking rates among social housing residents are secured.

Embedding tobacco control within the social housing sector therefore presents an opportunity for all partners across the social housing and public health sectors to radically improve the health, wellbeing, and lives of residents and society.

Why act: How smoking harms social housing residents

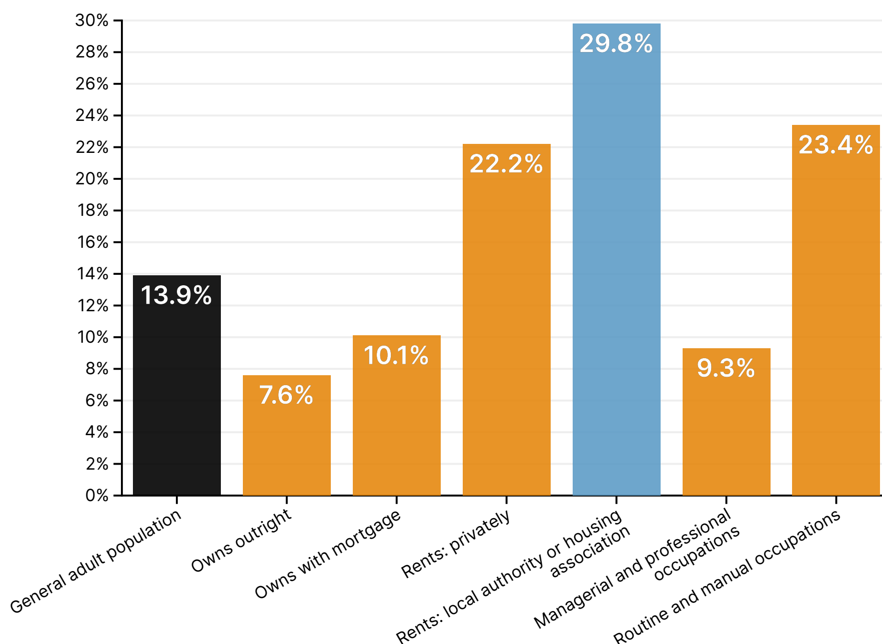
> **"If I hadn't decided to do it [a smoking cessation scheme], it wouldn't have happened. It's not my organisation, it was something I wanted to do and I was in that position to make it happen. For me it's about how we get social landlords, the actual organisations, to sign up to this, because I don't know that they have. I think you might have a lot of individuals who think it's a good thing but I don't know that housing organisations have."** — Housing sector professional at research roundtable

From our research with social landlords, we learnt that many are concerned about the impact of smoking on their residents. Positioning tobacco control as a missing element within social landlords' existing health and wellbeing agendas, as opposed to a new responsibility resonated with many providers. Despite this, social landlords felt further evidence was needed concerning the impact of smoking and benefits of addressing it for them and their residents before it could be prioritised within their health and wellbeing activities. This chapter therefore summarises the harmful impact of smoking on social housing and why action should be a priority.

Smoking rates in social housing

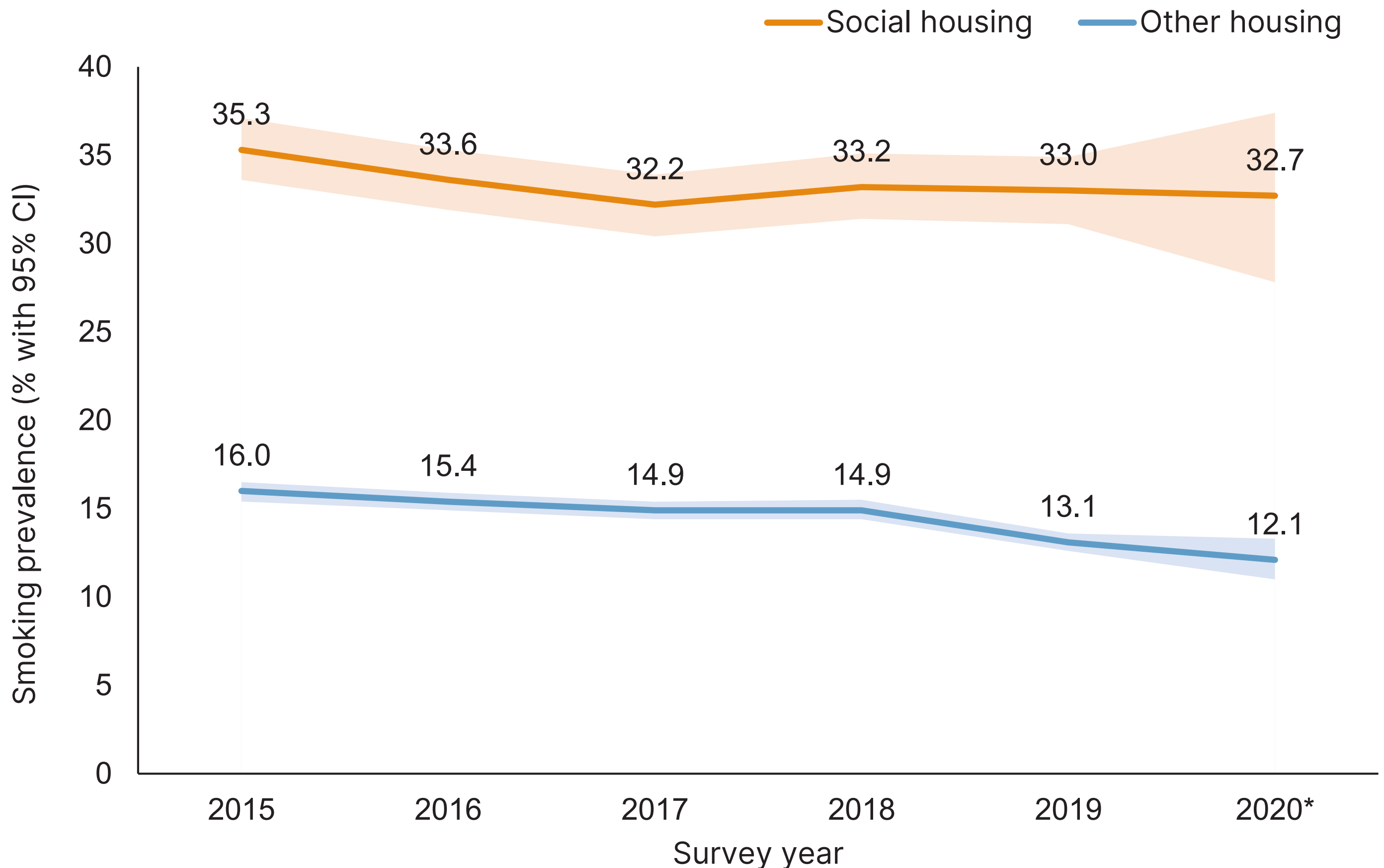
Smoking rates have fallen steadily in England for the last two decades thanks to a comprehensive strategy combining approaches to promote quitting with efforts to reduce uptake.[2] However, despite this progress significant inequalities have persisted and remain today.[8] The most disadvantaged groups in society have higher rates of smoking and see significantly slower declines in rates than the rest of the population.[2] These inequalities are most pronounced for social housing residents.[8] Smoking rates among people living in social housing are significantly higher than people living in other housing types and the general adult population.[2 5 8]

