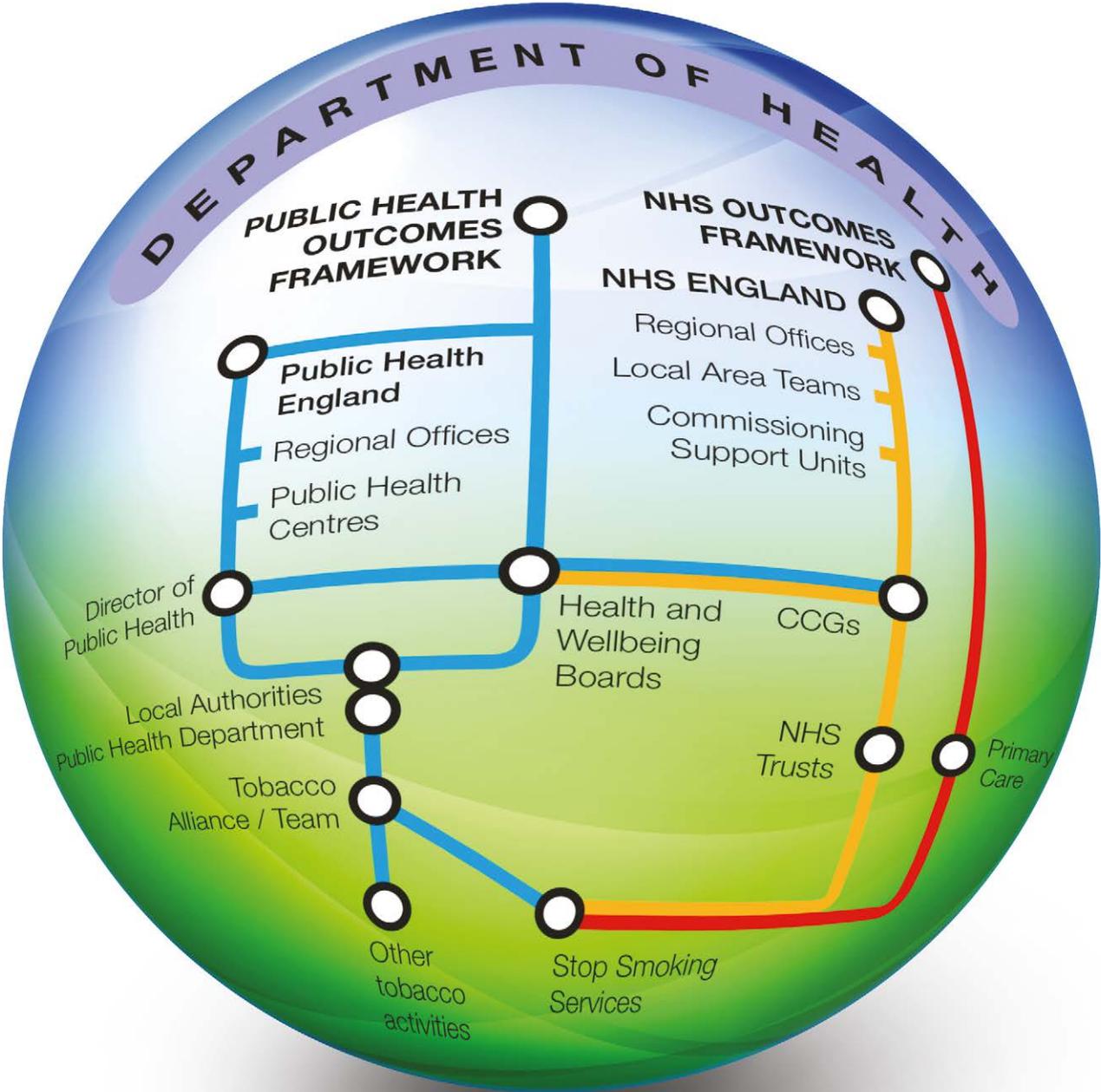


# TOP OF THE AGENDA 2013

## MAPPING THE NEW PUBLIC HEALTH LANDSCAPE



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### IS THIS FOR YOU?

This guide explores the risks and opportunities of the changing public health landscape for professionals engaged in reducing the harm from tobacco. If you work on tobacco issues and want to ensure that efforts to tackle the harm of tobacco are sustained and strengthened through the current period of organisational change, this guide is for you.

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## FOREWORD

As a long serving councillor in the London Borough of Brent and a passionate advocate of public health I have always viewed the transfer of public health to local government as a return home. Local government is ideally placed to take the long view on health and wellbeing, and reach into the most disadvantaged communities to make a difference.

Tobacco control's new home is providing tremendous opportunities to innovate and develop new partnerships. However, as we embrace the new it is important that we do not lose sight of the tried and tested.

We know a great deal about what we need to do to keep driving down smoking rates and the changes to the system provide an opportunity to step up the pace, not to move away from what we know works.

With change there is always some risk. If we are to ensure that we can make the most of this opportunity to re-energise public health then we must be alive to the issues which could undermine progress.

### LOW VISIBILITY OF TOBACCO CONTROL

While there can be no one in local government who hasn't noticed the addition of a new public health department that does not mean there is a good understanding of what public health does. Those who have never had contact with stop smoking services or other aspects of tobacco control are often surprised to hear just what a massive impact smoking has and what a difference tackling it can make to the levels of inequalities, the growth of local businesses, the cost of health services and the demand for adult social care, among other things.

Tobacco is the biggest preventable cause of ill-health and death in our country and to be effective local activity on public health needs to be proportionate. We need smoking in every Joint Health and Wellbeing Strategy and for tobacco control teams to be reporting on their own strategy directly to Health and Wellbeing Boards. I would also like to see high level engagement in local tobacco alliances with politicians and senior staff represented in the group.

### GRADUAL EROSION OF THE PUBLIC HEALTH BUDGET

While the current public health budget is ring-fenced this will change in the coming years. Where tobacco control has not achieved an appropriate level of visibility locally I am concerned that budgetary pressures will see tobacco control squeezed. We must remember that stop smoking services and other parts of tobacco control are highly cost effective. They are not currently on the list of activities which are mandatory for local government to deliver. However, if we start to see a scaling back in the quality or volume of services this may warrant review.

### A GAP IN REGIONAL ACTIVITY

Evidence from NICE has shown that some tobacco control work is best carried out at a regional and national level – in particular mass marketing campaigns and work to tackle illicit tobacco. There are a number of areas of the country where local government has not opted to invest in regional work. I hope in the coming months and years as public health beds in to local government those areas without regional activity will review this decision.



BOB BLACKMAN MP

## COUNCILLOR COMMENTATORS

With the transfer of public health to local government the political dimension of tobacco control has become all the more important. As a preface to this edition of Top of the Agenda we have asked three local councillors from each of the political parties to give us their perspective on why tobacco control is important to them and their party.

### JANE EVISON

CONSERVATIVE COUNCILLOR, EAST RIDING OF YORKSHIRE

*“As a Conservative councillor taking action on smoking is important to me. Whilst I respect the right of individuals to make their own life choices there is much that can be done to better educate and encourage decisions that will bring about personal choice and freedoms. We know that smokers start as children and most struggle to quit as adults. Nearly all smokers say they want to quit and wish they’d never started. There is a clear and important role for public health to play in diverting people away from a lethal habit and providing those who have been drawn in with an exit strategy.*

*“Whilst smokers will often rebel at being told to stop smoking themselves there is little or no opposition to the concept of a ‘tobacco and smoke free generation’. This above everything is a goal we should aim for, to protect our children from the known harm smoking can do.*

*“My ideal would be to see my local community to be strong and fully understanding the detrimental effect smoking has on society at many levels. While the health impact of smoking is significant and too often tragic, there is also a considerable burden on the economy and local businesses. For every pound spent on tobacco less than 10p stays in the local economy. What is left is poor health, smaller incomes and greater dependency on the state.*

*“When we are able to support people to quit we not only improve their lives but also our community’s prospects. Where we support smokers to quit we:*

- **Save smokers thousands of pounds a year** – disproportionately poorer people smoke and quitting can make a significant difference to household incomes, supporting people to budget in difficult times.
- **Reduce the costs to local businesses** – smokers take more sick leave than non-smokers and more breaks during the day. Cutting the level of smoking can improve productivity for small businesses.
- **Reduce demand for health and social care** – we know that smoking has a life long impact on people’s health and is the biggest cause of preventable illness. Tackling long term illness is a serious challenge for local services and reducing the level of smoking is an excellent place to start.

