ASH/ Cancer Research UK joint submission to the Health Select Committee Inquiry: *Public health post-2013 - structures, organisation, funding and delivery.*

Key recommendations

- **The future of the NHS requires a radical upgrade in public health, as identified in the NHS England Five Year Forward View. Cutting public health funding makes this objective much harder to achieve.**
- **A sustainable funding solution should be identified for reducing smoking rates as part of improving public health and ensuring the sustainability of the NHS.**
- **Smoking cessation should be seen as a core treatment by the NHS and funding to implement the NHS Five Year Forward View should be used to help smokers quit.**
- **Full consideration should be given to all options to ensure the future sustainability of evidence based support to smokers to quit.**
- **Tobacco control should be a case study for further consideration as part of this inquiry.**

About ASH

1. Action on Smoking and Health (ASH) is a health charity working towards the elimination of harm caused by tobacco. ASH receives core funding from the British Heart Foundation and Cancer Research UK and has received project funding for work to support government tobacco strategy for England from the Department of Health. ASH does not have any direct or indirect links to, or receive funding from, the tobacco industry.

About Cancer Research UK

2. Every year around 300,000 people are diagnosed with cancer in the UK and more than 150,000 people die from cancer. Cancer Research UK is the world's leading cancer charity dedicated to saving lives through research. Together with our partners and supporters, our vision is to bring forward the day when all cancers are cured. In 2014/15, we spent £341 million on research, plus £41 million to the Francis Crick Institute. We receive no funding from the Government for our research.

Public health spending

3. The NHS England Five Year Forward (FYFV) view forecasts a £30 billion shortfall in funding for the NHS by 2020. Even after the £8 billion in additional funding committed by the Government, there remains a predicted shortfall of £22 billion. This funding gap is highly unlikely to be closed through increased efficiency alone, since this would require efficiency savings of about 3% per year, a higher level of efficiency saving annually than the NHS has achieved since its foundation. Therefore, some of the funding gap will have to be met through cuts in NHS services, longer waits for treatment, or through reductions

in demand for NHS services. This latter possibility requires a sustained effort to improve public health, and to tackle the major causes of illness, in particular smoking.

4. The FYFV further states that: "*The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health."* The report notes that this has been long called for: *"Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.*"[1]

5. The in-year cut to public health funding of £200 million this year [2] and the recently announced 3.9% annual cuts to local public health budgets over the next five years [3] suggests that the Government has not heeded the recommendations of the FYFV nor the warning made by Derek Wanless in 2002.

6. The changes to the public health system, at a time when budgets have been reduced, both within the public health ring-fence and more generally across local government, raise serious concerns about the sustainability of current progress to reduce smoking rates. In England we have seen a steady fall in smoking rates, but international evidence shows that where investment is reduced these declines can be reversed. In New York, for example, sustained investment from 2002 led to declines in smoking rates until 2010, when the decline ceased following funding cuts. Investment was reinstated in 2014 and the rates began to decline again[4].

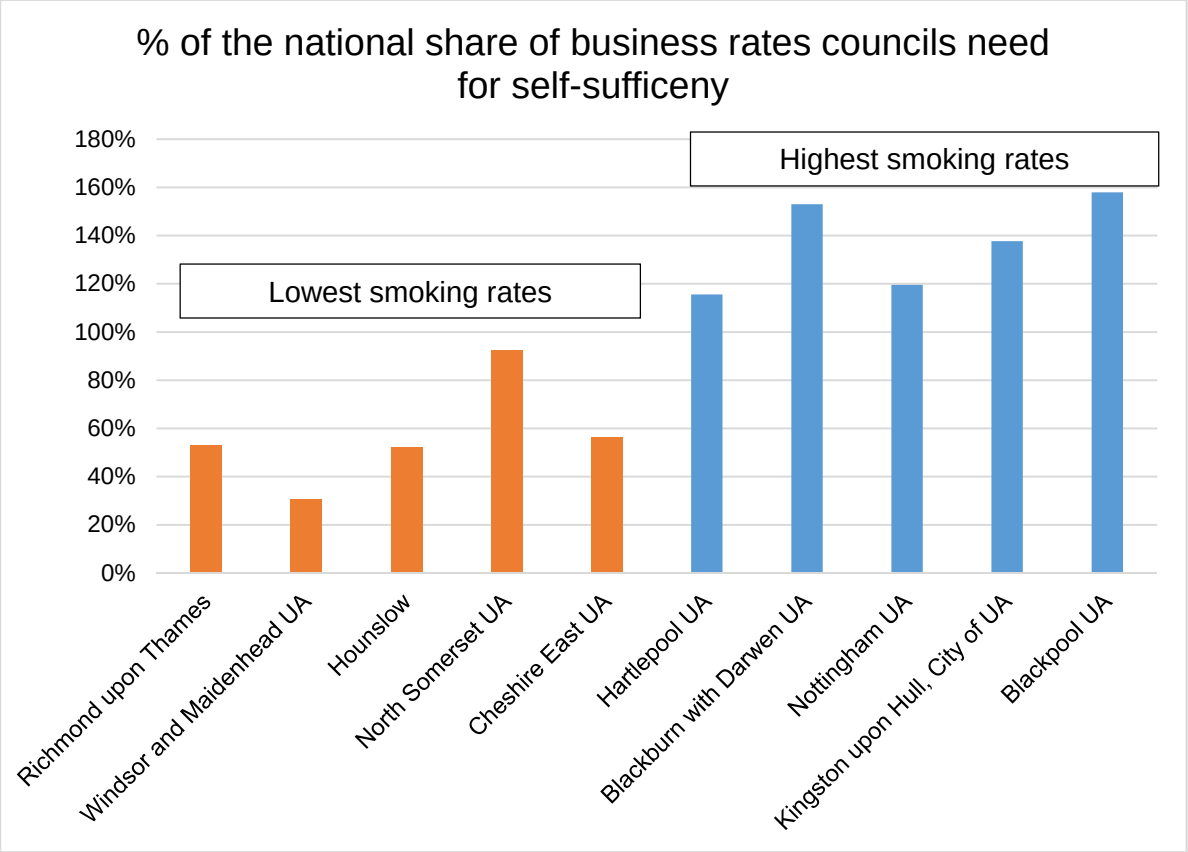
7. Disinvestment in tobacco control is taking place both nationally and locally. Councils faced with cuts to their budgets are reducing their investment in stop smoking services [5] and in other areas of tobacco control[6]. Nationally, the budget for mass marketing has been much reduced and is now far lower than best practice evidence suggests is most effective[7].

8. There are wide variations in council spending on reducing smoking. Using local authority revenue expenditure and financing for 2015 to 2016, [8] we have calculated the intended spend per smoker by each local authority for this financial year. The average intended spend is 21p per smoker and the range is from 4p per smoker to 49p per smoker (excluding City of London and Isles of Scilly). There does not seem to be a strong relationship between areas with high rates of smoking and their spend on reducing smoking. The average spend among the 10 authorities with the lowest rates of smoking is 21p per smoker (ranging from 11p to 31p). Among the 10 authorities with the highest rates of smoking the average spend is actually lower at 19p per smoker (ranging from 6p to 38p).

9. These differences may partly be accounted for through differences in the public health grants to local authorities, and may further be explained by the impact on public health of cuts to overall central government grants to local authorities[6]. However, these are not sufficient explanations for the differences we have observed.

10. In the Autumn Statement the Chancellor proposed that a future funding solution for public health could come through returning more of business rates to local authorities. We are concerned that far from addressing these variations between areas a funding solution for public health based on local business rates could entrench inequalities even further. Council's income from business rates vary widely, with richer areas raising more income than poorer ones, and since richer local authority areas generally have lower smoking rates than poorer ones, this form of funding would be unlikely to allocated resources to areas with the highest need.

11. The Local Government Chronicle [9] undertook an analysis in October 2015 to determine the 'winners' and 'losers' from returning the national share of business rates to local authorities while ending the Revenue Support Grant. ASH has applied their analysis to smoking rates across the country. The five areas (excluding London) which are the biggest 'winners' from this proposal have an average smoking rate of 16% while the five biggest 'losers' have an average smoking rate of 20%. Looking at the areas of the country with the highest and lowest rates of smoking, those with the highest smoking rates are much more likely to lose out than those with lower rates. Using the LGC calculations the 5 councils with the highest smoking rates would, on average, need 137% of the national share of the business rates to be self-sufficient while the five with the lowest smoking rates would need only 57%.



12. Not only would relying on business rates to resource efforts to reduce smoking reinforce inequalities, it would also fail to place the burden for reducing smoking with the businesses that benefit most from the sale of tobacco – the tobacco companies themselves.

13. Any funding solution for public health based on business rates will need to be adjusted to ensure that public health can be properly, and equitably, funded.

14. Policy work has already been done to determine alternative ways through which the necessary investment in tobacco control activity could be guaranteed. A recent report published by the All Party Parliamentary Group on Smoking and Health sets out the evidence for higher investment in tobacco control, funded through higher rates of taxation on tobacco products. The report found that an increase of £100 million per year

in funding to reduce smoking, combined with a 5% tax escalator on tobacco could deliver in excess of 1000% return on investment[7].

15. These findings support the case made in ASH's June 2015 report, Smoking Still Kills,[10] which set out the case for a levy on tobacco companies to fund increased activity to reduce smoking. Following a consultation on the concept of a tobacco levy the Chancellor ruled out this policy, a decision widely opposed by the public health community[11].