Figure 1. Smoking prevalence comparing inequalities in smoking rates by socio-economic measure, 2019 Annual Population Survey



New analysis by University College London (UCL) presented in this report reveals that the inequality in smoking rates between people living in social housing and people living in other housing types is getting worse, not better.[5] Smoking rates among people living in social housing are declining more slowly than the rate among people living in other housing types, exacerbating the already pronounced inequalities experienced by people living in social housing as a result (Figure 2 below).

Figure 2. UCL, annual smoking prevalence among adults in England living in social housing compared with other housing tenures, January 2015 through February 2020. Shaded bands indicate 95% confidence intervals. *Note data from 2020 is January and February only.



UCL's analysis also reveals that people who smoke and live in social housing have higher average levels of addiction and smoke more than people that smoke and live in other housing types. Current smokers living in social housing had 50% higher odds of smoking their first cigarette of the day within 30 minutes of waking (a commonly used measure for tobacco addiction) and smoked more cigarettes per day than current smokers living in other housing types (average 12.2 vs 10.5, respectively).[5]

To date public health interventions on smoking have tended to focus on the disparities between routine and manual population and others (see Figure 1 above).[2] For example, reducing the inequality gap in smoking prevalence between those in routine and manual occupations and the general population was a specific target in the 2017 Tobacco Control Plan for England, though this target has not been achieved.[9] However, the differences presented here suggest the inequalities are greater and widening more rapidly between social housing residents and the rest of the population,[5] though there are of course significant overlaps between these populations, with 1 in 3 people working in routine and manual occupations living in social housing.[10]

It's unclear why this gap might be widening – it may, for example, reflect growth in wider inequalities and vulnerability experienced by some people living in social housing. Whatever the cause of this growing problem the insights from social housing providers suggest they are well placed to help close this gap.

Smoking, health and health inequalities

Smoking remains the leading cause of preventable death and disease in England. In May 2021, Professor Chris Whitty, England's Chief Medical Officer, noted that "by the end of last year at least as many and probably more people will have died of smoking-related disease than of COVID-19."[11] For most people that smoke, no other aspect of their life will impact their health as significantly. Smoking prematurely kills half of all long-term users,[3] on average cutting 10 years from a person's life.[12] Quality of life is also affected – for every person killed by smoking, another 30 are living with serious smoking related illness.[13]

Around one and a half million people in England have social care needs attributable to smoking.[14] People that smoke are 2.5 times more likely to receive domestic social care support than never- smokers and, on average, receive social care support 10 years earlier than never-smokers, whilst they are still working age (average age of 63 years old vs 73 years old for never-smokers).[16] People who smoke need an average 3.5 times as many hours of social care support than never smokers and are more likely to need help with fundamental activities such as dressing (2 times more likely), bathing (2.4 times more likely) and getting in and out of bed (2 times more likely), hampering their independence.[16]

It is estimated that around 1 in 10 (9%) of all people living in social housing have a mental health condition and smoke.[15] Smoking is a significant cause of ill health and health inequalities among people with mental health conditions who as a population group experience disproportionately high rates of smoking.[16] Social housing residents are substantially over-represented in the population of people with mental health conditions who smoke, making up 27% of the total despite only 17% of households living in social housing.[17] Smoking affects mental as well as physical health. Quitting smoking associated with reduced depression, anxiety, stress and improved positive mood and quality of life equal to, or even larger than, those of antidepressant treatments for mood and anxiety disorders.[18]

The profound impact of smoking on health means it is the single biggest driver of health inequalities in England.[19] Someone living in the least deprived part of the country can expect to live around 7-10 years longer than someone living in the most deprived part of the country.[1] Differences in smoking rates between these areas are estimated to account for half of this gap in life expectancy,[21] making a larger contribution than any other modifiable risk factor. Smoking is also a greater source of health inequality than socioeconomic status and the scope for reducing health inequalities is therefore limited unless inequalities in smoking rates across society are eliminated.[20] With smoking more highly concentrated in social housing, it is disproportionately social housing residents who bear these costs and whose quality of life and life expectancy is limited by smoking.