*“The national Tobacco Control Plan for England provides a framework for local action based on the best international evidence of effectiveness. I strongly urge those working in local tobacco control to ensure that councillors are fully briefed on the national plan and the potential for tobacco control to make a real difference to local health and wellbeing and above all to work to stop our children ever starting to smoke.”*

**JOHN MCCLUREY**

LIBERAL DEMOCRAT COUNCILLOR, GATESHEAD COUNCIL

*“As a Liberal Democrat, a councillor and a local shopkeeper I am highly committed to tackling smoking. Liberal Democrats believe in an equal and free society built on the principles of a strong community and opportunity for all. These principles are undermined every time a child takes up smoking or is exposed to secondhand smoke or someone is put off trying to quit.*

*“It is clear to me that smoking stifles our communities, limiting opportunities and that reducing smoking can be transformative.*

*“The community agenda is an important one for local Liberal Democrats as it is in local tobacco control. We see our role as being the champions of community, removing barriers to developing strong and prosperous places and embedding services and support which lead to the greater wellbeing of all.*

*In tobacco control the success of community based interventions has been shown. Approaches such as stop smoking services, intelligence led efforts to tackle illicit tobacco and local enforcement action to protect our communities, from rogue businesses who flout the law by selling tobacco to children have all contributed to reduced harm from smoking and increased community wellbeing.*

*“As a councillor I’m regularly briefed on tobacco issues, which has been quite eye opening. While I knew about the dangers of smoking, the evidence on the extent of harm and the entrenched inequalities which tobacco contributes to was largely new to me and increases the need for urgent action on this issue. Liberal Democrats have long been committed to addressing the inequalities in our communities. In our 2010 manifesto we pledged to rebalance health inequalities through a greater investment in GPs in the poorest parts of the country. Under the Coalition tackling health inequalities has been a core part of the Public Health Outcomes Framework.*

*“I would like to see more action in the future on tackling tobacco marketing to children. I have been publicly supportive of standardised packaging as have others in my party including Norman Lamb MP, Minister in the Department of Health. Liberal Democrats at a local and a national level want to take action to reduce the harm from tobacco, particularly where we can protect children from becoming the next generation to live with the consequences of smoking.”*

**LUKE AKEHURST**

LABOUR COUNCILLOR, LONDON BOROUGH OF HACKNEY

*"I am proud of my party's track record on tackling smoking. The last Labour Government took some significant steps forward in protecting the public's health:*

- *Introduced a ban on tobacco advertising*
- *Banned smoking in public places*
- *Implemented a price escalator for tobacco products*
- *Set ambitious targets to reduce smoking prevalence*
- *Invested in stop smoking services and national mass marketing campaigns*
- *Invested in regional tobacco control*

*"In short we embraced the World Health Organisation's guidance and implemented a comprehensive approach to tobacco control, one that remains world leading. With the transfer of public health this responsibility has now passed to local government.*

*"In many Labour led areas, my own included, we continue to see tremendous harm from smoking and significant health inequalities. When half the difference in life expectancy between the richest and the poorest is still attributable to smoking it is clear the job is not done on tobacco.*

*"In this time of austerity when many councils, particularly those with communities in the most need, have seen significant cuts to budgets there is a need to be clear about what we are investing in and target our services. Prioritising those communities where prevalence is high is important as part of our overall approaches to reducing poverty and inequality.*

*"Providing access to high quality stop smoking services is a question of social justice in my view. It is right that we should continue to use a price mechanism to reduce smoking prevalence but it is immoral to do this without ensuring that we are giving people access to the services we know can make all the difference when trying to quit this highly addictive substance.*

*"My party is committed locally and nationally to continued action to reduce smoking. For us it is about reducing poverty and giving future generations the opportunity for a long and healthy life which has too often been denied their parents."*

## THE NEW PUBLIC HEALTH SYSTEM

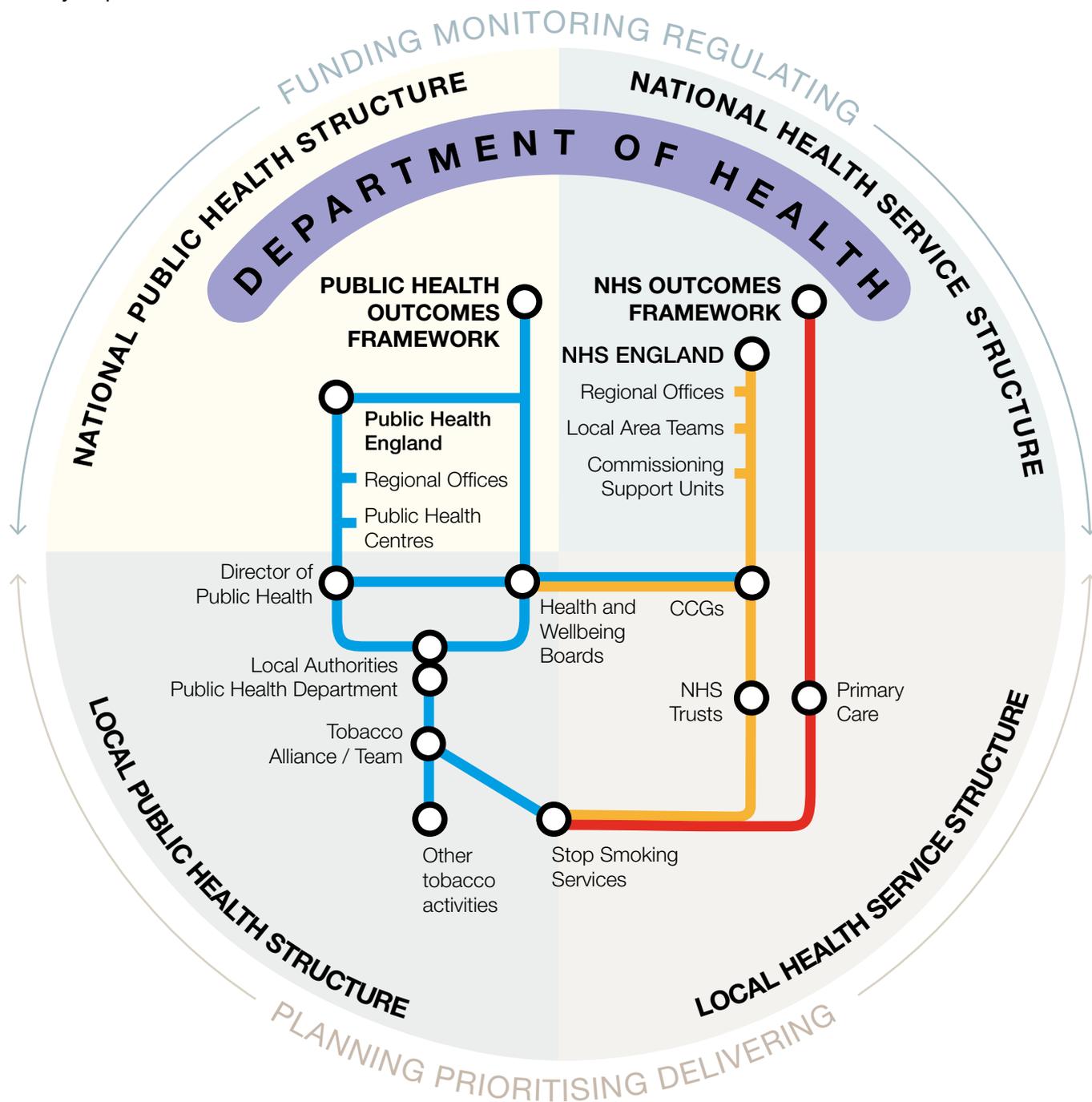
As part of the health reforms the Government has repositioned public health back into local government and revised the structures which sit around it. These changes have been made as the Government's response to 'significant challenges' in public health and the rising costs of preventable illness to the NHS. This is the model the Government has chosen to use to deliver their objectives of:

- Strengthening local action
- Supporting self esteem and behavioural changes
- Promoting healthy choices
- Changing the environment to support healthier lives<sup>1</sup>

The specific responsibilities of different parts of the new public health system are summarised in the table below:

<b>LOCAL AUTHORITIES</b>	<ul style="list-style-type: none"> <li>• A new duty to promote the health of their population</li> <li>• Lead the development of joint strategic needs assessments and joint health and wellbeing strategies through Health and Wellbeing Boards</li> <li>• Appoint Directors of Public Health jointly with Public Health England</li> <li>• Commission specific public health services with a ring-fenced public health grant</li> <li>• Provide a number of mandatory services: sexual health services, NHS health checks, National Child Measurement Programme, providing public health advice to NHS Commissioners and ensuring plans are in place to protect the health of the public</li> </ul>
<b>PUBLIC HEALTH ENGLAND</b>	<ul style="list-style-type: none"> <li>• Deliver services to protect the public's health through a nationwide integrated health protection service</li> <li>• Provide information and intelligence to support local public health services</li> <li>• Support the public in making healthier choices</li> <li>• Publish outcomes</li> <li>• Build the evidence base</li> <li>• Manage relationships with key partners, and supporting national and international policy and scientific development.</li> <li>• Jointly appoint local authority Directors of Public Health</li> <li>• Support excellence in public health practice</li> <li>• Provide a national voice for the public health profession</li> </ul>
<b>LOCAL NHS</b>	<ul style="list-style-type: none"> <li>• Provide health services and ensuring fair access to those services to contribute to improving health and reducing inequalities</li> <li>• Commission specific public health services including: brief interventions in secondary care, nutrition and other advice, alcohol workers, occupational health services</li> <li>• Maximise the impact of the NHS in improving the health of the public, making every clinical contact count</li> </ul>
<b>NHS ENGLAND</b>	<ul style="list-style-type: none"> <li>• Public health services for children from pregnancy to age 5</li> <li>• Immunisation programmes</li> <li>• National screening programmes</li> <li>• Public health care for people in prison and other places of detention</li> <li>• Sexual assault referral services</li> </ul>

The diagram below offers a picture of how the public health system is structured, though at a local level precise relationships may vary. The remainder of this chapter examines in more detail what different parts of the new system look like, what the implications are for tobacco control and what the early impact has been in different localities.



Tobacco control has experienced a number of changes as a consequence of reform which are explored in the following sections:

- Local authorities take on health improvement
- A new 'arms length' national framework for health and public health
- Local consortia take on the commissioning of health services
- Health and Wellbeing Boards bring local partners together
- Public health budgets are ring fenced – for now

## 2.1 LOCAL AUTHORITIES TAKE ON HEALTH IMPROVEMENT

On the 1<sup>st</sup> April 2013 152 top tier local authorities took over public health. This has been the really big change for tobacco control. The functions for planning, commissioning and delivering many tobacco control interventions now sit inside local government.