16. **We recommend that a sustainable funding solution be identified for reducing smoking rates as part of ensuring the sustainability of the NHS.**

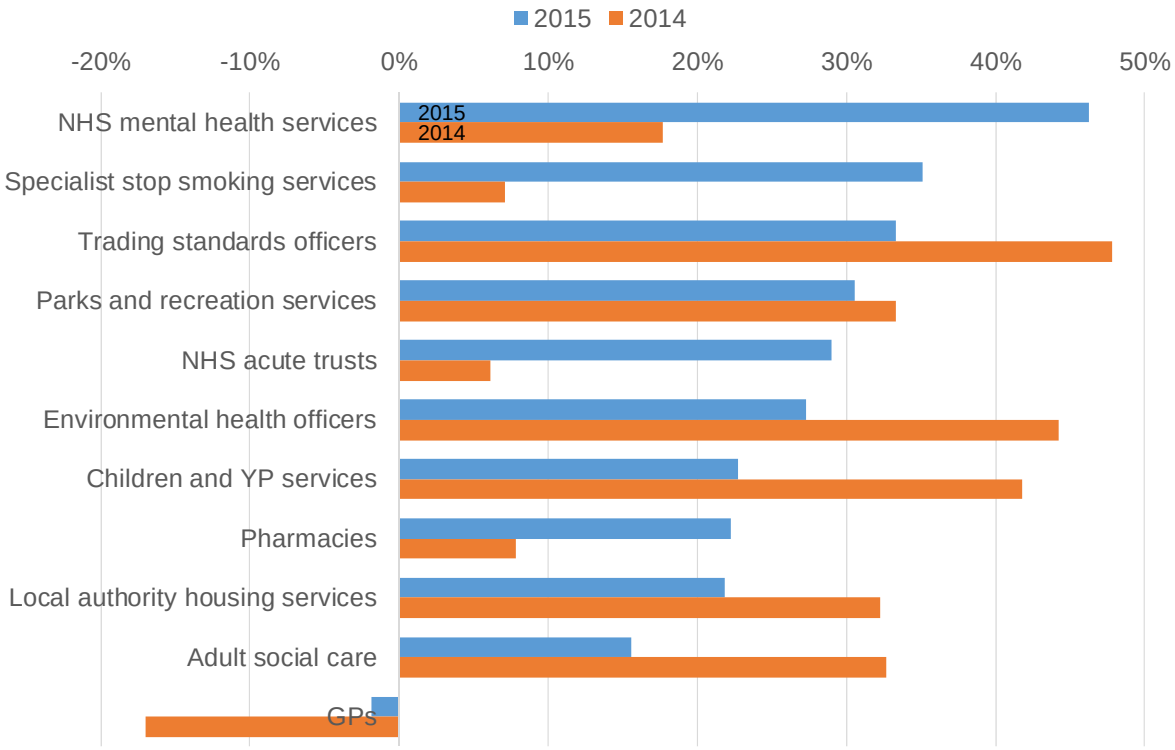
The delivery of public health functions

17. In this year's Autumn Statement the Chancellor announced that the NHS was being provided £6 billion as a "front end loading" of the additional resources the Government had already promised. He stated that this: "*fully funds the Five Year Forward View that the NHS itself put forward as the plan for its future"*. But this is not the case, certainly beyond the next two years. The FYFV makes a commitment to take further action on public health because this is essential to close the forecast spending gap by 2020. The report notes the priorities of Public Health England in seeking to reduce ill health, and states that: *"We support these priorities and will work to deliver them. While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change. That's why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing"*.

18. We are increasingly concerned about the delivery of support to help smokers quit within the NHS. The transfer of public health away from the NHS may have undermined their role in prevention activity. While local authorities must continue to provide comprehensive local tobacco control strategies, including services to help people quit, there remains an important role for the NHS both in prompting people to quit and providing help and support.

19. Our recent survey[6] of local authority staff with lead responsibility for tobacco control found problems with the relationship between primary care and local public health. The relationship with GPs is the only relationship to be scored as in decline overall in both 2014 and 2015.

Figure 1: Net improvement in relationships with key professionals and service providers over previous year, 2015 and 2014



20. Current NHS activity to reduce smoking also appears to be declining rather than increasing. There has been a decline in the number of GPs recommending that smokers quit and directing them to further support[12]. In addition, services to support people to quit smoking in secondary care are already far from universal and those that do exist are under threat. For example, funding was recently cut by Manchester City Council to specialist stop smoking services including provision at cancer hospital The Christie.[13] We understand the service will now only continue as a result of charitable income to the hospital.

21. If the NHS FYFV is to be fully delivered it must address the provision of support for smokers within the NHS. Stop smoking services should be recognized as perhaps the single most cost effective healthcare interventions, costing under £1,000 per quality adjusted life year (qaly).[14] This compares to, for example, up to £57,000 per qaly for statins to prevent coronary heart disease, [15] up to £130,000 per qaly for treatments for Chronic Obstructive Pulmonary Disease, and as much as £100,000 for just one course of treatment of the new lung cancer treatment "Opdivo".[16]

22. **We recommend smoking cessation be seen as a core treatment by the NHS and funding to implement the Five Year Forward View be invested in support to help smokers quit.**

The effectiveness of local authorities in delivering the envisaged improvements to public health

23. While there needs to be a revamped role for the NHS in supporting smokers to quit, this cannot replace the delivery of community based stop smoking services and comprehensive local tobacco control delivery.

24. Stop smoking services are one of the most cost effective healthcare interventions, according to NICE. Smokers are four times more likely to quit successfully with the combination of behavioural support and medication provided by services compared to unsupported quit attempts[17]. Services also play an important role in reducing health inequalities, as poorer smokers, who find it more difficult to quit, are more likely to be successful with their support[18].

25. There is clear guidance from NICE about the standards stop smoking services need to meet to be effective. However, our recent survey shows that there are major changes underway in services, and it is not clear that new approaches are evidence based[6].

26. Over half the respondents (53 per cent) described some form of reconfiguration or recommissioning of local smoking cessation services. One in five (19 per cent) described a shift to an integrated approach, in which smoking cessation is delivered as part of a wider 'lifestyle' package, including, for example, measures to tackle obesity and reduce the harm of alcohol. This has meant the loss of some specialist support.

27. The changes taking place within services raise questions about their efficacy and outcomes. In particular, the shift to 'integrated' or 'lifestyle' services has limited support from the evidence base. An authoritative Cochrane review did not find a significant effect on smoking rates from these interventions[19]. Local authorities may want to distance themselves from 'medical models' and adopt 'holistic' approaches to health, but this should not be at the expense of service models that have a track record of effectiveness.

28. It has been proposed that stop smoking services could be returned to the NHS as a means of securing their future as a life-saving healthcare intervention. Others have suggested that stop smoking services should be added to the list of services mandated for delivery. More work must be done to establish the most effective way forward and ensure that local authority funded stop smoking services meet NICE standards.

    We recommend that full consideration is given to all options to ensure the future sustainability of evidence based support to smokers to quit.

29. Stop smoking services are only one part of the local delivery of tobacco control. Effective local tobacco control must be comprehensive, and therefore include activity to enforce existing laws, tackle health inequalities and implement prevention strategies. While research shows that there are time and budget pressures across local authorities, there are real opportunities to do more at a regional level[6]. Several parts of the country have invested in a regional function but there is an opportunity for more to be achieved across the country particularly in tackling illicit tobacco[7].

Tobacco control: a case study for further consideration

30. The committee would benefit from focusing on tobacco control as a case study:
    a. Tackling smoking is a major public health challenge: Smoking remains the leading cause of preventable death and disease, [20,21] and is responsible for half the difference in life expectancy between rich and poor. [22]
    b. There is strong evidence for the effectiveness of tobacco control activity and on what policy and actions work most effectively to bring rates of smoking down.
    c. There is growing evidence that changes in the public health system and pressure on budgets are undermining the effectiveness of tobacco control delivery.

31. There are a number of sources a more detailed case study could draw from:

- ASH/ Cancer Research UK work to track local tobacco control activity in England. Appendix A includes our most recent report due to be published shortly.
- APPG on Smoking and Health report for the 2015 Spending Review
- ASH report Smoking Still Kills
- PHE review of the evidence underpinning the ROI for tobacco control
- National data set of stop smoking service activity
- National data sets on smoking
- Tracking surveys of smokers behaviour in England.

32. **We recommend that tobacco control be a case study for further consideration as part of this inquiry**

33. We would be pleased to supply any further evidence or analysis the Committee may need for its consideration and final report please contact deborah.arnott@ash.org.uk 020 7404 0242.

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[1] NHS Five Year Forward View: Chapter 2, page 9, October 2014
[2] Treasury, Budget, June 2015,
[3] Treasury, Autumn Statement, November 2015
[4] Politico New York, NYC smoking rate drops to lowest on record, September 2015
[5] Pulse Today, Local smoking cessation budget slashed 50% as public health cuts bite, November 2015
[6] ASH/CRUK, Taking a Reading 2015, publication TBC
[7] APPG on Smoking and Health, Representation to the 2015 Spending Review, October 2015
[8] DCLG, Local authority revenue expenditure and financing England: 2015 to 2016 individual local authority data, July 2015
[9] Local Government Chronicle, Financial Freedom: oasis or mirage?, October 2015
[10] ASH, Smoking Still Kills, June 2015
[11]Smokefree Action Coalition, Letter to the Chancellor, November 2015
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[16] Gapper J. The unhealthily high price of cancer drugs. Financial Times. 3 June 2015
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Appendix A

Taking a reading 2015

Results of a survey of tobacco control leads in local authorities in England

DRAFT 3rd December 2015

Contents

Summary and actions

This report presents the findings of a survey of tobacco control leads in English upper tier local authorities. The survey was conducted in summer 2015, two years after the transfer of responsibility and resources for public health to local government.