Smoking as a cause of socioeconomic inequalities

The harms of smoking reach beyond physical health. As a result of disability and illness caused by smoking and controlling for other factors, people who smoke long-term are on average 7.5% less likely to be employed than non-smokers.[21] For those in employment, illness caused by smoking can prevent someone from doing their job and progressing in the labour market in the longer-term. This likely explains why, controlling for other factors like educational attainment, current adult smokers in employment earn an average of 6.8% (£1,424) less a year than non-smokers.[23]

This is in addition to actual spend on smoking, which on average costs an individual £1,954 every year.[22] Given people who smoke and live in social housing on average smoke more cigarettes per day than people living in other housing types (12.2 vs 10.5)[5] this cost could also be higher, though this may be offset by an above average use of cheaper forms of tobacco (e.g. hand-rolled instead of factory made cigarettes). Either way, this average sum is not felt equally across the population. On average, for someone who smokes and lives in social housing, expenditure on smoking consumes an eighth of their total income (12.4%), whilst for someone who smokes and owns their home, it consumes less than half this (6.9%).[9]

Table 1. Average cost of smoking broken down by time period.[23] (Note: this breakdown is based on figures for the tax year 2018/19. Costs for 3 and 5 years will likely be higher than the estimates provided in the table as they do not account for future tax increases for tobacco products)

Time period	1 Day	1 Week	1 Month	1 Year	3 Years	5 Years
Average cost of smoking per adult in England	£5.35	£37.58	£162.83	£1,954	£5,862	£9,770

For some, these costs can make all the difference. Before tobacco expenditure is accounted for, around 1 in 4 social rented households (27.2%) are estimated to be below the poverty line.[24] When tobacco expenditure is taken into account, this increases to 1 in 3 households (32.5%). This means over quarter of a million social rented households (246,000) in England are in poverty as a direct result of income lost to tobacco.[26]

Smoking and the inequality trap

A child growing up in an environment where smoking is prevalent is not only more likely to be exposed to second-hand smoke but is more likely to start smoking themselves.

Figure 3. Inside smoking most days in households with children, ASH & YouGov Smokefree GB survey 2022

Around 1 in 5 children living in social housing are in a home where someone smokes inside most days, compared to 1 in 8 children living in privately rented housing and 1 in 10 children living in owner occupied housing.[17] Second-hand smoke harms the health of children and young people, increasing the risk of asthma attacks and respiratory infections.[25] Second-hand smoke exposure in the home is also significantly associated with sudden infant death syndrome (SID) – maternal smoking after birth is associated with a three-fold increased risk of SID in infancy, whilst having one or more smokers living in the household more than doubles the risk of SID in infancy.[26]

Children whose caregivers smoke are more than twice as likely to have tried cigarettes, and four times more likely to regularly smoke,[27] transmitting the harms of smoking through the generations and reproducing the inequalities they cause.

The benefits of tobacco control for social landlords

"A lot of organisations already have a big emphasis on wellbeing, and it is part of what sprung from the roots of social housing anyway, so I think you could be pushing at open doors. But it never hurts to understand where the organisation itself will benefit from its tenants being supported by this [smoking cessation]. You can see a tie up with quitting smoking and supporting your tenants' financially but also how that helps the financial stability and income streams of organisations.

"One of the issues a lot of organisations will be thinking of as we come out of COVID-19 and we wait to see what some of the impacts are for tenants in terms of employment, in terms of income levels, is finance, and something that helps support this could be a real win for everyone."
— Housing sector professional quotes from research interviews

Our research has indicated that there is an opportunity for stop smoking support to be integrated within social housing providers' existing health and wellbeing programmes for residents. Smoking causes significant harm for people living in social housing, driving, and exacerbating inequalities in health and wealth, and even locking households into poverty.[28] However, with the costs of smoking for the social housing sector so significant, the benefits of addressing it are accordingly huge, not just for individuals but also for housing providers and the wider community.

The health benefits of quitting start within hours of stopping smoking. Carbon monoxide is almost entirely removed from the body within 48 hours of quitting and lung function improves by up to 10% by 3 months.[29] Significant gains in life expectancy can be made through stopping smoking at any age. The benefits of stopping smoking are so substantial that the gap in life expectancy between socioeconomic groups can be drastically narrowed and even reversed through stopping.[22] Therefore, unless people who smoke quit, it is unlikely that other action taken to improve their life expectancy will have a significant impact, making reducing smoking a necessary pre-requisite for housing providers wanting to improve the health outcomes of their residents.

Stopping smoking significantly improves physical and mental health, reduces health inequalities, improves financial security and, consequently, helps to address wider socioeconomic inequalities. In 2020-21, around 1 in 4 social renters (23%) reported finding it either fairly or very difficult to afford their rent, 1 in 10 (9%) reported currently being in arrears, and around 1 in 12 (8%) reported falling behind with payments in the last year.[19] Social housing residents, along with many other groups facing inequality and disadvantage in society, are also at risk of further economic shocks in the years ahead. At the time of writing, the Office for Budget Responsibility (OBR) forecasts inflation to peak at 8.7% in 2022 as the UK enters a cost of living crisis.[30] Based on the OBR's forecasts, typical real incomes are estimated to be 4% lower in 2022-23 than in 2021-22.[31] This is an average loss of £1,100 per household and is the worst hit to living standards since 1975. This trend is expected to continue into 2023-24, leaving the average household income £1,500 lower than in 2021-22.[31] This cost will be more substantial

for social housing residents, where the loss is likely to account for a greater proportion of their total income.

These factors therefore have important housing management implications. While the socioeconomic inequalities faced by social housing residents cannot be solved through stop smoking support alone, supporting residents with tobacco dependency can improve household finances. By giving money directly back to households from day one, stopping smoking can be a potentially quick and straightforward boon to residents' financial security. This could mean simply more money available for other spending or savings or, for many, could be the extra help needed to pay off rental arrears, prevent homelessness, and to lift a household above the poverty line.

Just as ill-health caused by smoking negatively impacts employment and earning prospects, quitting can help reverse these effects, improving economic security. While long-term smoking is associated with a 7.5% reduced chance of being in employment compared with never smoking, ex-smokers are only 2.5% less likely to be in employment.[23]

These health and economic benefits are particularly salient in the context of the COVID-19 pandemic. The pandemic exposed and exacerbated existing inequalities in society, with people living in the most deprived areas of the country twice as likely to die from COVID-19 in the early stages of the pandemic.[32] The pandemic also dealt a significant economic shock for individuals, with 94% of housing associations reporting an increase in residents suffering from economic hardship because of COVID-19, and 66% of housing associations reporting an increase in their residents receiving housing benefit in 2020.[33] Action to address inequalities in smoking rates, particularly among social housing residents, could make a significant contribution to 'building back better' from the pandemic, both nationally and for individual housing providers.

Recovering from the pandemic involves not only the short-term public health measures needed to curb transmission and harm from the virus, but also longer-term action to address the substantial harms people have faced in health and economic terms and to eliminate the underlying inequalities which left people more vulnerable in the first place. Targeted action on smoking would deliver tangible improvements in quality of life for those most affected by the pandemic and help build resilience where it is most needed for the future, delivering health and economic benefits both immediately and longer-term.