Alongside this, local government has a more general local health planning and scrutiny role (this is discussed in more detail on page 19). Some have suggested that the new arrangements may not benefit public health as their primary purpose has been to create stronger integration between health and social care and as such public health could be sidelined. However, there is widespread political consensus that public health is well placed in local government and this is unlikely to change in the short term regardless of whether the national government changes.

Local authorities have, of course, always had a health improving role. Modern public health began in the nineteenth century with the efforts of local authorities to improve living conditions and public sanitation in order to prevent outbreaks of communicable diseases. The local authority post of Medical Officer for Health was only abolished in 1974. There is clearly a rationale for returning this role to local authorities, given local government's hold over so many of the levers of the 'wider determinants of health' including environmental health, housing and planning, as well as their role in providing social care. In fact many Directors of Public Health are already joint appointments between PCTs and local authorities.

### WHAT HAS CHANGED FOR TOBACCO CONTROL?

	BEFORE TRANSITION	AFTER TRANSITION
WHERE THE FUNDING IS	<ul style="list-style-type: none"> <li>Tobacco control activity funded through the NHS with ad hoc local government investment</li> </ul>	<ul style="list-style-type: none"> <li>Tobacco control activity funded through Public Health England, local government with ad hoc NHS investment</li> </ul>
WHO THE COMMISSIONER IS	<ul style="list-style-type: none"> <li>Stop smoking services, secondary care services etc through NHS</li> <li>Some enforcement activity by local government</li> </ul>	<ul style="list-style-type: none"> <li>Budget ring-fenced for now</li> <li>Cessation and tobacco control through local government</li> <li>NHS England brief interventions in primary care</li> <li>CCGs brief interventions in secondary care</li> </ul>
WHERE BUY-IN IS NEEDED	<ul style="list-style-type: none"> <li>NHS hierarchy</li> <li>Director of Public Health</li> <li>Tobacco Control Alliance</li> <li>Ad hoc involvement of local government hierarchy</li> </ul>	<ul style="list-style-type: none"> <li>Director of Public Health</li> <li>Lead member</li> <li>Local Government hierarchy</li> <li>Tobacco Control Alliance</li> <li>Health and Wellbeing Board</li> </ul>
WHERE THE ACCOUNTABILITY IS	<ul style="list-style-type: none"> <li>Monitoring of quit and prevalence targets through NHS</li> <li>Other local performance measures with NHS</li> </ul>	<ul style="list-style-type: none"> <li>Local Joint Health and Wellbeing Strategy</li> <li>Other local performance measures within local government</li> <li>National Public Health Outcomes Framework</li> </ul>

Many local authorities had well-developed plans for the transfer. The LGA reported that 95% of local authorities were expecting transfers to go well ahead of April 2013. Some tobacco control teams have seen little immediate change as a result of the transfer, with many reporting that they have adequate budgets and seem able to continue delivering as they have been. However, others have faced challenges. These include:

- **Politics:** one of the concerns raised by public health professionals moving into local authorities is the political component of their new organisations. Past structures have, to some extent, sheltered public health from political accountability and the change is something many are unfamiliar with. Taking account of political dimensions and priorities will be an important part of the cultural shift for those of us in tobacco control for which this is new. It will also be important to ensure briefings are effective and communicate tobacco control issues in a way that is meaningful to councillors whilst ensuring that strategies are evidence based and balanced. Many local councillors are also unfamiliar with the issues surrounding tobacco control. This can slow the progress of activity as more work is needed to explain issues to non-experts. However, addressing these gaps in knowledge is also an opportunity to build consensus and support for tobacco control.
- **Commissioning:** many stop smoking services have stayed in the NHS or as part of Community Interest Companies and the budget and commissioning responsibilities have gone to local authorities. Local tobacco control leads are now finding they are increasingly responsible for commissioning and contract management which is new area of responsibility for some. This takes up time and resources and may reduce the opportunity to engage with the wider tobacco control agenda.
- **Stop smoking services:** There are also some fears that stop smoking services will be a lower priority for local authorities than they have been for the NHS despite the strong evidence of their cost effectiveness. Some areas have reported significant scrutiny of budgets and demands for efficiency savings. Stop smoking services are often the most visible part of local tobacco control and the part of the service with a more clearly defined budget. In times of financial constraint they may prove to be a target for cuts.
- **Leadership:** while the NHS had a strong top down model the leadership in public health is now more diffuse with direction coming from DsPH, lead members, Health and Wellbeing Boards to mention a few. In addition to this there are some gaps in the provision of guidance and support locally with the loss of regional support in many places and a time lag while local and regional Public Health England resources are established. DsPH occupy different positions in local leadership structures. Some are in a strong role at the heart of the executive while others are reporting to Director of Adult Social Care or other members of the Executive. This variability in where DsPH does raise concerns about whether all local authorities have the appropriate level of leadership on public health.
- **Evidence:** Local authorities are used to focusing on quite localized data and information, with a particular focus on public opinion and perception. Public health teams may be used to more medical and scientific approaches to evidence which relies on population level data and peer reviewed evidence. The type of information which local authorities want may not always be readily available or reliable on a very local basis and public health professionals will need to become skilled at communicating the implications of regional or national data for a locality and in generating some of the more localised data which local councillors are interested in.
- **Impact of restructure:** Some areas have transferred over to local government with very few changes to staffing and structure while others have undergone significant change. Those areas which have new structures and reduced or changed staff appear to have found the process of transition harder and are continuing to 'find their feet' in the face of so much change. It is to be hoped that this challenge will dissipate over time, however, in the short term it may have an impact of the effectiveness of different teams.

- **Broader public health agendas:** For some time public health has been taking a broader perspective embracing ideas around social determinants of health among other things. For some the transfer of local government has accelerated the pace of change. There has also been a trend towards grouping tobacco more closely with other 'life style' issues. As such tobacco control as an issues faces more competition for resources locally and there is a greater need to emphasis the significant role it plays in issues such as inequalities.
- **Greater localism:** Local government has less experience than some parts of the NHS of collaborating across regions. The NHS had a framework in Strategic Health Authorities to enable collaboration in a way that local authorities do not. Local authorities also have fewer incentives to work together particularly where neighbouring authorities are controlled by different political parties. Despite the challenges around regional collaboration local authorities in the North West, North East and South West have effectively partnered to fund an ongoing regional program through the offices of tobacco control.

### **A VIEW FROM A TOBACCO CONTROL LEAD**

*"My experience has been really positive. Our tobacco control work feeds in to the Health and Wellbeing Board and the lead councillor for health and wellbeing is very supportive of the tobacco agenda. This is a contrast to the PCT days when it felt like tobacco was not connected to the larger structure. As smoking is a priority in the Health and Wellbeing Strategy I have more leverage within the council to make things work amongst its large and varied departments. It feels like we fit in better here in terms of the wider public health agenda.*

*"It has been much easier to work with council departments that we haven't engaged with before such as children's services. We are now going to make all children's events completely smoke free – I doubt I would have even known about the events if I had not been here in the council.*

*"The issue of campaigning or lobbying for issues such as standard packaging may be more difficult, as the council can't lobby on political issues if the councillors don't agree with the issue. However if we do get agreement then we could actually be more engaged in the political process. Closer connection to the political process may enable us to influence issues on a larger scale. At this stage I'm not sure which way the council will go on this. My only concern is that some tobacco control work is not necessarily a vote winner, but may be effective.*

*"Working for the council gives tobacco control access to a really large workforce that often falls within our target audience. The council is also in touch with many residents who are our target audience. This is a great opportunity to connect with people and support them to make a positive behaviour change."*

*"We have embraced the change and the opportunities that working in the council has opened up. Being in the council enables us to work on tobacco control and the wider issues related to health rather than focusing only on the stop smoking service which often happened whilst in the NHS."*

## **A VIEW FROM INSIDE A DEPARTMENT OF PUBLIC HEALTH**

*“The Department of Public Health has been co-located for some time and subject to the corporate reporting and scrutiny of the council. My early experience is that frameworks are robust but metrics do not reflect an understanding of the data. For example a smoking quit target time lag and the target not being equal across quarters.*

*“Reporting structures are still being established but there is engagement and reporting at senior level through the Health & Wellbeing Board. We are still learning about the day to day policies and procedures for getting routine things done, which has taken up a lot of time.*

*“The NHS structure had a dedicated focus and experience of public health. Although the transfer of public health had a high profile across all service areas, and I doubt if anyone doesn’t know that there is a Department of Public Health, there is less understanding about what public health is. We need to do more to explain what we do and how we do it and form new partnerships across Departments to implement work programmes, rather than being on the periphery.*

*“There are huge opportunities to influence and support work on the wider determinants of health in a way that we couldn’t in the NHS. There is ambition for us to work together in a more integrated way and we are seeing this take shape in children’s services in particular in our work on obesity and on alcohol. With limited and reducing funds (we are subject to efficiency savings) we are already working creatively in our partnerships to implement our ambitions.*

*“My advice to others is to use the relationships developed prior to transfer as the way into developing the wider relationships with teams that will be needed. Tailor reports to the intended audience by losing public health jargon and academic ways of writing as it alienates colleagues and is much easier to understand in plain English.”*

### **A VIEW FROM A TOBACCO ALLIANCE**

*“We have been particularly fortunate in our area in that the transition has been embraced, both by those of us moving into the local authority and those receiving us. There has been a drive to apply good practice systematically throughout the council using the lifecourse approach advocated by Marmot (2010).*