Political support for tobacco control

Tobacco control was perceived to be an above average or high priority in 55 per cent of English upper-tier local authorities, and perceived to be a below average or low priority in 18 per cent. This core result characterises the findings as a whole: a divide between the majority of respondents who see tobacco control prospering in the local government setting and a substantial minority who are struggling to gain the necessary political support for their work.

Active political support for tobacco control from the leader, the member for health and wellbeing and senior officers was the single most important factor in shaping a positive outlook for tobacco control: it was associated with a higher perceived priority for tobacco control, a more optimistic view of the future of smoking cessation and tobacco control services, and with the integration of tobacco control in the wider business of the council.

Relationships and opportunities

Tobacco control leads are building fruitful relationships with their local authority colleagues, exploiting the many opportunities presented by community-focussed organisations to reach smokers and protect local people from the harm of tobacco. In three quarters of local authorities, tobacco control alliances remain key to this activity: 93 per cent of respondents who participate in an alliance feel that the alliance is important to the delivery of local tobacco control outcomes.

There has been a marked improvement in relationships with the NHS: nearly half of all respondents reported improvements in their relationships with NHS mental health services (49 per cent) and NHS maternity services (47 per cent). However relationships with GPs have continued to decline more often than they have improved.

Changes in budgets and services

Despite the public health budget ring fence, smoking cessation budgets were cut in 39 per cent of local authorities in England in 2015-16, including 29 per cent where the cut was greater than 5 per cent. Budgets increased in 5 per cent. Wider tobacco control budgets were cut in 28 per cent of local authorities and increased in 10 per cent. At the time of the survey, few respondents knew what the impact of the in-year cut in the national public health budget would be.

Cuts to smoking cessation and tobacco control budgets were unrelated to the perceived priority given to tobacco control or to the extent of political support for tobacco control from key members and senior officers. However, cuts to tobacco control budgets, but not smoking cessation budgets, were much more common in local authorities that had experienced deep council-wide cuts over the period 2010-2014.

Smoking cessation services have been undergoing significant change across the country with 53 per cent of respondents describing some form of reconfiguration or recommissioning. One in five respondents described a move to integrate smoking cessation into a wider lifestyle service, despite

the limited evidence for this approach. Elsewhere, specialist services are being increasingly targeted on priority populations.

The pros and cons of local government

The benefits of the local government context were widely acknowledged by respondents to the survey. Above all, they valued the constructive relationships with their colleagues in other departments (cited by 86 per cent) and the integration of tobacco control in the wider strategy and business of the council (60 per cent). The leading difficulty of the local government context, identified by 75 per cent of respondents, is the current pressure on tobacco control and smoking cessation budgets.

A majority (59 per cent) of respondents felt positive about the future of tobacco control in local government but a quarter (24 per cent) felt negative about the future of tobacco control. A positive outlook was associated with active support for tobacco control from key members and senior officers, a perception of a high priority for tobacco control in their local authority, constructive relationships with colleagues in other departments, and the integration of tobacco control in the wider business of the council.

Conclusion

The integration of tobacco control with the broader interests of local authorities is, to date, the primary success story of tobacco control's short life in local government. Tobacco control leads are building new relationships, creating new alliances, devising new initiatives and bringing tobacco control to the table in wider policy discussions. The reach of local authorities, deep into local communities, offers excellent long-term opportunities for tobacco control and smoking cessation services. However active political support for tobacco control is vital; where it is lacking, tobacco control leads are struggling to exploit these opportunities.

Unfortunately this generally positive outlook is clouded by the financial pressures that risk undermining not only new initiatives but also established services. The ring fence on the public health budget has offered only limited protection for tobacco control and smoking cessation budgets, and soon it will be gone. As local authorities are required to find ever deeper savings, it is no wonder that tobacco control leads are worried about what the implications of these cost pressures will be.

Recommended actions

1. **As a matter of urgency, the government must establish a sustainable funding model for local tobacco control and stop smoking services before budgets are eroded further**. As smoking remains the leading cause of preventable death, disinvestment now will have an impact for generations.

2. **All stop smoking services should be evidence-based and meet NICE standards**. Public Health England and NICE should offer support and guidance to local authorities to ensure that any local reconfiguration of stop smoking services remains compliant with NICE guidance and standards.

3. **The role of GPs in reducing smoking prevalence should be strengthened**. The Royal College of GPs, NHS England and Public Health England should identify what can be done nationally to enable GPs to engage in local activity to reduce smoking. Clinical

Commissioning Groups should back the NHS Statement of Support for Tobacco Control as a route to securing closer involvement of GPs in smoking cessation.

4. **Local politicians should continue to champion action to reduce the burden that smoking places on local communities**. Those local authorities that have yet to sign the Local Government Declaration on Tobacco Control should do so.

5. **Using tools such as the CLeaR model, local authorities should ensure that they are taking a comprehensive and evidence-based approach to reduce local smoking prevalence**.

1. Introduction

In England, public health and tobacco control have now been based within upper-tier local authorities for over two years. The period of transition from the NHS is over. Tobacco control leads are established workers within local government, dealing with the political realities of locally-accountable organisations and seizing the opportunities of working within community-focussed organisations. They are also coping with the increasing financial pressures that currently preoccupy local authorities.

This report describes the result of a survey of tobacco control leads, conducted in summer 2015, which sought to explore their experience of working in local authorities and to describe the opportunities and obstacles they face. It follows a similar survey conducted in 2014 which focussed on the impact of the transition of public health from the NHS to local government[1]. The original survey described a generally positive picture, with a good deal of optimism expressed by respondents about the opportunities for tobacco control in the new setting, but also raised concerns about the experience of the minority where support for tobacco control was limited.

This report reiterates this broad picture and adds more detail. It describes a high level of political support for tobacco control and the increasing integration of tobacco control into the wider business and activity of local authorities, while also drawing attention to the significant challenges faced by tobacco control leads who do not enjoy political support.

The effects of budget cuts within local authorities are already evident in this study. The survey will be conducted again in future years to explore the longer-term impact of these financial pressures on the work of tobacco control and smoking cessation services.

2. Methods

The aim of the survey was to assess the current health of tobacco control within upper-tier local authorities in England, which now have responsibility locally for public health–. Prior to the formulation of the questions for the survey, two focus groups were conducted in London and Wakefield to communicate and review the results from the 2014 study and consider the range of appropriate questions for the new survey. These focus groups were recorded but were not treated as sources of empirical data.

The revised survey was piloted with ten tobacco control leads before being finalised. The survey went online through Survey Monkey in June 2015 and was open for two months. Tobacco control leads in England were emailed about the survey and subsequently telephoned to maximise the response rate. Respondents were told that all their responses would remain anonymous except for data on their budgets.

The sampling frame was all the upper-tier local authorities in England. However, some of these local authorities share their tobacco control teams and leads. In these cases, special versions of the survey were prepared that allowed respondents to answer questions separately for each of the

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

authorities they represented, where this was appropriate. Consequently some of the results represent all local authorities and some represent all respondents.

There were 118 respondents to the survey, a response rate of 86 per cent. These respondents represented 126 local authorities, 83 per cent of upper-tier local authorities in England.

Two thirds (68 per cent) of respondents identified as the tobacco control lead for their local authority and nearly as many (64 per cent) identified as a commissioner of tobacco control/smoking cessation services, with 12 per cent identifying as a consultant in public health. Overall, 43 per cent of all respondents identified both as a tobacco control lead and as a commissioner. Four respondents (3 per cent) described themselves, under the 'other' option, as being solely stop smoking or tobacco control service providers.

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

3. Political support for tobacco control

Key findings

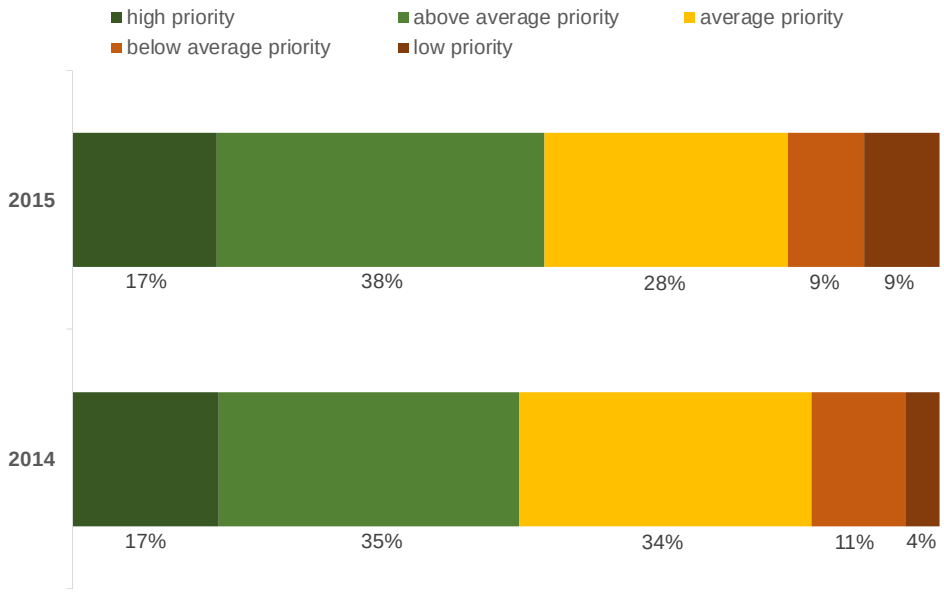
- Tobacco control was perceived by respondents to be an above average or high priority in 55 per cent of English upper-tier local authorities. It was perceived to be a below average or low priority in 18 per cent of local authorities.
- The number of local authorities where tobacco control is perceived to be an above average or high priority has increased over the last year, but so has the number of local authorities where it is perceived to be a below average or low priority.
- In a majority of local authorities, tobacco control enjoys the active support of key members and senior officers. Active opposition is rare.
- Active support for tobacco control is associated with a higher perceived priority for tobacco control, a more optimistic view of the future of smoking cessation and tobacco control services, and with the integration of tobacco control in the wider business of the council.
- The Local Government Declaration on Tobacco Control has been adopted by 65 of the local authorities represented in the survey (63 per cent). A further 17 are likely to sign in the next year.
- The Local Government Declaration has been widely used to drive strategy and action plans, advocate for tobacco control, and secure endorsement of national consultations.