Effective support to smokers can also help deliver on social landlords' wider duty of care to their residents. For example, smoking is the fourth most common cause of house fires, accounting for just 8% of the total in England, but are the biggest cause of fatalities from house fires, accounting for 1 in 3 of all house fire deaths (32%).[34]

Many social housing providers are already adept at supporting the health, wellbeing, and wider needs of residents. From supporting people to maintain healthy lifestyles and stay active in older age to preventing loneliness and isolation and providing financial advice. Supporting residents to live smokefree therefore not only fits well with social housing providers' commitment to the health and wellbeing of residents – potentially delivering unmatched improvements to residents' health and financial security at a time such benefits are needed most – it also fits in with their asset management plans, supporting sustainable tenancies and preventing fire-related damage to properties.

Next steps: Supporting social housing residents to go smokefree

> **"We've got a captive audience of people that we can support to live a healthier lifestyle."**
> — Housing sector professional quote from research interviews

Work to address smoking through social housing is already underway in many parts of England, involving productive partnerships between social housing providers, local authority public health teams, and the NHS. However, while there is clearly motivation to pursue such programmes, particularly from local government public health teams, action is not yet widespread, consistent or sustained. This chapter sets out key lessons from existing practice across England for launching effective tobacco control programmes and embedding them in existing health and wellbeing activities, in addition to the national action that can support effective local delivery.

The opportunity to address smoking

There is not only a clear case for embedding tobacco control measures into social housing providers' existing health and wellbeing activities, as outlined in the previous chapter, but also a significant opportunity to do so. Levels of motivation to quit among current smokers living in social housing are no different to the wider adult population of current smokers – a majority want to quit and around 1 in 7 current smokers living in social housing report that they 'really want and plan to stop within 3 months'.[5] However, while motivation to quit is similarly high across housing tenures, quitting behaviour is already significantly higher in social housing. UCL's research has found that people who smoke and live in social housing were more likely to have made a serious quit attempt in the past year and more likely to have used quitting aids (specifically e-cigarettes or prescription medication like nicotine replacement therapies) than people who smoke and live in other types of housing.[5] However, they had 37% lower odds of successfully quitting compared to people in other housing types.[5]

This does not mean stop smoking support was less effective for people living in social housing, once their levels of dependency are taken into account, but rather reflects the challenge and case for action outlined in the previous chapter. People who smoke living in social housing are just as likely to want to quit, but face more barriers to quitting, such as higher average levels of addiction and higher levels of smoking in their environment.[5] Put together, these findings point to a significant opportunity to support social housing residents that smoke to quit.

Recommendations for social landlords

1. Recognise and embed support to help smokers quit, in consultation with residents

Recognising smoking as a significant and relevant issue for social housing residents is an important step towards addressing it effectively. This recognition should be right across

the organisation, from senior staff with responsibility for strategic direction setting, to those working on the ground with residents. This cannot be left to proactive individuals who on their own do not have the capacity or resource to effect systematic organisational change. Rather, a realistic and sustainable solution requires embedding an understanding of the harm tobacco causes and action to address it in the culture of the organisation. This could initially involve sharing the evidence set out in the earlier chapters of this report with senior leadership or using this information to build a more locally tailored case, as in the Flagship case study set out below.

Smoking should then be considered a relevant and important housing management issue which is factored into any strategies or projects seeking to improve the health and economic circumstances of residents and any systematic approaches the organisation may undertake to address income maximisation and health inequalities. In reviewing and embedding stop smoking support into such strategies and projects, partnerships with local professionals working across the public health and health sectors will be invaluable.

The Flagship Homes case study below provides an example of local public health teams supporting a social housing provider to review their policies and embed stop smoking support across the organisation. Flagship Homes have been comprehensive in their approach, ensuring staff are aware of the motivation and relevance of stop smoking support for them as a social housing provider, locating this within the wider support they offer to residents. Flagship have also successfully consulted with residents to inform their approach and have a comprehensive programme of communications planned to raise awareness of available support and make the health and wellbeing motivation for this work clear. This engaging and comprehensive approach will help to secure buy-in from staff and residents and avoid misperceptions that tobacco control measures are punitive in nature or motivation.

2. Establish and build relationships with local authority public health teams

Single and upper-tier local authorities in England are responsible and funded to provide a public health function, including tobacco control. A 2021 survey of local authorities with public health responsibility in England found that 43% reported undertaking tobacco control or smoking cessation work specifically with social housing providers.[35] This included a broad range of activity, from delivering free stop smoking services on site for residents to training housing association staff to deliver very brief interventions on smoking.[35] This is a positive start, but many programmes were described as still being in a 'scoping', or 'development' stage. It also indicates that there is an opportunity for many social housing providers to develop a relationship with their local public health team.

This was supported by our research with social housing providers, which found wide variation in relationships with local authority public health teams. Some social housing providers had strong links, particularly where they had a wider relationship with the council. For other providers, these relationships were not in place and although the value of such relationships were often acknowledged, concerns were raised that differing geographical boundaries and working across multiple local authority footprints could be a barrier to developing effective relationships.

Local authority public health teams hold a wealth of expertise in improving the health of their communities and addressing inequalities. They are a key partner for social housing providers who want to maximise the impact of their health and wellbeing work and improve the lives of their residents. Public health colleagues can provide expertise, capacity and in some cases funding and training, supporting housing providers to integrate stop smoking support in their health and wellbeing offers.