*“The tobacco control agenda is overseen by the Alliance. This partnership group is chaired by the Chief Executive of the local authority with the Director of Public Health as Vice-Chair. Transition presented an opportunity to refresh the Tobacco Control Strategy and review membership.*

*“Previously the Alliance reported to a health improvement group which fed through to the Strategic Partnership. Now the Alliance reports directly to the Health and Wellbeing Board which monitors its performance. Public Health is not placed within either the ‘People’ or ‘Places’ directorates, but sits in Corporate Services with an over-arching role spanning the council. The Director of Public Health reports directly to the Chief Executive and is part of the Corporate Leadership Team.*

*“There were a variety of learning events for elected members and for public health staff in preparation for the transition and these have been valued. There are countless new opportunities and our relationships with familiar departments such as trading standards have grown closer with excellent results. In addition, new opportunities for marketing via leisure and library services have already been warmly received. We are still seeking improved member engagement but this has been delayed due to elections. Easier access to new data sources such as business contacts are proving valuable and we are benefitting from a highly sophisticated communications team with its technological back-up.*

*“We are still learning how to make our arguments with a different focus. The evidence-based approach is less valued but member’s passions and priorities, such as health inequalities and the health and wellbeing of children and families with complex needs, are real drivers. Our language is also having to change and the skills of presenting complex arguments in simple format are being honed.”*

### **ANOTHER VIEW FROM A TOBACCO ALLIANCE**

*“With the advent of Public Health “coming home” to local government, we have huge potential to join things up even more on a local level. Reducing the harm from tobacco is one of the priorities in our Health and Wellbeing Strategy and the tobacco control alliance’s core strategy group, chaired by the Deputy Director of Public Health, will report to the Health and Wellbeing Board.*

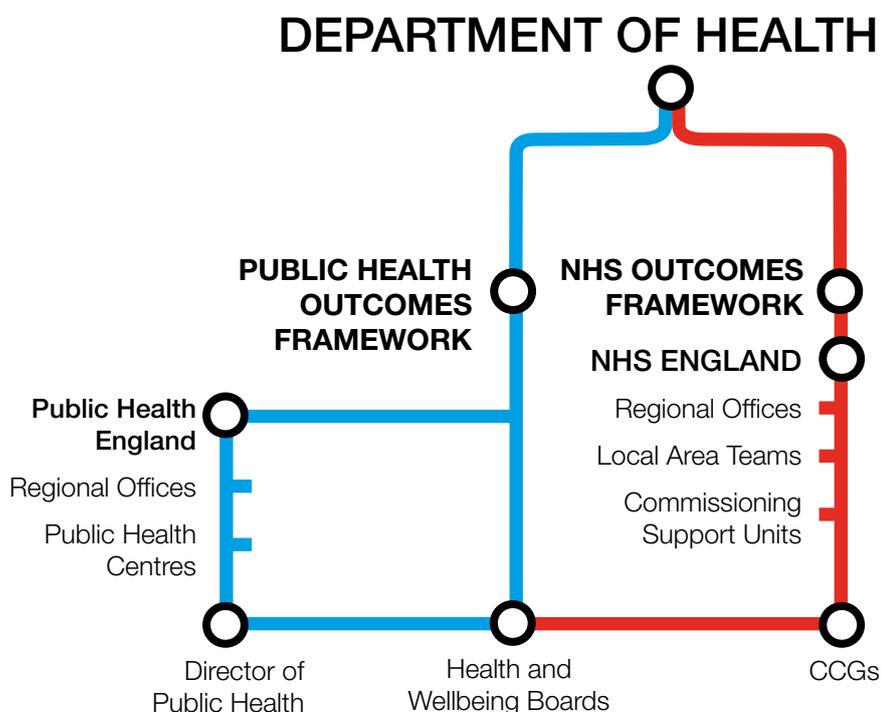
*“We already have the foundations of a strong alliance in place and a good track record for partnership working. We worked hard to recruit tobacco control champions in our ten district councils and getting elected member support has been a key element of our success so far.*

*“Our future success will be dependent on ensuring we balance district and county council commitment with the opportunity the transition brings us to review our alliance membership and bring on board new partners.”*

## 2.2 A NEW 'ARMS LENGTH' NATIONAL FRAMEWORK FOR HEALTH AND PUBLIC HEALTH

Public Health England (PHE) is the new national organisation for public health. It works with others to promote good evidence and has primary responsibility for health protection and emergency preparedness. It is also responsible for national health improvement services such as behaviour change campaigns. Public Health England has become an executive agency of the Department of Health made up of the following former agencies:

- Health Protection Agency
- National Treatment Agency
- Public health observatories and cancer registries
- Regional public health groups
- National screening committee



Public Health England recently published their priorities for 2013/14 which includes harm from smoking:

*“Accelerate efforts to promote tobacco control and reduce the prevalence of smoking. We will identify, support and champion national and local efforts to accelerate smoking cessation, promoting the use and implementation of evidence based-interventions, and addressing variations in smoking.”<sup>2</sup>*

Tackling smoking falls under the Health and Wellbeing Directorate for PHE. As a ‘major driver of mortality and morbidity’ it is one of five priority areas:



# Health Impact Priorities

## Health and Wellbeing Directorate

### Health and Wellbeing Directorate Health Impact Priorities

While supporting and ensuring progress against the PHOF, the Directorate will provide enhanced focus on the **major drivers of mortality and morbidity** in England where further gains may be made by scaling known, effective strategies

#### Well being and Mental Health

Mental disorder accounts for largest burden (23%) of diseases in England and affects >1 in 4 of the population at any time  
Mental wellbeing assoc with improved outcomes in health, education, employment, reduced crime and antisocial behaviour  
Public mental health: Better assessment; interventions; prioritization

#### Diet, Obesity, and Physical Exercise

All major causes of CVD and cancer. Poor diet accounts for one third of deaths from cancer and CVD. Low levels of physical activity increases the risk CVD, colorectal and breast cancer by 20-35%. Obesity increases risk of type II diabetes (5-13 times), hypertension (2-3 times) and colorectal cancer (3 times) in men.

#### Tobacco Control and Smoking Cessation

Accounts for 20% of new cases of cancer (23%M and 16%F)  
Tobacco causes nearly 1 in 5 deaths in England annually  
For each death, 20 more suffer tobacco-related illnesses  
Comprehensive cessation programs; excise tax increases; 100% smoke-free policies; media campaigns; cessation access; advertising restrictions work.

#### Alcohol Moderation and Drug Recovery

Much of the cost of drug and alcohol misuse occurs to the criminal justice system. The main costs to society from drug and alcohol is from related crime. This is different to other lifestyle health related areas and needs a different public health response.

#### HIV and Sexual health

By the end of 2012 likely more than 100,000 PLWHA in the UK  
Late diagnosis a major problem with 50% diagnosed with CD4<350  
Millions of STD diagnosed annually, esp. among youth, MSM, minorities  
HIV/STD screening, early treatment, partner notification, social marketing campaigns, condom access, and policy to address stigma and discrimination are key interventions

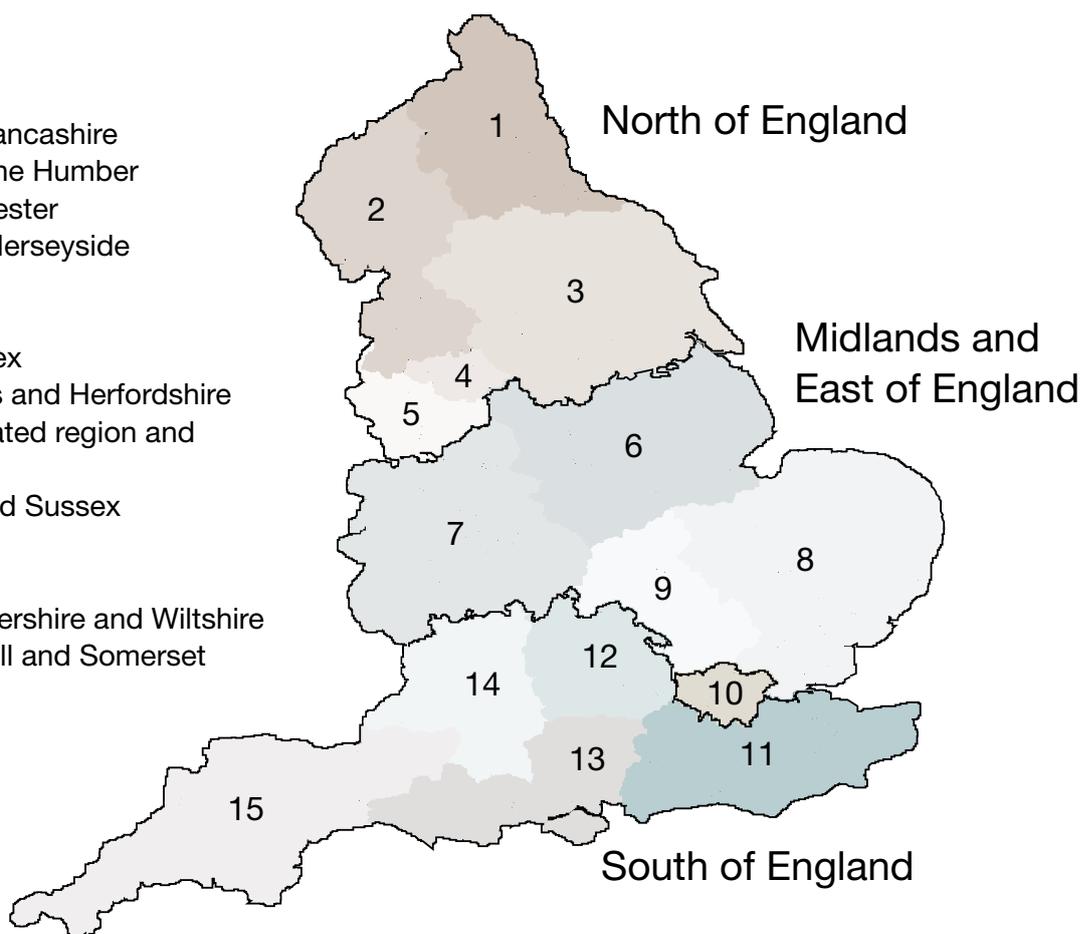
This priority is supported by a set of activities within the Directorate's business plan:

- Increase healthy life expectancy by reducing smoking prevalence and its consequences (includes social marketing campaigns).
- Support and facilitate delivery of policy and governmental aspects of the Tobacco Strategy.
- Sustain and support infrastructure for tobacco control and smoking cessation, collaborating with key players in tobacco control and smoking cessation.
- Increase system-wide emphasis on tobacco control and smoking cessation in specific vulnerable and high impact groups.
- Support development of information and intelligence for tobacco control and smoking cessation, including appropriate guidance and advice on practice.