The perceived priority of tobacco control in local authorities

Respondents were asked to identify the level of priority they felt tobacco received in the local authorities they represented. Figure 3.1 illustrates the results, comparing the 2015 results with those from 2014. Overall, tobacco control is perceived by tobacco control leads to be an above average or high priority in a majority of local authorities (55 per cent). It is, however, perceived to be a below average or low priority in more than one in six local authorities (18 per cent).

Compared to 2014, these result show relatively little change, though there has been an increase in the overall divergence of experience: more people are reporting above average/high priority and more people are reporting below average/low priority. In particular, the proportion of respondents reporting a low priority has doubled.

Figure 3.1. Priority of tobacco control in local authorities in England, as perceived by tobacco control leads, 2015 and 2014



Support for, and opposition to, tobacco control

Respondents were asked to identify whether the leader, the member for health and wellbeing, and the senior officers in their local authority (or local authorities) supported or opposed tobacco control. Figure 3.2 illustrates the results. Overall, there is a high level of support for tobacco control. Those who actively oppose tobacco control are very much in the minority: 3 per cent of council leaders, 3 per cent of members for health and wellbeing, and one per cent of chief executives. Opposition to tobacco control by any of these members and officers was reported in seven local authorities (6 per cent) overall.

There are, however, many more local authorities where members and senior officers 'neither support nor oppose' tobacco control. This is important because there are significant differences between the experience of respondents in local authorities where members and senior officers actively support tobacco control and the experience of respondents in local authorities where this active support is not forthcoming (combining those who neither supported nor opposed tobacco control with active opposition). Statistically significant relationships were found as follows:

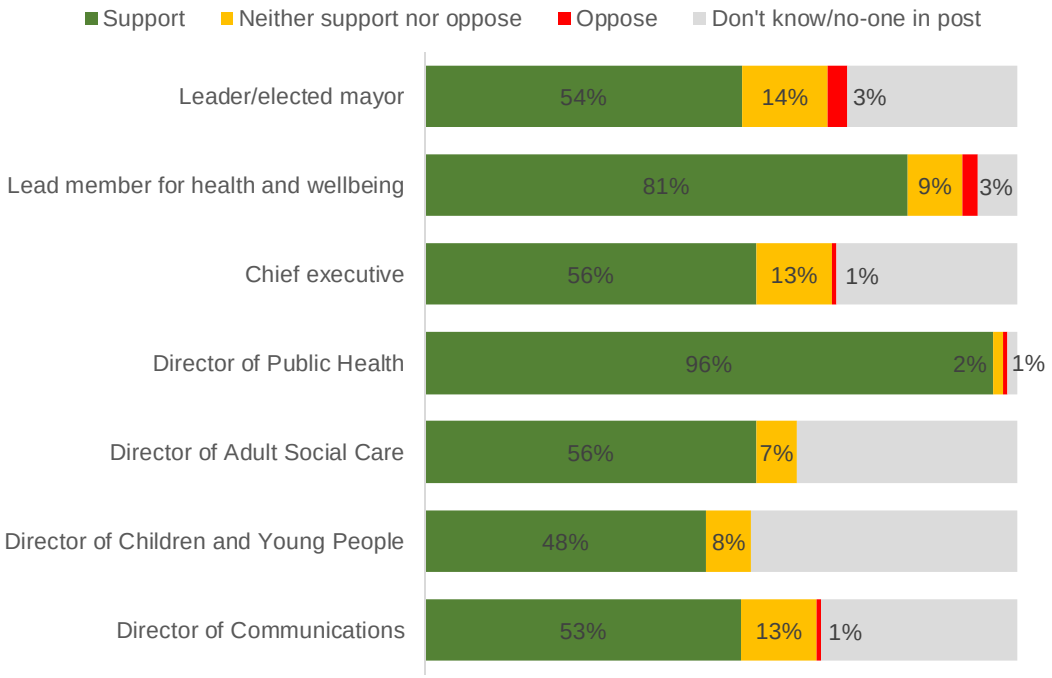
- The perceived priority for tobacco control was positively associated with active support from all of the members and senior officers identified in Figure 3.2.
- An optimistic outlook on the future of both smoking cessation services and wider tobacco control was positively associated with active support from all of the members and senior officers identified in Figure 3.2 except the Director of Communications.
- The integration of tobacco control in the wider business of the council was positively associated with active support from the leader, lead member for health and wellbeing and chief executive

Some respondents explained why the absence of direct opposition did not necessarily mean that they could be sure of support at every turn:

> "There is little direct opposition but there is a perception of how far we can go with proposals."

"I think councillors are cautious about tobacco control initiatives as their perception is that they may be unpopular with citizens."

Figure 3.2. Support for, and opposition to, tobacco control in local authorities in England (specific values for 'support', 'neither support not oppose' and 'oppose' shown)



The Local Government Declaration on Tobacco Control

The Local Government Declaration on Tobacco Control is a statement of a local authority's commitment to ensure tobacco control is part of mainstream public health work and commits local authorities to taking comprehensive action to address the harm from smoking. It was developed by Newcastle City Council and launched in May 2013. The Declaration commits local authorities to:

- Reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Participate in local and regional networks
- Support Government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Monitor the progress of our plans
- Join the Smokefree Action Coalition

Across the local authorities represented by respondents in the survey, 65 local authorities (63 per cent) had already signed up to the Local Government Declaration on Tobacco Control, 17 were likely to sign in the next year, 10 were unlikely to sign in the next year and 12 were unlikely ever to sign. There were 13 respondents who did not know whether or not the local authority they worked in had signed the Declaration.

Twice as many respondents working in councils where the Declaration had been signed reported a high priority for tobacco control (67 per cent) than in local authorities where it had not been signed (32 per cent). This relationship between signing the Declaration and level of priority for tobacco control is likely to be two-way: signing the Local Government Declaration may reflect a high priority

given to tobacco control, while also potentially helping tobacco control to gain a higher priority. Certainly some degree of political leadership is needed for the Declaration to be signed: sign-up was significantly associated with active support from the leader of the council, but not with support from any other senior members and officers.

In the 2014 survey, 51 respondents reported that their local authority had already signed the Declaration and 30 said that sign-up was likely in the next year. The increase to 65 this year suggests that some of the 30 may have been over-optimistic, though the samples from the two surveys are slightly different.

The survey explored the impact of signing the Declaration by asking respondents to describe how the Declaration had been used once it had been signed. A few said that it had not subsequently been used but most were able to identify ongoing value. The Declaration has mainly be used:

- To kick-start and support tobacco control alliances and action plans
- To advocate for tobacco control within the local authority
- To secure endorsement of national consultations on tobacco policy
- To raise awareness among member and officers
- To clarify the local authority's relationship with the tobacco industry

The following single response captures several of these functions

> "By signing the declaration the council is committing to reduce smoking prevalence and health inequality across the borough, develop plans with partners and local communities and work with partners locally, regionally and nationally. The declaration also commits the council to protect their tobacco control work from the commercial and vested interests of the tobacco industry and join the Smokefree Action Coalition."

Discussion

Local government is a political environment in which the values and priorities of members and senior officers play a vital role in shaping strategy, corporate priorities and what actually gets delivered. It is therefore encouraging that so many key members and senior officers have shown active support for tobacco control, and that tobacco control was perceived to be a high or above average priority by the majority of respondents to the survey.

Where tobacco control does not enjoy the active support of key members and officers, tobacco control leads have more work to do to get their programmes and new initiatives approved. Although active opposition was rare, a lack of fully-fledged support was significantly associated with a lower perceived priority for tobacco control and weaker integration of tobacco control in the wider business of the council. It is therefore vital that tobacco control leads have the skills and resources to advocate for tobacco control at all levels, an objective which national leaders would do well to support. The Local Government Declaration on Tobacco Control has proved itself to be a valuable tool in pursuing such advocacy because it articulates and formalises local political support for tobacco control.

Where members and senior officers are wary of public attitudes to tobacco control interventions, they need not be. Tobacco control leads have the advantage of strong public support in making their case for ambitious local tobacco control programmes. In 2015, 37 per cent of adults in England felt that the government was not doing enough to limit smoking and 39 per cent felt that government action was about right. Only 14 per cent felt that the government was doing too much[2].

[2] YouGov: *Smokefree Britain Survey*, ASH 2015.

Since the last survey in 2014, the proportion of local authorities where tobacco control is perceived to be a low priority has risen from 4 per cent to 9 per cent. This result highlights the inevitable downside of the political culture of local government. Where political support is not forthcoming, tobacco control is going to suffer. Although this is a minority experience across respondents to the survey, this minority still represents hundreds of thousands of smokers and their families.