Case study: Collaboration to embed tobacco control across Flagship Homes' practice

On No Smoking Day 2022, Flagship Homes, a social landlord providing over 30,000 homes across the East of England, launched its smokefree homes project. -The multi-stranded, phased project aims to comprehensively support residents to quit smoking and lead healthier lives. The project, which began six months earlier in September 2021, is the result of close collaboration between Flagship Homes, Norfolk County Council, Suffolk County Council, and Essex County Council. The project involves:

- A survey of Flagship Homes residents to gather data and insights on smoking behaviours and engagement with quitting support.
- 90 frontline staff provided with free training by Norfolk County Council equipping them to deliver very brief interventions on smoking and providing them with a behaviour change framework that can be applied to other aspects of their work with residents.
- Further Level 2 Stop Smoking Practitioner Training to be delivered to 1 to 2 'champions' across each of Flagship Homes frontline teams.
- Establishing referral pathways from Flagships Homes to Stop Smoking Services across the 3 councils covering their footprint.
- Introducing a new clause in tenancy agreements which reinforces Flagships commitment to smokefree homes and encourages residents not to smoke in the property. The clause explains Flagship's health and wellbeing motivation and is not enforced with punitive measures.
- Any new homes being built will be advertised as smokefree from the outset.
- Collecting data on new residents' smoking status to understand scale of issue and better direct support.
- A comprehensive internal and external communications programme, explaining the project and its health-based motivation to internal staff. This also includes raising awareness of quitting support for staff that smoke, and to residents for a period of at least 12 months from the project launch, with a new focus/theme each month communicating the multi-faceted benefits of quitting and support available.

All the project elements have been collaboratively developed with substantial resource and support provided free by the participating councils. The group intend to scope the possibility of further support in the future of the project, such as offering free e-cigarette starter kits. Thanks to the councils' contacts, the project will also be evaluated. Further resident surveys will also be undertaken by Flagship Homes - initial feedback from staff has been very positive.

As the case study above demonstrates, public health teams work across a wide range of areas and are likely able to add value to existing programmes offered to residents by social housing providers.

In addition to linking social housing providers with wider council services and partners, public health teams can also be an invaluable connection into local NHS organisations and Integrated Care Systems (ICSs). Our research with social housing providers revealed that many wanted to grow and develop their relationships with ICSs. This is crucial, given ICSs are due to be established as statutory bodies in 2022 and will become the key players in the development of local plans and arrangements to address broader health, public health, and social care needs for the local area. Social housing providers will be able to provide valuable insight to ICSs on

the challenges their residents face, helping ensure the wider health and care system meets their needs and delivers better outcomes for them. Local authority public health teams are key stakeholders in ICSs, alongside the NHS, and can support engagement with them, particularly in ICS Health and Care Partnerships, which are still under development but can involve third sector organisations like housing providers.[36] Contact details for local public health teams are widely available on council websites, however for support connecting with them, social housing providers can contact admin@smokefreeaction.org.uk.

> **"Hitherto coronavirus, certainly speaking for my organisation, we never really explored the ways in which public health and housing could interact, but I don't recall that we've set up any projects [between public health and housing] for years."**
>
> **"We would never have been able to it without those [local authority] partnerships to be honest, we don't have the expertise and we wouldn't have resourced the training. With the local authorities it's all been made easy and possible [...] Every hurdle that we've come across we've managed to get over, but it just shows that it can be done. I've been really surprised by the sheer amount of support, time, and resource they've given."**
> — Housing sector professional quotes in research interviews

3. Explore options for delivering stop smoking support and aids directly to residents

Existing practice shows collaboration between social housing providers, local authorities and other partners to deliver specific and targeted programmes supporting residents who smoke to quit can be highly effective.

Case study: Salford 'Swap-to-Stop'[37]

In 2018, local housing associations in Salford joined worked with Salford City Council to run a 3-month scheme aimed at support social housing residents who smoke to quit with the help of e-cigarettes. The scheme enabled smokers in Salford to receive a free e-cigarette alongside a standard stop smoking programme, delivered by trained professionals in the local stop smoking service and community pharmacy.

Housing staff in contact with residents were trained in how to signpost to the scheme, with participants receiving vouchers which were exchanged for a free e-cigarette, charger, and nicotine liquid. E-cigarettes were distributed via the stop smoking service and community pharmacies, where participants would also receive standard smoking cessation advice, in addition to follow-up consultations at two and four weeks, which were incentivised with additional bottles of liquid for their e-cigarettes.

The scheme was highly successful, with over 1,022 people taking up the e-cigarette offer, the majority of whom were from the most deprived IMD quintile. The city wards most represented in the scheme's participants also had the highest proportion of people living in social housing. The scheme was a huge success. A total of 614 participants returned for the 4 week follow-up, with 62% of these (383) having a clinically validated quit at this point (37% of the 1,022 people that took part). The local stop smoking service saw 4 times as many service users compared the same period in the previous year and, overall, the scheme successfully engaged 2.3% of all smokers in Salford in just 3 months. However, due to lack of funding, the project was discontinued and after it stopped the level of service use fell back to previous levels, demonstrating the need for a sustained approach.

Although it was only a pilot programme which has not been sustained, the evaluation of its impact demonstrates that this is a successful intervention, and provides a promising model for action across the rest of the country. The Salford programme has already inspired similar schemes elsewhere for example in the South West, where a partnership between the housing association Curo and Bath and North East Somerset Council delivered 50 e-cigarette starter kits to residents in 2020, during the early stages of the COVID-19 pandemic. Curo's independent living team were trained to provide e-cigarettes and refer residents to the council's stop smoking service, with residents who were shielding or clinically vulnerable prioritised. The project was funded by Curo and was reported to be very successful by staff involved, with a formal evaluation of the project underway. These schemes demonstrate the value of targeted initiatives supporting residents to quit and collaboration between social housing providers and local public health teams.

These particular examples also shine a light on the potential of e-cigarettes for people who smoke and live in social housing. Reviews of the evidence by the National Academies of Sciences, Engineering and Medicines in the US and the UK Committee on Toxicity have concluded that the relative risk of adverse health effects from e-cigarettes are likely to be substantially lower than from smoking.[38 39] E-cigarettes have also been shown to be an effective aid for quitting, in clinical trials and at population level,[40 41] with some evidence suggesting they are even more effective than traditional forms of nicotine replacement therapy, like patches and gum.[40 42] They also appear to have been particularly valuable among groups who face higher levels of addiction and more barriers to quitting, for example among people experiencing homelessness and people with mental health conditions. Considered alongside the evidence from the 'Swap-to-Stop scheme, e-cigarettes therefore present a real opportunity to substantially benefit people who smoke and live in social housing.