It is anticipated that this national agenda will inform PHEs regional and centre level activity. Public Health England's role also includes jointly appointing Directors of Public Health with local authorities. This gives them some direct local influence and provides DsPH with a measure of independence from local government. PHE will also be operational across regions and sub-regions. There are four large regions and 15 local centres which will provide advice and intelligence to local areas and will develop specific expertise in PHE's priority areas including tobacco control:

**CENTRE**

1. North East
2. Cumbria and Lancashire
3. Yorkshire and the Humber
4. Greater Manchester
5. Cheshire and Merseyside
6. East Midlands
7. West Midlands
8. Anglia and Essex
9. South Midlands and Herfordshire
10. London intergrated region and centre
11. Kent, Surrey and Sussex
12. Thames Valley
13. Wessex
14. Avon, Gloucestershire and Wiltshire
15. Devon, Cornwall and Somerset

**OTHER NATIONAL SUPPORT AND ACCOUNTABILITY MECHANISMS**

Alongside the national role taken by PHE there are a number of other national influences on local practices. These include:

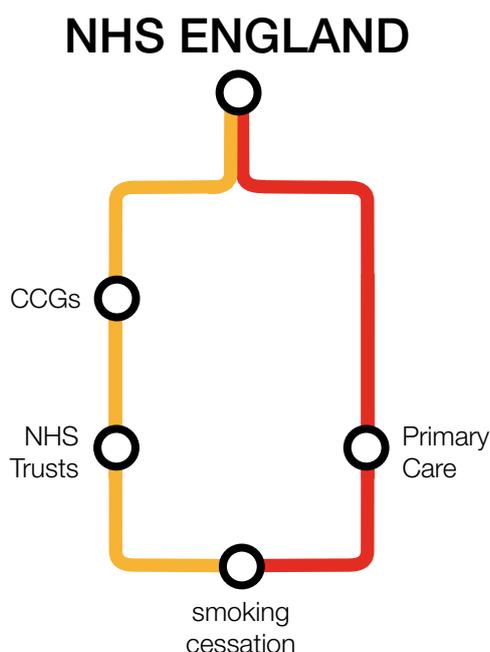
- **Public Health Outcomes Framework:** This is the yard stick against which public health performance will be judged. Its overarching vision is: *“To improve and protect the nation’s health and wellbeing, and improve the health of the poorest fastest”*. It has two high level outcomes the second of which is: *“Reduced differences in life expectancy and healthy life expectancy between communities”*. Within the overarching vision there is a clear role for tobacco control. Specific indicators which relate to smoking are found in the domain on Health Improvement. Being able to clearly articulate the extent to which tobacco control can contribute significantly to achieving these outcomes will be an important local lever for activity. Local Authorities are urged to include Public Health Outcome measures in their Joint Strategic Needs Assessment and accountability for how the ring fenced public health budget is spent will be through the outcome measures in the outcomes framework. More detail on specific tobacco targets within the Public Health Outcomes Framework is on page 26.

- **NICE guidance:** NICE has become an executive non-department public body. In addition to its past role of providing guidance to the NHS and the public health, it has also become responsible for developing quality standards and guidance for social care in England. As part of the transition to local government NICE has also been revising and extending some of its public health guidance including tobacco control guidance.
- **LGA guidance:** The LGA is working to provide guidance to local government in its new public health role through sharing good practice and case studies. The LGA has already produced a brief guide to tobacco control.<sup>3</sup>
- **NHS Constitution:** a supplement to the NHS Constitution has been created on public health which sets out core principles which all those involved in public health should follow.<sup>4</sup>
- **Commissioning Support Units:** these have been set up by the NHS to offer commissioning support to Clinical Commissioning Groups. CCGs are not obliged to use the support provided by NHS CSUs and could instead make use of private or voluntary sector commissioning advice.
- **Local Area Teams:** There are 27 local teams who are responsible for commissioning local GP services and supporting the development of CCGs. They have oversight of the local NHS system.

### 2.3 LOCAL CONSORTIA TAKE ON THE COMMISSIONING OF HEALTH SERVICES

Primary care trusts were replaced on 1<sup>st</sup> April 2013 by Clinical Commissioning Groups. These are local consortia led GPs. Every GP practice in the UK has been allocated to a CCG so in theory they are all now involved in the commissioning of care. In addition all CCG governing bodies will include at least one hospital doctor, nurse and member of the public.

CCGs are accountable to NHS England and NHS England can intervene where they feel a CCG is underperforming or not delivering against local priorities.



As noted above NHS England has a role in public health commissioning particularly in primary care. CCGs are also part of the Health and Wellbeing Boards (discussed in the next section) and are required to have regard to the Joint Health and Wellbeing Strategy and to submit their own strategies for scrutiny by Health and Wellbeing Boards.

A number of healthcare functions, particularly those in community settings, have been spun off from the NHS into Community Interest Companies. These non-profit entities will bid for NHS work alongside other competitors from all sectors.

Commissioning has become a more complex environment with ‘any qualified provider’ able to bid for work. In addition public health commissioning is effectively split across at least four organisations in any given area: local authorities, CCGs, PHE and NHS England.

There is a risk that these changes could lead to a loss of smoking prevention activity within NHS services. GPs do not have to be persuaded of the risks of smoking but they may not be convinced that they should be spending core NHS money on prevention advice when the local authority has the lead on running stop smoking services and local campaigns. Keeping CCGs up to date on the role they can play in tobacco control will be important.

### **A VIEW FROM A STOP SMOKING SERVICE**

*“The stop smoking service is part of the NHS Trust, which is one of the two largest healthcare providers in the county, formerly a mental health trust, but now encompassing community health services, services for children, families & young people, and health improvement. We are part of a block contract for a number of health improvement services, and are accountable to the two Public Health Directorates, formerly PCT managed, now Local Authority. We enjoy a high profile in the organisation, having demonstrated our value to patients, staff and the community, offering added-value training such as Making Every Contact Count (MECC), and contributing to the Tobacco Control agenda via local networks.*

*“Essentially it is business as usual. We have successfully navigated the ‘settling down’ period, partly due to our secure reputation as a capable and effective service, but also because we have ensured that our achievement of performance targets is not compromised by the disruption that may have affected service delivery. This has provided assurance to commissioners and our own senior managers that there is no risk to momentum.*

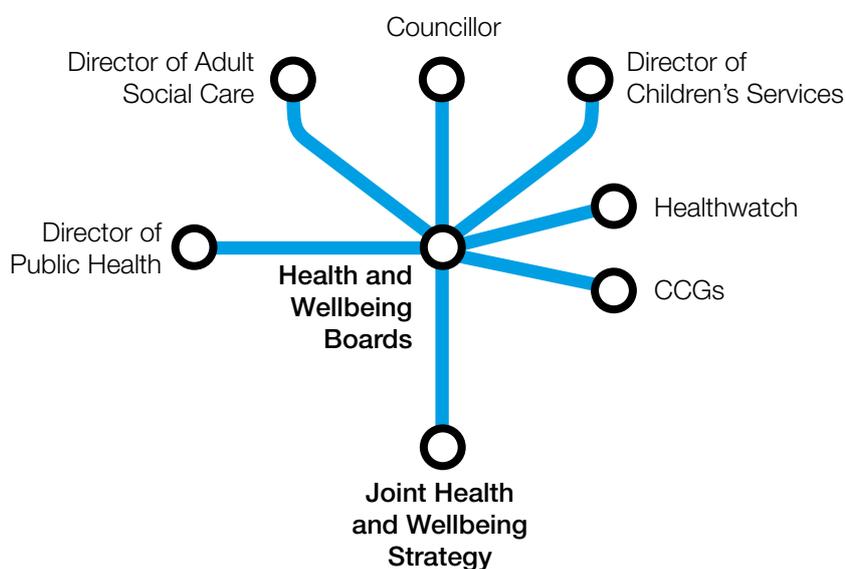
*“The stability we have achieved has contributed to a high level of staff motivation, and a wealth of new ideas for demonstrating that we are good value for money. We are looking forward to a second year of leading on MECC, we are increasing brand awareness in both NHS and non-NHS organisations, and are expecting to increase our collaborative work with the CCGs.*

*“Although there is a need to explore new routes to better health under the new system, there is also an enthusiasm to see must-dos taken care of without disruption. Reducing smoking rates could be said to come under this banner, and we have been able to maintain a strong position in our local health economy by doing what we are commissioned to do, and more.”*

## 2.4 HEALTH AND WELLBEING BOARDS BRING LOCAL PARTNERS TOGETHER

Health and Wellbeing Boards are intended to provide the strategic glue to bind all the old and new stakeholders in health together. All top tier local authorities now have a Health and Wellbeing Boards in place and while membership and structures vary a core membership is set out in law:

- A councillor
- A representative from the Clinical Commissioning Groups
- Director of Public Health
- Director of Adult Services
- Director of Children's services
- A representative from the local Healthwatch



Health and Wellbeing Boards are the local strategic lead on health and have ultimate responsibility for the health of their population alongside CCGs. Health and Wellbeing Boards also have a specific duty to provide public health advice to CCGs. The Health and Wellbeing Boards are responsible for two key statutory documents: the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. In principle, these documents will underpin the strategic decisions made by all institutions represented on the board including the specific commissioning plans for the NHS, social care, public health, and other services that the health and wellbeing board agrees to consider. It is therefore vital that the harm from smoking and the scope of tobacco policy are fully acknowledged in these documents.