4. Relationships and opportunities

Key findings

- Over the 12 months prior to the survey, respondents' relationships with colleagues and partners within and beyond the local authority consistently improved more often than they declined, with the exception of relationships with GPs, which declined more often than they improved.
- Relationships with other NHS services have improved markedly: 49 per cent of respondents reported improvements with mental health services and 47 per cent reported improvements with maternity services.
- Three quarters (76 per cent) of local authorities are part of a tobacco control alliance and 93 per cent of respondents who participate in an alliance feel that the alliance is important to the delivery of local tobacco control outcomes.
- The relationships that respondents have built with their local authority colleagues have created opportunities to pursue a diverse range of initiatives, exploiting the community focus and links of local government.
- A majority of respondents (71 per cent) work in partnership with other local authorities on some or all of their brief. This takes many forms from funding a regional organisation to joint commissioning programmes.
- Half of the respondents to the survey said they were not satisfied with the current level of national leadership from government, Public Health England and other statutory bodies.

Relationships within and beyond the local authority

Respondents were asked to describe how their relationships with a range of professionals and providers, within and beyond the local authority, had changed over the previous year. Figure 4.1 illustrates the results, listed in descending order of net improvement (percentage improvement in relationships less percentage decline in relationships). For clarity, these results exclude 'don't know' responses which were never more than 4 per cent.

With one exception, all relationships had improved more often than they had declined. The exception is relationships with GPs, at the bottom of the list, which had declined for 19 per cent of respondents and improved for 17 per cent. Local authority communications teams are at the top of the list, followed by three clinical services. Nearly half of respondents reported improvements in their relationships with both mental health and maternity services. There are, however, three local authority services for which sizeable minorities of respondents reported 'no relationship': parks and recreation services (25 per cent with no relationship), social care (24 per cent) and housing services (22 per cent).

Figure 4.2 compares the 2015 results with those of the 2014 survey, which explored changes in relationships over the period of the transition of public health to local government. The values

compared are those for net improvement in relationships. In both years, all relationships improved more than they declined, except for relationships with GPs, which declined more than they improved in both years. All relationships with local authority colleagues improved less in the year up 2015 than they did over the period of transition, whereas all relationships with NHS and clinical services, including specialist stop smoking services, improved more in the year up to 2015 than they did in the period of transition.

Figure 4.1. Changes in relationships with key professionals and service providers over previous year (specific values for improvement and decline shown)

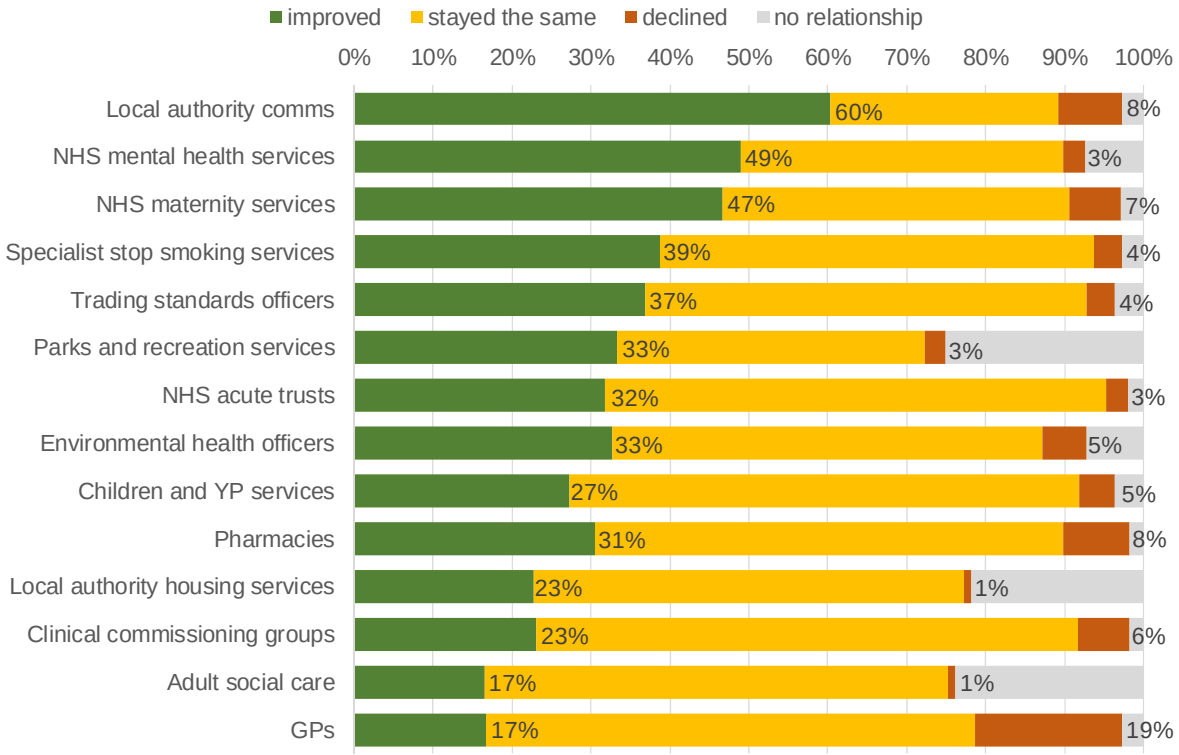
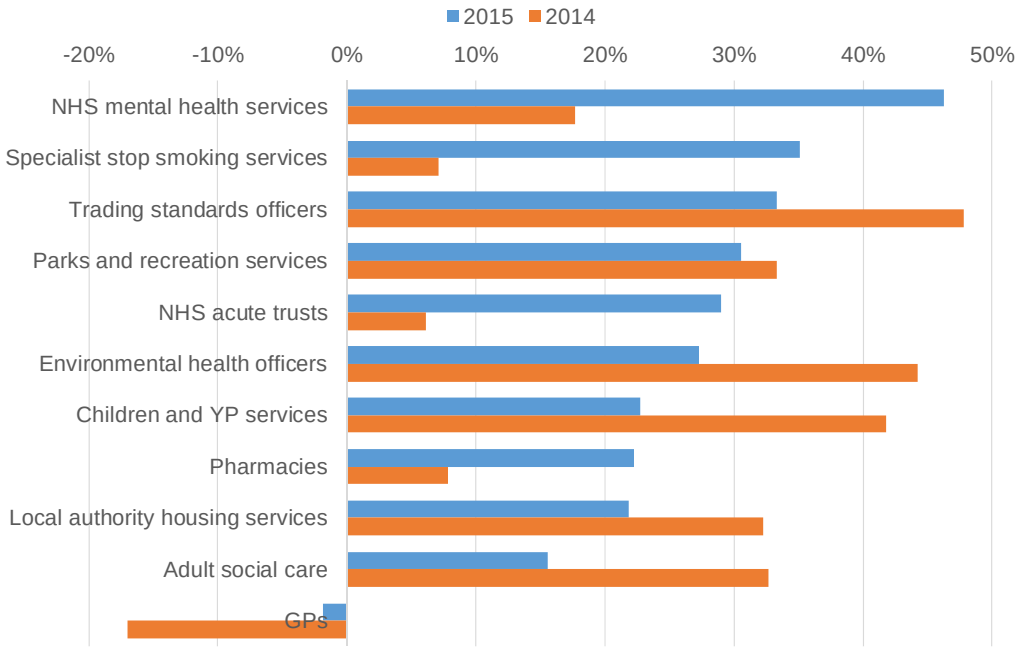


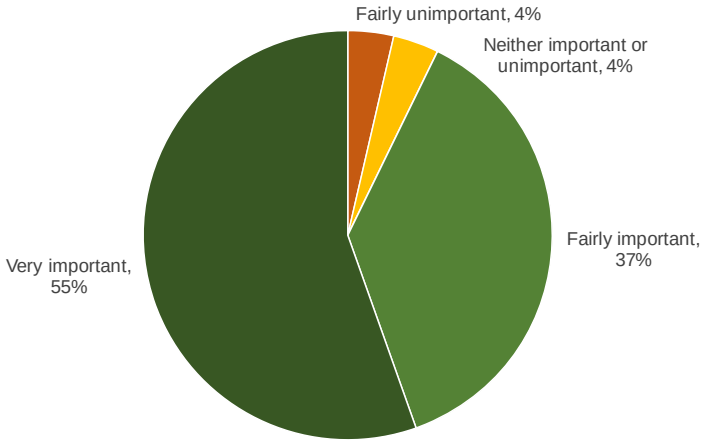
Figure 4.2. Net improvement in relationships with key professionals and service providers over previous year, 2015 and 2014



Tobacco control alliances

Tobacco control alliances are locally accountable partnerships that plan and deliver comprehensive strategies to reduce the harm of tobacco. Three quarters (76 per cent) of the local authorities represented by survey respondents are part of tobacco control alliances. Nearly all (93 per cent) of the respondents who participated in an alliance felt that the alliance was important to the delivery of tobacco control and smoking cessation outcomes locally (Figure 4.3).

Figure 4.3. Importance to respondents of tobacco control alliances in delivering tobacco control/smoking cessation outcomes



The opportunities for collaborative work within local authorities

Respondents were asked to describe any tobacco control or smoking cessation initiatives in their locality that had been made possible by inter-departmental relationships within their local authority.

Over two-thirds of respondents (69 per cent) gave details of one or more projects in response to this question. The departments mentioned most often were those with a track record of working with tobacco control: trading standards and environmental services, closely followed by children and young people's services. However, many other partners were also mentioned: parks and recreation services; housing; drug and alcohol teams; licensing and regulatory services; planning and transport departments; human resources; plus the fire and police services.

These findings also correspond to those from a recent survey conducted by Chartered Institute of Trading Standards. They found that there was significant tobacco control enforcement activity and strong relationships with local public health teams with 77% of trading standards teams saying they work in partnership with public health[3].