However, misperceptions about the safety of e-cigarettes may be having a disproportionate impact on the willingness of people living in social housing who smoke to try e-cigarettes compared to those in other housing types. One in 6 people who smoke and live in social housing (17%) report that safety concerns are the main reason they have not tried e-cigarettes, compared to 1 in 10 private renters who smoke (10%) and around 1 in 14 home-owners who smoke (7%).[17] Improving residents' understanding of the relative harms of vaping compared to smoking could have a big impact on people's willingness to switch.

4. Promote quitting, signpost residents to existing support and embed smokefree communications

In addition to exploring opportunities to directly deliver smoking cessation support and aids to residents, social housing providers can also signpost residents to local stop smoking services and embed messaging which encourages quitting and keeping a smokefree home.

Case study: Training staff to refer and offer support in Leicester

Leicester City Council's public health team worked with the council's housing department to deliver Very Brief Advice (VBA) training on smoking to all frontline housing officers in contact with residents. The training demonstrates how to raise smoking without being judgemental, advise how to stop and offer support, for example via a referral to a local service, all in less than a minute. Around 60 housing officers received training delivered by Leicester City Public Health, with no additional resource required beyond staff time. Additionally, more in-depth training has been provided to housing officers working in one city ward where smoking rates are higher than the city average. This will support staff to have more comprehensive conversations around smoking ensuring a referral to a stop smoking service takes place and a free e-cigarette starter kit is offered at new tenancy visits or at welfare check-ins, alongside wider holistic wellbeing checks. Evaluation of these initiatives are underway to assess the number of residents engaged through the initiatives and staff experiences.

These case studies provide practical examples of how social landlords can access evidence-based stop smoking services which are already established across the country. In our research, many social housing providers said they did not necessarily see it as their responsibility to operationalise smoking cessation services or initiatives. However, this finding may be a reflection of a gap in knowledge regarding (a) the existing support available to people wanting to quit smoking and (b) what supporting residents to stop smoking looks like in practice and the range of options available. Further, these same providers who didn't believe it was their responsibility to directly provide smoking cessation support, which may not be a feasible option for all providers, did see a role for themselves in signposting residents to existing stop smoking support. Indeed, a majority of social housing providers engaged through our research reported having existing support and wellbeing programmes that they thought smoking cessation could easily fit within.

Indeed, for all social housing providers, the return on investment from a relatively small commitment in staff time is potentially considerable. Rather than establishing their own services from the ground up, social landlords need only engage with local authority public health teams who can provide the expertise, training, and information needed to signpost residents to existing local stop smoking support and embed smokefree messaging in social landlords' communications.

> **"As we already provide health and wellbeing support, signposting residents to stop smoking services requires little additional resource, we just need to know where these services are and which ones are most effective.**
>
> **"It's about making sure we don't miss any opportunities, so I like the idea of asking [about smoking] at sign-up but we also need to be ensuring the people who do the sign-up are fully trained and fully aware of the services available.**
>
> **"Often with these things there's so many different avenues that you can do to get support so just knowing where you refer to is really important."**
> — Housing sector professional quote from research interviews

The role of local government public health teams and partners in the NHS

Securing improvements in the support available to social housing residents who smoke will be more rapidly and consistently achieved with the buy-in and leadership of both local government and the NHS. These organisations have expertise in supporting smokers and developing strategies to reduce harm across populations. They can provide access to treatment services and leverage the involvement of wider community organisations.

They are also well placed to nest activity in social housing into the broader strategic context of prevention health and to support consistent approaches across multiple providers which can add value to activity.

It is important to note that many local authorities in England will also simultaneously hold public health expertise and directly provide social rented homes, providing a clear case and opportunity for action supporting residents who smoke.

1. Engage social housing providers to help support residents who smoke to stop

As health leaders, local government public health teams have a role in securing buy-in from local social landlords, including their own council where applicable, supporting them to understand their role as a partner in tobacco control, and involving them in local alliances and partnerships. The evidence set out in this report, in addition to further research published by ASH, will support councils in this engagement role.

2. Support the implementation of tobacco control approaches in social housing, in consultation with residents

The success of interventions to support people who smoke will likely be improved by the involvement of public health teams and local stop smoking services. Councils should provide the expertise, capacity and, where appropriate, resource required to embed and launch tobacco control initiatives in collaboration with social landlords, as described above.

3. Embed social housing-based tobacco control programmes within ICS level prevention and inequalities strategies

ICSs will shortly become an important footprint across which health, public health and care approaches will be organised. They have been established on the principle of collaboration with Integrated Care Boards (ICBs), will oversee the running of NHS services across the system while Integrated Care Partnerships (ICPs) will co-ordinate the collaboration between healthcare, local government, and other partners.

While ICBs and ICPs are still being established, reducing health inequalities, and preventing ill health will be a duty set out in legislation.[43] Embedding social housing-based tobacco control programmes within the developing strategies across ICSs will help to drive the agenda forward, promote consistent practice between areas, and support NHS partners to fulfil their legal obligations.

National action to support local delivery

While social housing providers, public health and NHS providers will provide the 'boots on the ground' to ensure support is delivered to people living in social housing who smoke, this activity will be more coherent and equitable if it is a supported part of the national strategy to reduce smoking.

For the Government, reducing rates among social housing residents will be crucial to achieving its ambition for England to be smokefree by 2030.[11] [10] It can also help deliver Government commitments to increase healthy life expectancy by five years by 2035, while reducing inequalities and improving wellbeing and productivity by 2030.[44]

1. Provide funding for targeted programmes supporting people to quit in social housing

> **"It also comes round to funding. The challenge for social landlords always being funding these kind of schemes through rent if you aren't able to access specific health funding, because that always raises question marks about how much along this route do we go bearing in mind where our funding comes from."**

> **“There’s the question about using rental income to do things that you could argue public health and other sectors should be supporting with.”**
> — Housing sector professional quotes from research roundtable

While some action supporting social housing residents who smoke to quit can be delivered with low levels of investment, the most effective and evidenced practice supporting people to quit will require new funding, as demonstrated in the Salford ‘Swap-to-Stop’ pilot.