The Communities and Local Government Committee in Parliament recently looked at arrangements for local governments involved in health and expressed concern about the lack of accountability around Health and Wellbeing Boards. They were concerned that there was no clear mechanism for intervening where a Health and Wellbeing Board was deemed to be underperforming. The Department for Communities and Local Government have indicated that they expect the Scrutiny function in local authorities to carry out this role<sup>5</sup>.

## **A VIEW FROM A HEALTH AND WELLBEING BOARD CHAIR**

*“The transfer of Public Health responsibilities into local authorities was, perhaps, one of the few aspects of the controversial reforms of the NHS which received a general welcome. There was a widely shared sense that ‘public health is coming home’. In truth the warmth of the welcome from local authority colleagues seems to have been a widely enjoyed experience until the impact of local authority austerity became all too obvious in social care budgets especially.*

*“Now three issues seem to be emerging. Firstly the ‘Health and Wellbeing’ rubric is becoming a ‘Health and Social Care’ agenda shifting attention and resources toward issues of safeguarding and child protection, Dilnot and long term care strategies. In there somewhere we may find an articulated suspicion of ‘the medical model’. This in turn detracts from the obvious agendas for public health of tobacco, income and (sometimes to local government’s surprise) education.*

*“Secondly the terms and conditions of the Public Health workforce, largely adopted by local authorities as they transferred staff, now raise eyebrows when local authority colleagues examine their own pay slips.*

*“Finally the Health and Wellbeing Boards and their associated Strategy are only now taking on statutory form have already been subjected to direction from ‘the centre’ although such direction is now taking the form of a ‘troika’ involving the Department of Health, the Local Government Association and Public Health England. How local authorities will take to such centralism remains unclear.*

*“But for tobacco control having public health now in the same organisational framework alongside trading standards, environmental health, education, development control and more (tricky though the two tier District County divide can be) has to be an enormous step forward. It can’t be plain sailing - the issues raised above and others will create their own frustrations but to have all those local politicians now tied into a life saving agenda has got to be an improvement on the past.”*

## A VIEW FROM A DIRECTOR OF PUBLIC HEALTH

*“The 1st April 2013 was a momentous day as, rather like the prodigal son, public health came home to local authorities bringing with it leadership and responsibility for the health and wellbeing of their residents. But it was much more than that – the prodigal son brought home a prized possession – the Health & Wellbeing Board which brings democratic accountability to the NHS for the first time in its history. So, the key here is not the transfer of technical public health functions or the transfer of a few public health contracts or even the transfer of a small ring fenced budget but the transfer of public health leadership and the accompanying democratic leadership for health and social care across the local authority area.*

*“Too much attention is being paid to the number of individual flowers in the garden or the condition of the trees in the orchard – we need to look up and take in the magnificence of the overall landscape that we have been given to work in – we are free from the top down constraints or the high walled garden of the NHS and we now live in new world and in an organisation that is focussed on shaping and creating place and much less on delivery of services.*

*“We have an opportunity to move away from the constraints of having to focus almost entirely on the helpful but far too narrow concept of 4 week quitters which, a bit like the 4 hour A&E target, is good as part of a wider strategy but of limited value on its own. Don’t get me wrong, the targets helped to suck funds into tobacco control. However, by and large, we then had to use smoke and mirrors, sleight of hand or even subterfuge to shift small amounts of funding away from those delivering widgets (smoking quitters) to the wider agenda of tobacco harm reduction.*

*“All that has changed – we are now centre stage and have the opportunity to lead and drive things forward. We can now develop a true tobacco harm reduction strategy that covers **preventing** people starting smoking, **supporting people to give up** in any way they can without being fixated on 4 week verified smokers, **using enforcement** to tackle under age sales, counterfeit and contraband tobacco, smoking in public places as well as **advocating and lobbying** for further change. In my area we have strong political support and leadership from local politicians and local MPs. This means we can work through the CCG to influence NHS partners and we can use the Health and Wellbeing Board to drive forward change across the whole health and social care system. Our local tobacco control alliance goes from strength to strength and local politicians are now starting to drive the agenda forward at a scale and a pace that didn’t happen in the NHS when the same politicians were simply “partners”. Now they have ownership and that is already making a difference.*

*“The world changed on 1<sup>st</sup> April 2013 and it changed for the better – the tools in our box have changed and relationships have changed – we can lead the tobacco control agenda in a way we have never been able to do before. Let’s use social media, social marketing and community engagement to shape our approach and let’s focus our attention on shaping and changing place and focus less on the nuts and bolts of service contracts and the 4 week quitter target. It’s a wonderful new world.”*

## 2.5 PUBLIC HEALTH MONEY IS RING-FENCED

### THE PUBLIC HEALTH BUDGET

Prior to the changes to the health system Department of Health money for tobacco control was spent either directly on national programmes or locally through PCT budgets including public health-led stop smoking services and campaigns.

In the new world, the Department of Health has divided its budget in three: a public health budget has been allocated to Public Health England, a further budget has been allocated to local government and an NHS budget has been allocated to NHS England (and then on to CCGs). However, in practice even defining the amount of money which was being spent on public health proved complex. The public health ring fenced budget which was finally agreed has been welcomed by some as more than expected – though it remains dwarfed by the wider NHS budget.

The current allocation is only for two years after which it is not clear what level budgets will be. The Government has also only committed to ring-fencing the budget until 2015. There are a small number of services which local authorities are legally obliged to provide as part of their role in public health and tobacco control does not feature on this list. Given that many non-statutory services in local government have suffered greater cuts than those local authorities are obliged to provide this may raise some concerns for the future.

Regardless of the current ring-fence, if tobacco control activity is to be secure in the future many areas will need to continue to make a strong case for the value of investment. There is, and will continue to be, great competition for budgets at a local level.

### OTHER FINANCIAL ISSUES

When the current budget arrangements were announced the Government also announced plans for local authorities to be able to attract a 'health premium', a special payment on top of their ring-fenced grant, if they achieve improvements in health and wellbeing outcomes and reductions in inequalities. This financial incentive is likely to be attractive to hard-pressed local authorities. As smoking is a primary driver of adverse health and wellbeing outcomes and is linked to steep inequalities, smoking could be an obvious focus for gaining this premium. The details of how the premium will work are yet to be published.

Currently the Labour Party is consulting on integrating health and social care funding in the future. If this were to happen it would create both further opportunities and risks for public health spending.

## ESTABLISHING LOCAL SUPPORT FOR TOBACCO CONTROL

Making the case for tobacco control will not be new to most of us. However, we know that many people in local government are not as knowledgeable about the impact of smoking as some in the NHS were and that the context in which policies are set and budgets are allocated has changed significantly.

As such it is appropriate for us to review our strategies, ensure that we are seeking to develop support in the right areas and are making the most of all our new resources.

It may be worth reflecting on your own answers to the questions below as part of developing your own approach to establishing and growing support for tobacco control in your local area.

### WHO ARE WE?

In general we are local government staff with an interest in reducing the impact tobacco has on local communities. We tend to be in middle management positions with varying relationships with senior officers, councillors other local government colleagues and external partners. We are able to carry out agreed operational work without seeking senior level or political buy-in but we often need to work with others to:

- Set strategy
- Change policy
- Agree budgets
- Speak publically about issues which may be seen as political

However, while as individuals we may be constrained we are often members of groups or linked to other organisations which have greater freedoms. These include: tobacco control alliances, youth groups, external delivery organisations and NHS partners.

### WHAT DO WE WANT?

We want smoking rates in our local areas to go down, children and vulnerable adults to be protected from the harm of second hand smoke and fewer young people to be taking up smoking. To do this within our local area we need:

- Tobacco control to be a priority area for action for local government and the local NHS.
- Good levels of knowledge and awareness about the impact of smoking on local communities.
- Investment in high quality stop smoking services which reach targeted populations.
- Appropriate levels of action taken to reduce the harm from smoking.
- Effective local enforcement of national tobacco control measures such as age of sale legislation, marketing restrictions and smokefree legislation.
- Appropriate levels of resources in place to deliver on necessary activity.
- Effective partnership working to ensure that impact is maximised.
- Engagement with the national and regional agenda to ensure policy and activity at this level has a local impact.