Table 4.1 summarises the range of activity identified by respondents. This table is not comprehensive, as respondents were not asked to describe *all* the initiatives undertaken jointly with local authority colleagues. Nonetheless it gives an indication of the variety of work that the local government context has made possible, or at least made easier.

Table 4.1 Tobacco control/smoking cessation activities made possible by joint working with local authority colleagues

Area of work	*Reported activities included:*
Strategy/policy	CLeaR assessments undertaken cross-council
	New tobacco control policy / action plan
	Review of council smoking policy
	New Health and Wellbeing tobacco control focus on reducing health inequalities
	New e-cigarette policy
	Launch/re-launch tobacco control alliance
	Signing Tobacco Control Declaration
	Sector-led improvement review
Smokefree	Smokefree policy compliance within the council and by council staff
	Smokefree children's centres
	Smokefree homes training through children's centres
	Smokefree homes and cars initiative promoted through social housing provider
	Smokefree parks and outdoor areas
	Smokefree playgrounds and play areas
	Smokefree touchlines and sports clubs
	Smokefree at the school gates
	Smokefree events
	Protection for council staff who visit people's homes
	Dealing with shisha premises
Young people	Incorporating tobacco in young people's substance misuse programmes
	Multi-agency programme on reducing young people's access to, and use of, tobacco
	Age-restricted products project
	New youth prevention programme in schools, amplified through social media
	Film on shisha shown in schools
	Development of mobile phone app in partnership with young people

[3] CTSI, Tobacco Control Survey, England 2014/15, November 2015

	Integration of tobacco control messages in school curriculum
	Sessions for children in residential care
	Free proof of age cards for 18-year-olds
Enforcement	Illicit and counterfeit tobacco programmes
	Increases in seizures and convictions for sale of illegal tobacco
	Improved intelligence on illicit tobacco sales
	Sniffer dog operations
	Multi-agency work to crack down on ‘head shops’, proxy sales, underage sales and illicit tobacco
	Embedding tobacco control in mainstream enforcement teams
	Resources and training for retailers
Awareness	Stoptober and No Smoking Day
	Joint awareness programme on the dangers of non-RIP cigarettes
	Smokefree homes/stop smoking communications to local authority housing tenants
	‘Get money smart’ campaign
	New factsheets on e-cigarettes, shisha and cannabis
	‘Faulty chargers’ e-cigarette campaign
Cessation	Providing smoking cessation to refuse collectors
	Fixed penalty notice scheme for littering or smoking in prohibited areas, linked to refund for successful quit
	Programmes for young people
	Training health champions across council in smoking cessation
	Training children’s centre staff to be stop smoking advisors
	Outreach into deprived communities including council estates
	Free leisure centre passes for pregnant women who quit
	Collaborative programmes to support women to stop smoking in pregnancy
	Pregnancy pilot with children’s centres and maternity services
	Training sixth form college students as level 1 advisors
	Tackling high smoking prevalence among clients with mental illness
Research	Illicit tobacco survey
	Research into smoking in the Turkish community
	Smoking behaviour among young people survey

Supra-local work

Respondents were asked if they worked with other councils in the area (supra-locally or regionally) to deliver tobacco control/smoking cessation interventions. Seventy-one per cent said that they did so. These partnerships are diverse and include joint commissioning programmes, joint alliances, joint delivery groups, networks for sharing information and best practice, and *ad hoc* partnerships for specific pieces of work. Many local authorities still collaborate principally by funding a regional tobacco control organisation, which operate in the northwest, northeast and southwest of England. A regional tobacco control post is also funded in Yorkshire and Humber.

The main areas of collaboration or joint commissioning, each identified by more than ten respondents, were smoking cessation services, tackling the illicit trade, communications/campaigns and programmes for pregnant women. Other areas of work that were each identified by less than ten respondents were smokefree programmes, sharing good practice, training, and data sharing.

Respondents were also asked if they were satisfied with the current level of national leadership on tobacco control from government, Public Health England and other statutory bodies. Overall, 45 per cent were satisfied, 50 per cent were not satisfied and 5 per cent did not know.

Discussion

To be effective, local tobacco control strategies need to be comprehensive and cross-cutting, bringing together diverse actions to help smokers quit, prevent smoking uptake and reduce exposure to secondhand smoke. Local authorities are well-placed to lead such strategies, given their extensive community links which offer diverse opportunities to reach smokers and potential smokers alike. The results above suggest that these opportunities are being grasped by many tobacco control leads, who have built productive relationships with their colleagues and are working with them to reach communities and deliver new initiatives across the full scope of tobacco control activity. However, given the number of respondents reporting no relationship with key local authority partners, it is clear that many of these opportunities remain unexploited.

The improvements in relationships with health services are also encouraging, given the recent history of tobacco control leaving its long-established NHS home. The widely reported improvements in relationships with NHS mental health and maternity services are particularly significant, given the importance of reducing smoking prevalence among mental health services users and pregnant women. These changes may reflect the impact of the 2013 NICE guidelines on tackling the harm of smoking through acute, mental health and maternity services[4] and subsequent national action to address these issues including specific guidance on smoking cessation in mental health service settings from Public Health England[5,6]. The report of the Smoking in Pregnancy Challenge Group was also published in 2013[7].

The exception of respondents' relationships with GPs is notable. There has been improvement here, for 17 per cent of respondents, but more have seen a decline. The decline is not as great as over the period of transition, but the fact that the trend remains negative is of concern. These results are consistent with data from the Smoking Toolkit Study which indicate that the proportion of smokers who have been advised to stop or offered help to stop smoking by their GP has declined since 2012, the year before the transition of public health to local government[8]. Sitting at the heart of community health services, GPs ought to be leading players in reducing smoking prevalence, yet they appear to remain marginal to this task in many areas.

[4] NICE guidelines: *Smoking: acute, maternity and mental health services* [PH48], NICE 2013
[5] Public Health England: *Introducing self-assessment for NICE guidance smoking cessation in secondary care: mental health settings (PH48), A practical guide to using the self-assessment model*, PHE 2015
[6] Public Health England: *Smoking cessation in secure mental health settings: Guidance for commissioners*, PHE 2015
[7] Smoking in Pregnancy Challenge Group: *Smoking in Pregnancy: a call to action*, Smokefree Action Coalition, 2013.
[8] Smoking Toolkit Study 2015 www.smokinginengland.info.

5. Changes in budgets and services

Key findings

- Smoking cessation budgets were cut in 39 per cent of upper-tier local authorities in England in 2015-16, including 29 per cent where the cut was greater than 5 per cent. Budgets increased in 5 per cent of local authorities.
- Wider tobacco control budgets were cut in 28 per cent of local authorities in 2015-16 and increased in 10 per cent.
- Cost pressures within local authorities due to central government cuts was the principle reason given for cuts to smoking cessation and wider tobacco control budgets.
- Cuts to smoking cessation and tobacco control budgets were unrelated to the level of active political support or priority given to tobacco control within local authorities.
- Cuts to tobacco control budgets, but not smoking cessation budgets, were much more common in local authorities that had experienced deep council-wide cuts over the period 2010-2014.
- At the time of the survey, only 10 respondents knew what the impact of the national in-year cut in the public health budget would be on their own budgets.
- There has been a net increase in the time given to tobacco control by respondents to the survey. In some areas this is a consequence of a loss of wider organisational capacity for tobacco control.
- Smoking cessation services have been undergoing significant change across the country with 53 per cent of respondents describing some form of reconfiguration or recommissioning. One in five respondents described a move to integrate smoking cessation into a wider lifestyle service. Elsewhere, specialist services are being increasingly targeted on priority populations.

Budgets for smoking cessation and tobacco control

Respondents were asked if their smoking cessation and tobacco control budgets had increased, decreased or stayed the same between 2014-15 and 2015-16. Overall, smoking cessation budgets were down: in 39 per cent of local authorities, smoking cessation budgets had been cut compared to only 5 per cent where they had increased. They stayed the same in 54 per cent of local authorities. More than a quarter of local authorities (29 per cent) had seen cuts of more than 5 per cent (Figure 5.1). Similar, though less pronounced, results were reported for tobacco control budgets: they had been cut in 28 per cent of local authorities, increased in 10 per cent, and remained the same in 62 per cent.

No other factor explored in this survey was statistically correlated with experience of budget cuts. Cuts were no more likely in local authorities where political support for tobacco control was lacking than in authorities where key members and officers actively supported the work of tobacco control leads. Likewise the likelihood of cuts was unaffected by whether the priority of tobacco control was perceived by respondents to be above average, average or below average. However the effect of cuts on feelings about the future approached significance (see page 21).

Figure 5.2 compares the budget changes identified by the survey to the changes recorded in the 2014 survey, in which budgets for 2014-15 were compared to budgets for 2012-13, the last year in which tobacco control remained in NHS primary care trusts. Smoking cessation and tobacco control budgets have in the last year suffered much greater cuts than in the early period of transition.