While social housing providers have and may opt to fund such programmes, this is very unlikely to be undertaken consistently and at scale without a dedicated stream of funding. Indeed, despite the evaluation of the Salford pilot showing it was highly effective, funding was not sustained for the programme after the pilot ended, even though the cost per quit was lower, because of the increased success rates using e-cigarettes.[37] The spend per quit for Swap to Stop clients was £159.73 compared to £322.65 for clients who received standard stop smoking offer.[37] A national scheme modelled on the Salford Swap-to-Stop pilot and administered through local authorities would see this highly effective approach delivered at scale, equitably reaching smokers in social housing.

Modelling by University College London estimates that providing targeted quitting support including an offer of a free e-cigarette starter kit to people who smoke and live in social housing across England would result in approximately an additional 298,000 long-term ex-smokers between 2022 and 2030.[11] Overall, this intervention alone could deliver a 3.9 percentage point reduction in smoking prevalence among people who live in social housing.[11]

Funding for public health and tobacco control, provided through the Public Health Grant, has been reduced substantially over recent years, amounting to a cut of a third in real terms since 2015.[45] Significant reinvestment is needed to improve support for disadvantaged smokers. The All Party Parliamentary Group on Smoking and Health, supported by many leading health organisations across the UK have called on the Government to introduce a Smokefree 2030 Fund, which would place a ‘polluter pays’ levy on the tobacco manufacturers,[11] forcing them to pay for the harm they cause, and the measures needed to reduce smoking and support people to quit. Interventions resourced by the Smokefree 2030 Fund could include the activities set out above to support people who live in social housing and smoke to quit.

2. Set targets for reducing smoking prevalence in social housing

The current national Tobacco Control Plan,[12] which ends this year (2022) has targets to reduce smoking among adult smokers, pregnant women, and 15-year-olds and reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population. The next tobacco control plan, which the Government has committed to publishing this year,[46] needs to focus more forensically on addressing inequalities. One of the ways this can be achieved is by setting a target to reduce smoking among those living in social housing.

Securing the Government’s Smokefree 2030 ambition would see smoking prevalence reduced to less than 5% by 2030. Achieving the 2030 ambition is crucially important and a mid-term review will be essential to determining whether the approach is delivering the progress needed and whether further adjustments or further interventions are needed. Setting milestones for 2025 is therefore key, to bridge the gap between the current position and the destination.

Using Office for National Statistics data, an appropriate mid-term target for smoking rates in social housing would be to reduce prevalence from 29.8% in 2019 to 16% by 2025.[11]

Conclusion

People living in social housing face significant inequalities in health as a result of smoking. The ramifications of these inequalities are deep and far-reaching, locking families into poverty and potentially trapping whole communities into generational cycles of disadvantage.

However, just as there is a significant challenge to be addressed, there is a significant and untapped opportunity to be seized. Housing status is the strongest independent socioeconomic predictor of smoking in England.[8] By embedding tobacco control programmes in existing health and wellbeing strategies in social housing, the lives of residents can be radically improved.

This work is already well underway in parts of the country, demonstrating that such measures can be implemented, but a lack of funding and national direction means they are not comprehensive nor consistently sustainable. Without additional funding to reinstate the cuts to public health budgets, and support innovative approaches, nationwide action to seize this opportunity will not be achieved. This puts at risk not just the Government's Smokefree 2030 ambition, but also the missions to level up the health, productivity and wellbeing of our nation.

References

1. Office for National Statistics. Adult smoking habits in the UK: 2019. July 2020.
2. Jackson SE, Brown J, Cheeseman H, Arnott D, Titmarsh R. Smoking in social housing among adults in England, 2015-2020: A nationally representative survey. MedRxiv, Pre-print, January 11 2022, Accessed February 2022, doi: https://doi.org/10.1101/2022.01.11.22 269062
3. ASH. Smoking in the home: New solutions for a smokefree generation. November 2018.
4. Housing LIN and ASH. Roundtable: The case and opportunities for social landlords to promote tenants' health and wellbeing in relation to tobacco use reduction. Accessed February 2022.
5. Beard E, Brown J, Jackson SE, West R, Kock L, Boniface S, Shahab L. Independent Associations Between Different Measures of Socioeconomic Position and Smoking Status: A Cross-Sectional Study of Adults in England. Nicotine Tob Res. 2021 Jan 7;23(1):107-114. doi: 10.1093/ntr/ntaa030. PMID: 32026943; PMCID: PMC7789954.
6. ASH. The quitting dividend for landlords and tenants. May 2019.
7. Department of Health & Social Care and Cabinet Office. Advancing our health: prevention in the 2020s – consultation document. July 2019.
8. APPG on Smoking and Health. Delivering a Smokefree 2030: The All Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021. June 2021.
9. Department of Health. Towards a Smoke-free Generation. A tobacco control plan for England. July 2017.
10. Department for Levelling Up, Housing, & Communities. English Housing Survey, Headline Report 2020-21. December 2021.
11. Daily Mail. Professor Chris Whitty attacks 'kill for profit' tobacco companies and warns smoking killed 90,000 Brits last year - more than Covid. Published online, 19 May 2021. [Accessed November 2021].
12. Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ. 2004 Jun 26;328(7455):1519
13. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed November 2021].
14. ASH. The cost of smoking to the social care system. March 2021.
15. ASH & YouGov Plc. Smokefree 2022 (England). Total sample size was 10883 adults. Fieldwork was undertaken between 16/02/2022 - 21/03/2022. The survey was carried out online. The figures have been weighted and are representative of all English adults (aged

18+).