## HOW WILL WE CHANGE IT?

There are a number of ingredients which can support the delivery of a comprehensive approach to tobacco control locally. These include:

- **Strong political engagement:** Support from local councillors may always have been important for the local agenda, but it is clearly crucial now. Political engagement and awareness is useful in allowing areas to be innovative and proactive but also in ensuring there is enough local visibility to move day to day work forward.
- **Good understanding of tobacco control at a senior level across local government and the NHS:** Public health is new to many councillors and officers and they may lack detailed knowledge of the issues. A good local understanding about how reducing smoking prevalence can contribute to tackling poverty and inequalities is essential to ensuring tobacco control receives the priority it deserves.
- **Vocal public support for tobacco control and engagement in the issues:** Strong public support and community engagement in the issues can be useful in securing political engagement. However, it is also an important end in its self. Strong community engagement can enable communities to take ownership over addressing the harm in their community and supporting approaches such as reaching disadvantaged groups and tackling illicit tobacco.
- **Fitting tobacco control activity within existing local government and NHS priorities:** Having a good understanding of local priorities and drivers for action can support the positioning of tobacco control locally. Useful documents to be familiar with include: Joint Health and Wellbeing Strategy, Sustainable Community Strategy, CCG Commissioning Strategy other local strategies which set the agenda for your local area.
- **Utilising partnerships to implement effective tobacco control measures:** There are many parts of local authorities which can be engaged on tobacco control agenda from varying perspectives. Some key departments to consider working with include: adult social care, children and young people, parks and leisure, planning and housing.
- **Engaging with national and regional activity where possible and appropriate:** NICE recognises that some tobacco control activity has the best return on investment and impact where it is undertaken nationally and regionally. Some interventions can only be done at a national level such as taxation and comprehensive smokefree legislation. Keeping local areas as fully engaged as possible with these agendas can have important local benefits.

## WHAT RESOURCES AND MEANS DO WE HAVE?

- **CleaR:** This is a purpose-designed improvement tool that enables a comprehensive review of local action to tackle tobacco against the latest evidence-based practice. It was developed by ASH, in conjunction with partners. Local areas can use CLeaR in a number of ways – they can complete the self-assessment independently, they can undertake the CLeaR training and complete the self-assessment, they can add value to their self-assessment by undergoing a peer assessment which will give them an expert and independent view of their activity: <http://bit.ly/Jq0ZED>
- **Tobacco control alliances:** Where alliances have been established and have the membership of all key partners including local politicians they can be an extremely effective way of driving change. Revisiting the membership and activity of your alliance in light of the transfer of public health can

be a useful way of stimulating change. There are a number of regional tools for developing tobacco control alliances including:

- Tobacco Alliance toolkit from London: <http://bit.ly/11z22E9>
  - Tobacco Alliance toolkit from Yorkshire and the Humber: <http://bit.ly/15xl2Hk>
  - Local alliance delivery planning guide from the North East: <http://bit.ly/1aVDuLo>
- **Strong evidence about Return On Investment (ROI):** In tobacco control we are lucky to have a great deal of evidence to support the cost effectiveness of interventions:
    - The NICE ROI tool can usefully demonstrate ROI in some areas. It can be used to make a powerful case for investment, particularly in stop smoking services. An enhanced version is expected some time later this year: <http://bit.ly/TgNMIL>
    - The national case for cost-effectiveness is set out in the Inquiry into the effectiveness and cost-effectiveness of tobacco control published by the All Party Parliamentary Group on Smoking and Health: <http://bit.ly/1aVENK5>
  - **Evidence of the local impact and harm:** This can be extremely useful in prompting local organisations and politicians to dedicate resources and take action:
    - ASH local toolkit provides data on impact and harm of smoking: <http://bit.ly/19BUEQk>
    - Public Health England has a new website which allows you to see local data on premature mortality at local authority level. One of the most useful aspects of the website is the ability to compare premature mortality data with other areas with similar levels of deprivation. Differences in mortality can often be linked to different smoking rates: <http://bit.ly/12AGILP>
    - The Marmot Report on inequalities made clear that “Tobacco control is central to any strategy to tackle health inequalities”: <http://bit.ly/d1fd0H> ASH has published a guide to the content of the review which is of relevance to tobacco issues: <http://bit.ly/11QVs2a>
    - The London Health Observatory has produced local authority profiles of the Marmot indicators of inequality: <http://bit.ly/huKqhK>
    - The tobacco profiles produced by the Association of Public Health Observatories (APHO): <http://bit.ly/x94SjB>
    - The data on hospital admissions can be used as an indicator of potential social care need. Local authority data on demand for adult social care is available from the National Adult Social Care Intelligence Service: <http://bit.ly/102E6x>
    - The ASH factsheets provide useful summaries of national epidemiological data: <http://bit.ly/IUXsul>
  - **Commissioning tools:** Alongside the evidence of Return on Investment and the impact on local communities there is good guidance available on commissioning Stop Smoking Services. Supporting smokers to quit is a vital tool in driving down health inequalities. They are a key part of any local tobacco control approach. In delivering excellent local tobacco control it is important that services not only reach high prevalence groups but that they are also delivering high quality support.
    - The Government’s Stop Smoking Service delivery and monitoring guidance: <http://bit.ly/11qo8ZU>
    - The National Centre for Smoking Cessation and Training also have some extensive materials to support the development of local services <http://bit.ly/192q29u>

- **Political mechanisms:** There are opportunities to engage politicians and develop local understanding and action through the political process. This could include getting a new tobacco control strategy signed-off by councillors, securing a Health Scrutiny Committee inquiry or taking specific policy issues to council. Providing regular briefings to interested politicians can also be a useful approach.
- **Ring-fenced budget:** Having a ring-fenced budget for the next few years is useful. It gives the tobacco control community time and opportunity to make a strong case for continued funding in the future through a clear presentation of the return on investment which tobacco control offers local government.
- **National level targets and outcomes which tobacco control can deliver against:** There are a number of areas at a national level to which tobacco control can contribute. These include:
  - Public Health Outcomes Framework includes a number of specific measures which relate to tobacco control including: Smoking status at time of delivery, Smoking prevalence – 15 year olds , Smoking prevalence – adult (over 18s). However, the overarching outcomes are also highly relevant to tobacco control in particular “reduced differences in life expectancy and healthy life expectancy between communities Through greater improvements in more disadvantaged communities”. Local authorities should include appropriate outcome measures in their Joint Strategic Needs Assessment. These are also the measures that will be used to determine eligibility for any health premium payments in the future: <http://bit.ly/11agZ0T>
  - Tobacco Control Plan for England contains detailed targets for reducing smoking prevalence in key areas. In addition, it also sets out a comprehensive approach to tackling smoking which needs to be delivered both nationally and locally: <http://bit.ly/18ZEJtS>
  - NHS Outcomes Framework also has useful objectives relevant for tobacco control in particular Domain 1 “preventing people from dying prematurely” which contains objectives to reduce the number of people dying from a number of conditions which smoking is known to cause: <http://bit.ly/103wOdz>
- **Local priorities which fit well with tobacco control outcomes:** Most areas have local priorities which include protecting children from harm, improving local health and wellbeing, reducing local crime and the impact of crime and supporting local businesses to thrive. Tobacco control can make a contribution to all of these areas.
- **Strong public support for tobacco control measures:** We know that the public are already strong supporters of a range of tobacco control policies. This can be useful to demonstrate to local politicians but can also be a good foundation from which to build community engagement.
  - NICE guidance on community engagement: <http://bit.ly/12cqTFx>
  - The ASH local toolkit has public opinion polling by region: <http://bit.ly/19BUEQk>
- **Local voluntary sector support:** Many voluntary sector groups are interested in smoking related harm and are keen to take action to address it. There will be a wide variety of local groups in your area who you could engage with, some national organisations with strong local groups include:
  - Cancer Research UK Ambassadors: <http://bit.ly/1bo6Sdt>
  - British Lung Foundation Breathe Easy Groups: <http://bit.ly/15S2fdj>
  - British Thoracic Society Champions: <http://bit.ly/15ditLz>

- **Relationships with a wide range of professionals:** This is a tremendous asset which should not be underestimated. Thinking strategically about who can make the case or take action on different issues to achieve your overall objective can be useful.
- **Networks across the regions:** Not all areas have a dedicated regional function any more but most have existing networks to some extent as part of the legacy of regional offices. Where there is no dedicated regional resource local areas would benefit from finding informal ways of retaining these networks to enable the sharing of good practice and to explore ways of delivering activity which is best delivered at a regional level. The regional offices which remain are:
  - Fresh North East: <http://bit.ly/aM7bHS>
  - Tobacco Free Futures (North West): <http://bit.ly/HXN484>
  - Smokefree South West: <http://bit.ly/divmf6>
- **National opportunities for support and engagement:** There is a range of national organisations actively engaged on tobacco control work which can support local activity:
  - Smokefree Action Coalition: <http://bit.ly/McLFbl>
  - Action on Smoking and Health: <http://bit.ly/7AmTPE>
  - Cancer Research UK: <http://bit.ly/19X84GN>
  - British Heart Foundation: <http://bit.ly/gmp7Lo>
  - British Medical Association: <http://bit.ly/11qrzzS>
  - Royal College of Physicians: <http://bit.ly/16WjxYh>
  - The National Centre for Smoking Cessation and Training: <http://bit.ly/192q29u>
- **Access to high prevalence communities:** Relocating to local government alters the access which public health has to communities with high concentrations of smoking. These include: people in social housing, people with mental health problems and low income groups. Often local government is landlord, service provider or commissioner of support to these groups and can offer innovative routes to reaching them.