Figure 5.1. Changes to local authority smoking cessation and tobacco control budgets between 2014-15 and 2015-16 ('don't know' responses excluded)

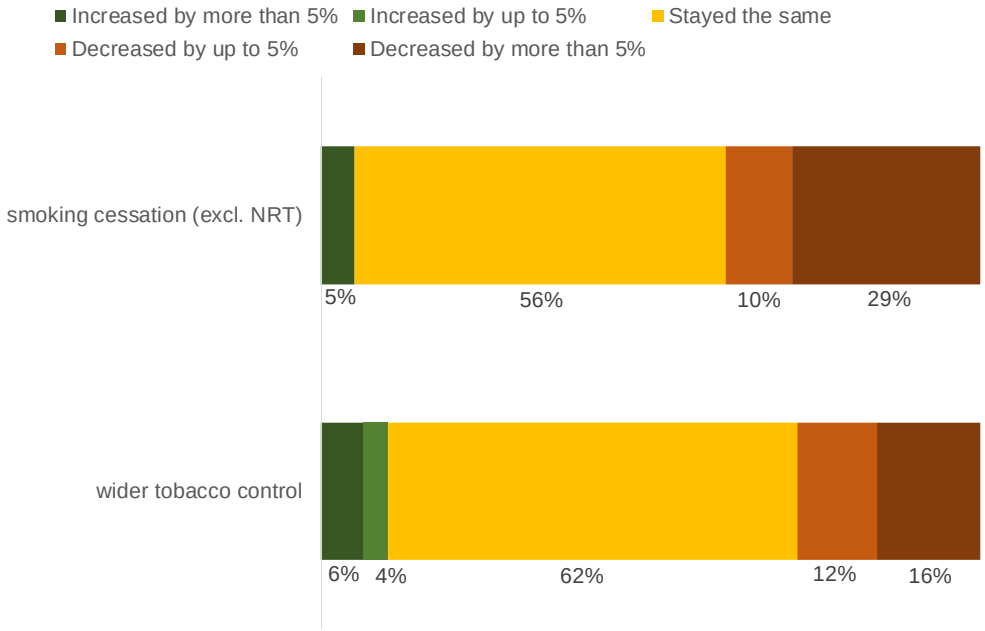
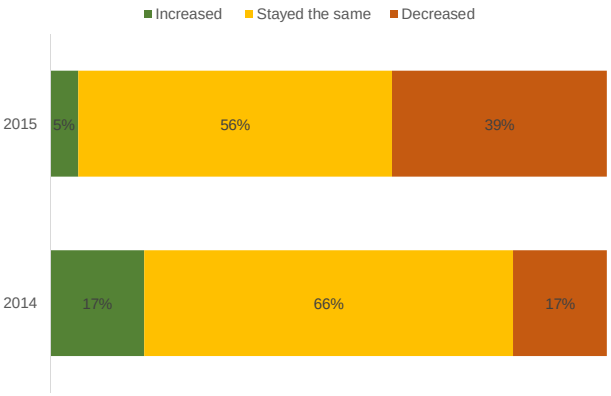
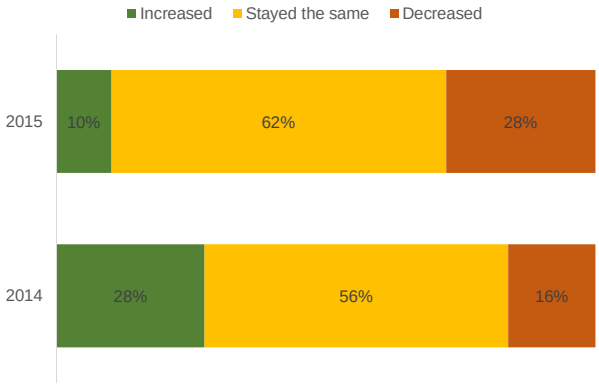


Figure 5.2. Comparison of changes to local authority smoking cessation and tobacco control budget: survey year 2015 (change in budget from 2014-15 to 2015-16) and survey year 2014 (change in budget over transition period from 2012-13 to 2014-15)

Smoking cessation



Wider tobacco control



The most common reason given for reductions in the smoking cessation and tobacco control budgets was the cost pressures within local authorities due to central government cuts. This was specifically identified, in response to an open question, by 17 per cent of all respondents (n=20). Other reasons cited by respondents were:

- Cuts in the national public health allocation or reprioritisation within local public health budgets
- Recommissioning, new approaches to service delivery, or the loss of non-recurrent project costs
- Reduced demand for stop smoking services

Budget increases largely reflected service developments including a new smoking in pregnancy scheme, a smokefree homes programme, a school peer mentoring service, the creation of

smokefree playgrounds, the promotion of smokefree cars, and a new funding allocation to regional partnership work.

These results exclude smoking cessation treatment costs, which are being borne, wholly or partially, by nine out of ten (89 per cent) local authorities, with 55 per cent bearing the entire treatment budget. Contributions to the treatment budget are also made by CCGs (in 31 per cent of localities), GPs (12 per cent) and NHS Trusts (10 per cent).

Tobacco control budgets and council-wide cuts

Respondents were not asked about the size or scale of central government cuts to their local authority budgets as a whole. Data are, however, available on the changes in local authorities' overall spending power between 2010-11 and 2014-15, compiled by Newcastle Council[9]. Although tobacco control has only been based in local authorities for the last two years of this four-year period, these data provide an overall indication of the relative size of the cost pressures which local authorities have faced in these two years.

Data from this public dataset were available for 65 of the local authorities represented in this survey. A simple statistical comparison was made between local authorities that had experienced large central government cuts of more than £250 per capita and those that had experienced cuts of anything up to £250 per capita. Cuts to smoking cessation and wider tobacco control budgets were treated as the dependent variables.

There was no relationship between the experience of deep council-wide budget cuts and reported cuts to smoking cessation budgets. Respondents were no more likely to report a cut to their smoking cessation budget if they were based in an authority that had experienced cuts of more than £250 per capita than those respondents based in local authorities that had experienced less severe cuts. There was, however, a strong relationship between the experience of deep council-wide budget cuts and reported cuts to wider tobacco control budgets. In 62 per cent of the local authorities that have experienced deep cuts, tobacco control budgets were also cut this year, compared to 22 per cent of local authorities that have experienced lesser cuts ($p<0.01$).

The impact of the in-year cut in the national public health budget

The survey was conducted in July and August 2015, not long after the national announcement of an in-year £200m cut in the local public health budget, made on 4th June 2015. Respondents were asked if they knew what the impact of this cut would be. A majority – 58 per cent – did not know at that time what the local impact would be; a third (33 per cent) had 'some idea' and 9 per cent said they knew what the impact would be. The few (10 respondents) who knew what the impact would be described this impact principally in terms of cost savings, decommissioning and recommissioning with a leaner specification. However two said there would be no impact in 2015-16.

Respondents' time for tobacco control

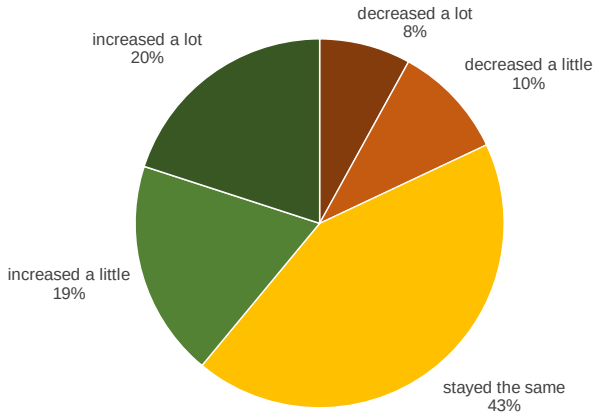
Respondents were asked if the time they personally spent on tobacco control and smoking cessation had changed over the previous year. Overall, an increase in time was more than twice as common as a decrease in time: 39 per cent of respondents were spending more time on tobacco control compared to 18 per cent who were spending less time, with 43 per cent reporting no change (Figure 5.3).

[9] Council spending cuts: the north loses out to the south. Patrick Butler's blog, *The Guardian*, 11th January 2013.

The main reason given by respondents for spending more time on tobacco control was an increase in the tobacco control workload, frequently due to recommissioning. New strategies, signing the Local Government Declaration, and involving new stakeholders were also cited. Most of the respondents who were spending *less* time on tobacco control reported that they now had additional portfolios to manage.

A reduction in organisational capacity for tobacco control, for example due to the loss of posts, was given as a reason for a change in personal time, more often for increases in time than decreases in time, by 10 per cent of all respondents.

Figure 5.3. Changes in the time respondents spent on tobacco control



Changes in smoking cessation and tobacco control services

Respondents were asked to describe in their own words any changes in services that had been made or were planned for the current year. Almost all respondents answered but 17 per cent said there were no changes to report.

Over half the respondents (53 per cent) described some form of reconfiguration or recommissioning of local smoking cessation services. One in five (19 per cent) described a shift to an integrated approach in which smoking cessation is delivered as part of a wider 'lifestyle' package including, for example, measures to tackle obesity and reduce the harm of alcohol. This has meant the loss of some specialist support, though most respondents were positive about the opportunities the approach presented:

> "Public Health has recently commissioned the Healthy Lifestyle Service which adopts an integrated approach to behaviour change, addressing multiple lifestyle risk behaviours: physical activity, smoking cessation, weight management and alcohol. The stop smoking element will be available to all smokers requiring access to support including pregnant women."

This quote reveals a tension between reaching more people through a generic approach and targeting services more effectively on those most in need. Fifteen per cent of respondents identified the latter as a key issues for their recommissioning. These respondents were not pursuing an integrated route but typically focussing specialist services more carefully:

> "More emphasis on targeted work: most disadvantaged wards with high prevalence, clients with mental health issues, smoking in pregnancy, routine and manual. Less emphasis on 4 week quits, although retaining a target."

Other changes to smoking cessation services described by respondents included the introduction of a harm reduction offer, increasing the overall accessibility and flexibility of services, and changing the provider mix responsible for delivering the service.