16. ASH. The stolen years: The mental health and smoking action report. April 2016.
17. Department for Levelling Up, Housing & Communities. English Housing Survey, headline report, 2020-21. December 2021.
18. Taylor G, McNeill A, Girling A, Farley A, Lindson-Hawley N, Aveyard P et al. Change in mental health after smoking cessation: systematic review and meta-analysis BMJ 2014; 348 :g1151 doi:10.1136/bmj.g1151
19. Jha P, Peto R, Zatonski W, Boreham J, Jarvis MJ, Lopez AD. Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland, and North America. Lancet. 2006 Jul–Aug;368:367–70.
20. Gruer L, Hart CL, Gordon DS, Watt GC. Effect of tobacco smoking on survival of men and women by social position: a 28 year cohort study. BMJ. 2009 Feb 17;338:b480. doi: 10.1136/bmj.b480. PMID: 19224884; PMCID: PMC2645845.
21. ASH. Smoking, employability, and earnings. September 2020.
22. ASH. Ready Reckoner 2022. Accessed February 2022.
23. ASH Ready Reckoner 2022: Methodology. Accessed February 2022.
24. Landman Economics. Estimates of poverty in the UK adjusted for expenditure on tobacco–2021 update. July 2021.
25. Royal College of Physicians. Passive smoking and children. March 2010.
26. Smoking in Pregnancy Challenge Group. Getting back on track: Delivering a smokefree start for every child. February 2021.
27. Laverty AA, Filippidis FT, Taylor-Robinson D, et al. Smoking uptake in UK children: analysis of the UK Millennium Cohort Study. Thorax 2019;74:607-610.
28. Stoten B. Lighting up the health and housing agenda. Housing LIN, 2015.
29. NHS. Better Health: Quit smoking. Accessed February 2022.
30. Office for Budget Responsibility. Economic and fiscal outlook – March 2022. March 2022.
31. Resolution Foundation. Inflation Nation: Putting Spring Statement 2022 in context. March 2022.
32. Office for National Statistics. Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 31 July 2020. August 2020.
33. Communities that Work. The impact of Covid-19 on housing sector led employment support. January 2021.
34. Home Office. Detailed analysis of fires attended by fire and rescue services, England, April 2020 to March 2021. September 2021.
35. ASH and Cancer Research UK. Reaching out: Tobacco control and stop smoking services in local authorities in England, 2021. January 2022.
36. The Kings Fund. Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England. February 2018. Accessed March 2022.

37. Greater Manchester Health and Social Care Partnership. E-cigarette 'Swap to Stop' evaluation summary. August 2020.

38. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on the Review of the Health Effects of Electronic Nicotine Delivery Systems. Public Health Consequences of E-Cigarettes [Internet]. Washington (DC): National Academies Press; 2018 [cited 2022 Mar 3]. Available from: doi: 10.17226/24952

39. Committee on Toxicity of Chemicals in Food, Consumer Products, and the Environment. Statement on the potential toxicological risks from electronic nicotine (and non-nicotine) delivery systems (E(N)NDS – e-cigarettes). September 2020.

40. Public Health England. Vaping in England: An evidence update. February 2021.

41. Hartmann-Boyce J, McRobbie H, Lindson N, Bullen C, Begh R, Theodoulou A, Notley C, Rigotti NA, Turner T, Butler AR, Fanshawe TR, Hajek P. Electronic cigarettes for smoking cessation. Cochrane Database of Systematic Reviews 2020, Issue 10. Art. No.: CD010216. DOI: 10.1002/14651858.CD010216.pub4. Accessed 03 February 2022.

42. Hajek P, Phillips-Waller A, Przulj D et al. A Randomized Trial of E-Cigarettes versus Nicotine-Replacement Therapy. February 14, 2019. N Engl J Med 2019; 380:629-637. DOI: 10.1056/NEJMoa1808779

43. UK Parliament. Health and Care Bill 132 (as amended on report). 17th March 2022. Accessed March 2022.

44. Department for Levelling Up, Housing and Communities. Levelling up the United Kingdom. February 2022.

45. The Health Foundation. Why greater investment in the public health grant should be a priority. October 2021.

46. UK Parliament. Smoking: Question for Department of Health and Social Care UIN 122663. 30 November 2020, Accessed February 2022.

About the Housing LIN

The Housing LIN is a sophisticated network bringing together over 20,000 housing, health and social care professionals in England, Wales and Scotland to exemplify innovative housing solutions for an ageing population. Recognised by government and industry as a leading 'ideas lab' on specialist/supported housing, our online and regional networked activities, and consultancy services:

- connect people, ideas and resources to inform and improve the range of housing that enables older and disabled people to live independently in a home of their choice
- provide insight and intelligence on latest funding, research, policy and practice to support sector learning and improvement
- showcase what's best in specialist/supported housing and feature innovative projects and services that demonstrate how lives of people have been transformed, and
- support commissioners and providers to review their existing provision and develop, test out and deliver solutions so that they are best placed to respond to their customers' changing needs and aspirations

To access a selection of related resources on the health interventions in housing, check out the Housing LIN's curated 'Health and Wellbeing' pages at: www.housinglin.org.uk/Topics/browse/Housing/hwb/

And for more information about how the Housing LIN can advise and support your organisation go to: https://www.housinglin.org.uk/consultancy/consultancy-services/

Housing Learning and Improvement Network
c/o PRP, The Ideas Store
10 Lindsey Street, Clerkenwell
London EC1A 9HP

Housing LIN
Connecting people, ideas and resources

Email: consultancy@housinglin.org.uk
Web: www.housinglin.org.uk/consultancy

Twitter: @HLINConsult, @HLINComms & @HousingLIN

About ASH

Action on Smoking and Health (ASH) is a public health charity that works to eliminate the harm caused by tobacco. ASH was established in January 1971 by the Royal College of Physicians. We do not attack smokers or condemn smoking. ASH is recognised nationally and internationally for driving progress and innovation in tobacco control and public health. ASH is a founding member and coordinator of the Smokefree Action Coalition (SFAC), a group of over 300 organisations across the UK committed to ending smoking.

ASH aims to be innovative and agenda setting in its work and policy. ASH's work is always evidence based and follows a dual approach:

- Information and networking: To develop opinion and awareness about the "tobacco epidemic"
- Advocacy and campaigning: To press for policy measures that will reduce the burden of addiction, disease and premature death attributable to tobacco.

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 and Social Care to support tobacco control.

Action on Smoking and Health (ASH)
Unit 2.9, The Foundry,
17 Oval Way,
London, SE11 5RR

ash.
action on smoking and health

Email: admin@smokefreeaction.org.uk
Web: www.ash.org.uk

Twitter: @AshOrgUK