### **BEFORE YOU GET INTO THIS LEVEL OF DETAIL, IT IS WORTH REITERATING THE KEY MESSAGES OF TOBACCO ADVOCACY:**

- *Smoking is the leading preventable cause of death and ill health in our communities.*
- *Smoking delivers nicotine in a form as addictive as heroin or cocaine.*
- *Smoking may be a personal choice but this choice is shaped by family and community norms, and by the marketing strategies of tobacco companies.*
- *Secondhand smoke is harmful and no-one should be forced to breathe it.*
- *The decline in smoking in Britain is a measure of the effectiveness of the tobacco policy interventions.*
- *Tobacco policy is not about smokers vs. non-smokers. It is about the whole community – smokers and non-smokers – overcoming addiction, social norms, disinformation and the power of the tobacco industry.*

## WHAT'S ON THE AGENDA?

### 4.1 TOBACCO PLAN FOR ENGLAND

In March 2011, the government published Healthy Lives, Healthy People: A Tobacco Control Plan for England. This strategy has set the agenda for tobacco policy both nationally and locally. It promotes a comprehensive approach to tobacco policy, citing the words of the US Surgeon General:

*A comprehensive approach — one that optimizes synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies — has been established as the guiding principle for eliminating the health and economic burden of tobacco use.*

	NATIONAL ACTION ON:	LOCAL ACTION ON:
<b>STOPPING THE PROMOTION OF TOBACCO</b>	Retail displays Consultation on plain packaging Vending machines Advertising of accessories Visibility of smoking on TV, films and the internet	Enforcing advertising/display bans Protecting young people from exposure to smoking behaviour Changing social norms among young people Reducing visibility of smoking in local media
<b>MAKING TOBACCO LESS AFFORDABLE</b>	Tobacco taxes Illicit tobacco sales Restricting personal imports of tobacco	Controlling and de-normalising illicit tobacco sales Ensuring duty is paid on all tobacco products
<b>EFFECTIVE REGULATION OF TOBACCO PRODUCTS</b>	Support for enforcement Children's access to tobacco RIP cigarettes EU Tobacco Products Directive (product labelling) Nicotine-containing products	Enforcing tobacco sales legislation including minimum age and niche products Educating tobacco retailers
<b>HELPING TOBACCO USERS TO QUIT</b>	Stop smoking communication Support and intelligence for stop smoking services Support for the development of safer sources of nicotine	Providing stop smoking services that: <ul style="list-style-type: none"> <li>• are tailored to community needs</li> <li>• are targeted at high prevalence groups</li> <li>• offer diverse options</li> <li>• are value for money</li> </ul> Increasing access to, and uptake of, stop smoking services. Widening professional and community involvement in providing basic stop smoking advice and referrals Encouraging local organisations to be exemplars in supporting staff to quit
<b>REDUCING EXPOSURE TO SECONDHAND SMOKE</b>	Communication about risks of secondhand smoke to children Prisons Supporting action in other countries	Enforcing Smokefree legislation Promoting smokefree homes and cars Supporting wider adoption of smokefree areas in outdoor settings such as children's playgrounds
<b>EFFECTIVE COMMUNICATIONS</b>	National marketing and education Support for local communication campaigns and commissioning	Educating the public about the risks of smoking Motivating smokers to quit, including pregnant smokers De-normalising smoking within communities Encouraging young people to adopt healthy lifestyles Promoting smokefree homes and cars

The strategy employs the six internationally recognised strands for tackling smoking comprehensively. The following is a summary of the national and local issues identified by this strategy against these strands:

## 4.2 MAKING THE CASE FOR TOBACCO CONTROL

All the major parties support a comprehensive approach to tobacco control. The coalition Tobacco Control Plan for England contains much of the same commitments that the previous Labour strategy did. The fact that tobacco is a unique consumer product and the level of harm it causes our society is unlike any other has driven a consensus in the centre-ground of British politics with most agreeing on the actions which need to be taken. However, where there is not good understanding around the harm tobacco causes or what makes a difference to reduce smoking there can be less support for interventions.

When communicating with politicians from different parties it is important to emphasise the national consensus on interventions. Different parties often come at this issue from slightly different perspectives and it can be useful to approach communications in a way which reflect those perspectives.

**The harm principle:** This is a political philosophy important to all the major parties but particularly to Liberal Democrats and Conservatives and is an important test which many politicians will apply to new laws or interventions before supporting them. According to the harm principle Government may only act to limit the actions of individuals where those actions harm others. It is based on the ideas of John Stewart Mill who wrote that: *“The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others.”* Given the wide-ranging harm which tobacco causes all tobacco control measures can be seen as conforming to the harm principle.

**Protecting children:** Again all political parties support action to protect children. Many tobacco control interventions aim to alter the adult world as a means to protect children from harm. For example supporting smokers to quit through services, mass marketing and higher prices protects children from living in households with smoking parents which is a strong predictor of taking up smoking. Restrictions on marketing reduce the appeal of smoking to children and smokefree legislation promotes awareness of the harms of secondhand smoke reducing prevalence in the home as well as protecting people at work.

**Health inequalities:** Reducing health inequalities is a stated objective for all three parties. Labour in particular has been highly committed to interventions which will narrow the gap between richest and poorest. Reducing the level of smoking in high prevalence communities can make a massive difference to health inequalities as half the difference in life expectancy between richest and poorest in the UK is attributable to smoking. This makes the case for targeted interventions at a local level but also for national universal interventions such as controls on marketing and tax escalators which have the biggest impact on the poorest communities.

### CONSERVATIVE APPROACH TO TOBACCO CONTROL

- Part of the Coalition Government which introduced the comprehensive Tobacco Control Plan for England.
- The Coalition Government acted to implement point of sale display ban and have consulted on standardised packaging to protect children.
- The 1993 Conservative Government was first to raise taxes above inflation as a public health measure.
- Support harm reduction as an effective market based response to smoking which enables people to take an alternative and more responsible choice.

- In 2007 the Conservative party publicised the diversion of funds by Primary Care Trusts from smoking cessation clinics and urged that funding for smoking cessation services should be sustained.
- In general they have preferred activities to raise awareness about the risks of secondhand smoke rather than implementing new rules or legislation.
- Effective use of marketing is seen as an important tool for giving people choice and opportunity. This can be seen in the emphasis on so called ‘nudge’ approaches in Government.<sup>†</sup>
- A further important communications area for local Conservatives is to communicate the harm smoking causes to small business.

#### LIBERAL DEMOCRAT APPROACH TO TOBACCO CONTROL

- Part of the Coalition Government which introduced the comprehensive Tobacco Control Plan for England.
- The Liberal Democrats have long supported restricting the promotion of tobacco. The 2002 Tobacco Advertising and Promotion Act started as a Private Members Bill sponsored by a Liberal Democrat, Lord Clement Jones.
- Liberal Democrat MP Stephen Williams recently chaired an inquiry into the impact of illicit tobacco. The inquiry supported continued action on illicit tobacco.
- Liberal Democrats support action and targeted funding to address health inequalities.
- The Liberal Democrats have been strong supporters of smokefree legislation, allowing a free vote on 2002 legislation. They have also supported a ban on smoking in cars with children.
- The Liberal Democrats, like the Conservatives, are supportive of ‘nudge’ approaches to communications.
- Demonstrating the financial impacts on local communities is also likely to be important.

#### LABOUR APPROACH TO TOBACCO CONTROL

- Labour introduced a comprehensive strategy to tackle tobacco ahead of the last election.
- Labour is strongly supportive of protecting children from harm caused by advertising and are supportive of the introduction of standardised packaging. As the Shadow Secretary of State for Health recently stated: “Standardised cigarette packets are key to deterring our young people from taking up smoking.”
- Labour maintained pressure on tobacco prices through continued tax rises and an emphasis on strong, co-ordinated action on illicit tobacco.
- Harm reduction is seen by Labour as offering a potential route to tackling inequalities.
- Labour invested in smoking cessation services and implemented targets on reducing prevalence with specific targets around those in high prevalence groups.
- Labour introduced smokefree legislation in 2006 and have been strong supporters of it ever since. Effective enforcement of smokefree regulations is an important part of maintaining the effectiveness of legislation.
- Labour invested in mass media campaigns and funded supportive mass media activity at a regional level. They have a strong track record in this area.

<sup>†</sup> This is a useful summary of the Government’s approach to ‘nudge’ and behavioural economics: Paul Dolan, Michael Hallsworth, David Halpern, Dominic King, Ivo Vlaev, MINDSPACE: Influencing behaviour through public policy, March 2010, <http://bit.ly/HShwJV>

## NATIONAL ACTIVITY

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For all the gains of recent years, the national agenda for action on tobacco remains huge. A great deal still needs to be done through national policy and legislation to eliminate the harm of smoking.

Health professionals have a vital role to play in supporting the call for better tobacco policy at a national level. Recent changes to policy and legislation, including smokefree legislation, have been hard fought and support from every quarter will be needed to achieve further changes. The tobacco industry and its allies are fighting harder than ever.

You can contribute to national activity in the following ways:

- Join the Smokefree Action Coalition and contribute to its work. The coalition was formed to advocate for smokefree legislation but is now involved in promoting the new legislative agenda on tobacco. Find out more about joining up here: <http://bit.ly/11wR9UK>
- Respond to all Department of Health consultations on tobacco and public health. Where possible, describe specific examples of how progress on tobacco locally has been dependent on strong national leadership and support.
- Use your tobacco alliance and others to inform MPs directly. Seek to ensure that your own MP is properly briefed on tobacco issues and persuaded of the case for further legislative change.
- Use your tobacco alliance and other independent groups to raise issues through the media.

## REFERENCES

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# TOP OF THE AGENDA 2013

## MAPPING THE NEW PUBLIC HEALTH LANDSCAPE