Few respondents described changes to wider tobacco control work, though there was some mention of promoting smokefree in the NHS and in wider society, and of tackling illicit tobacco. This is not because little wider tobacco control work is going on (Table 4.1 suggests the contrary), but rather that 'significant changes' in services are dominated by changes to smoking cessation services. The following comment reveals the primacy of smoking cessation services in respondents' answers to this question:

> "The target for smoking cessation has been reduced. We are considering if, and how, we can include harm reduction into the smoking cessation service. We are using locally commissioned social marketing research to better target the smokers in our area. We are increasing the amount of outreach work that we do in community and workplace settings. Wider tobacco control initiatives are being rolled out around the county - e.g. illicit tobacco (confirmed), smoke free homes and cars (confirmed), smoke free play areas (being considered)."

Targets

Smoking cessation service outcomes continue to dominate the specification of targets. Respondents were asked to describe any targets they have in their own words. Nine out of ten respondents (89 per cent) reported that they had one or more targets. By far the most common target remains four-week quitters, though this is often supplemented by other quitting targets including 12-week quitters, the number of smokers (or the proportion of the local smoking population) accessing services, or the level of access by priority groups such as routine and manual workers, people with mental health needs, black and ethnic minority clients, young people, and pregnant women.

Some local authorities are adopting prevalence targets, which effectively encompass the impact of tobacco control work as well as smoking cessation services. Specific targets for tobacco control are typically linked to the specification of particular projects, for example targets to reduce tobacco-related litter, increase illicit tobacco seizures and increase the number of public smokefree areas.

Discussion

The budget cuts reported by respondents to this survey were driven by a variety of factors including recommissioning, reduced demand for smoking cessation services and the loss of one-off project development costs. However the pressure on local authority budgets due to cuts in central government funding was the leading reported cause. The ring-fence around public health budgets has proved to be far from impermeable.

The lack of any significant association between experience of budget cuts and political leadership or priorities is consistent with the cuts being part of an organisation-wide process, in which every department must absorb its share of the change. In general, the cuts do not appear to be the product of political decisions to disinvest in tobacco control. Nonetheless, political support is likely to be crucial in the longer term in containing the impact on tobacco control budgets of further council-wide cuts, especially when the public health ring-fence is removed.

The analysis of the relationship between council-wide cuts and cuts in tobacco control and smoking cessation budgets, using the Newcastle Council dataset, is limited given the smaller subsample used and the different time periods from which the data were gathered. Nonetheless it is does not

bode well for the future that cuts to wider tobacco control budgets appear to have been much more common in areas which have experienced deep cuts to their central budgets.

The changes taking place within smoking cessation services, budget-driven or otherwise, raise many questions about the efficacy and outcomes of these services. New approaches are needed, especially in addressing the inequalities that characterise the smoking epidemic, but as always they need to evidence-based and consistent with NICE guidelines[10]. In particular, the shift to 'integrated' or 'lifestyle' services in which smoking cessation is offered as part of a wider package of measures designed to reduce personal health risks has limited support from the evidence base. A long-standing Cochrane review of the outcomes of multiple risk factor interventions for the primary prevention of coronary heart disease, updated in 2011, did not find a significant effect on smoking rates from these interventions[11]. Local authorities may reasonably want to distance themselves from 'medical models' and adopt 'holistic' approaches to health[12], but this should not be at the expense of service models that have a track record for effectiveness.

6. The pros and cons of local government

Key findings

- The benefits of the local government context were widely acknowledged by respondents to the survey. Above all, they valued the constructive relationships with their colleagues in other departments (cited by 86 per cent) and the integration of tobacco control in the wider strategy and business of the council (60 per cent).
- The leading difficulty of the local government context, identified by 75 per cent of respondents, is the pressure on tobacco control and smoking cessation budgets, followed by bureaucratic procedures and the demands of a political culture.
- Half of respondents (51 per cent) identified a loss of personnel and/or time devoted to tobacco control.
- A majority of respondents felt positive about the future: 59 per cent were positive about the future of smoking cessation services and a slightly different 59 per cent were positive about the future of wider tobacco control in their local authority. However nearly a quarter of respondents (24 per cent) felt negative about the future of tobacco control services and 21 per cent felt negative about the future of smoking cessation services.
- A positive outlook was associated with active support for tobacco control from key members and senior officers, a perception of a high priority for tobacco control in their local authority, constructive relationships with colleagues in other departments, and the integration of tobacco control in the wider business of the council.

[10] NICE guidelines: *Stop Smoking Services* [PH10], 2008
[11] Ebrahim S, Taylor F, Ward K, Beswick A, Burke M, Davey Smith G: *Multiple risk factor interventions for primary prevention of coronary heart disease*. Cochrane Database of Systematic Reviews 2011.
[12] Local Government Association: *Public health transformation: adding value to tackle local health needs*, February 2015

The benefits of the local government setting

The 2014 survey of tobacco control leads asked respondents to identify in their own words what they felt the benefits of the local government setting to be. The principal benefits they identified were:

- Constructive relationships with local authority officers in other departments
- Integration of tobacco control into the wider strategy and business of the council
- A broad view of the scope of tobacco control
- High-level political support for tobacco control
- High status and power of director of public health
- Increased funding for tobacco control/smoking cessation

These themes were used to define a closed question in the current survey in order to quantitatively asses the prevalence of these perceived benefits. Respondents were also given the opportunity to describe additional benefits in their own words. Figure6.1 illustrates the results.

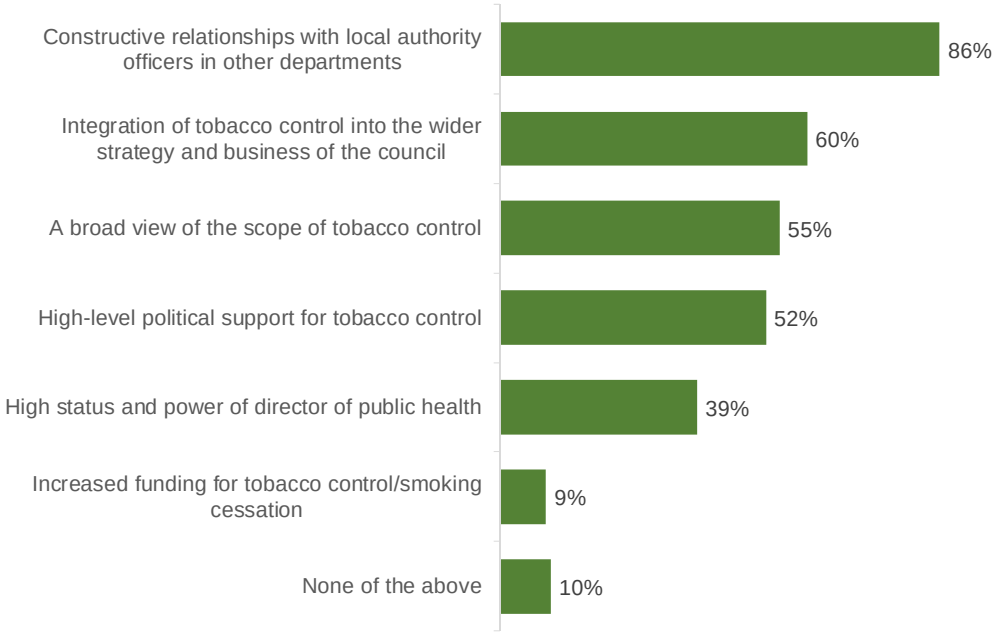
The most widely acknowledged benefit was the constructive relationships that tobacco control leads have built with officers in other departments. This result is consistent with the results set out in Section 4, which describes the extent to which relationships have improved, and the many opportunities that have been taken by respondents to pursue tobacco control initiatives with their colleagues in other departments. The second highest scoring benefit, the integration of tobacco control in the wider business of the council, is a similar theme to the first but goes beyond relationships to policy, strategy and everyday practice.

Among the ‘other’ responses to this question, one additional benefit was identified by several respondents: the access to the wider community offered by the local authority. The following responses describe this benefit in different ways:

> “The local authority is community focussed and this is shaping a new approach for public health. Health inequalities are extremely relevant to local government and tobacco use is a key example of this.”
>
> “Access to food premises and their employees through regulatory/environmental health services.”
>
> “Better reach into local communities and schools. More of a prevention agenda. Less target driven culture.”
>
> “Front facing with members of town who already access numerous services provided by council.”
>
> “Relationships with other public agencies - police, fire, HMRC etc.”

This emergent theme takes the theme of integration one step further: beyond relationships and strategy to the population and communities that the local authority serves.

Figure 6.1. Perceived benefits of the local government context for tobacco control



The difficulties of the local government setting

The 2014 survey of tobacco control leads also asked respondents to identify in their own words what they felt the difficulties of the local government setting to be. The principal difficulties they identified were:

- Pressure on tobacco control/smoking cessation budgets
- Bureaucratic procedures
- Demands of a political culture
- Loss of personnel and/or time dedicated to tobacco control
- A lack of understanding of the importance of tobacco control/smoking cessation
- Poor relationships with the NHS

As with the perceived benefits, these themes were used to define a closed question in the current survey in order to quantitatively asses the prevalence of these perceived difficulties. Respondents were also given the opportunity to describe additional difficulties in their own words. Figure 6.2 illustrates the results.

Pressure on budgets was the most widely cited difficulty, identified by three quarters of all respondents. The linked difficulties of bureaucratic procedures and the demands of a political culture were also identified by a majority of respondents. Half of respondents (51 per cent) reported a loss of personnel and/or time devoted to tobacco control.

The answers to the ‘other’ option tended to reiterate and elaborate the themes in in Figure 6.2. The demands of a political culture, including its bureaucracy, were brought up by several respondents and their comments highlight the importance, for tobacco control leads, of being able to operate effectively in this political environment:

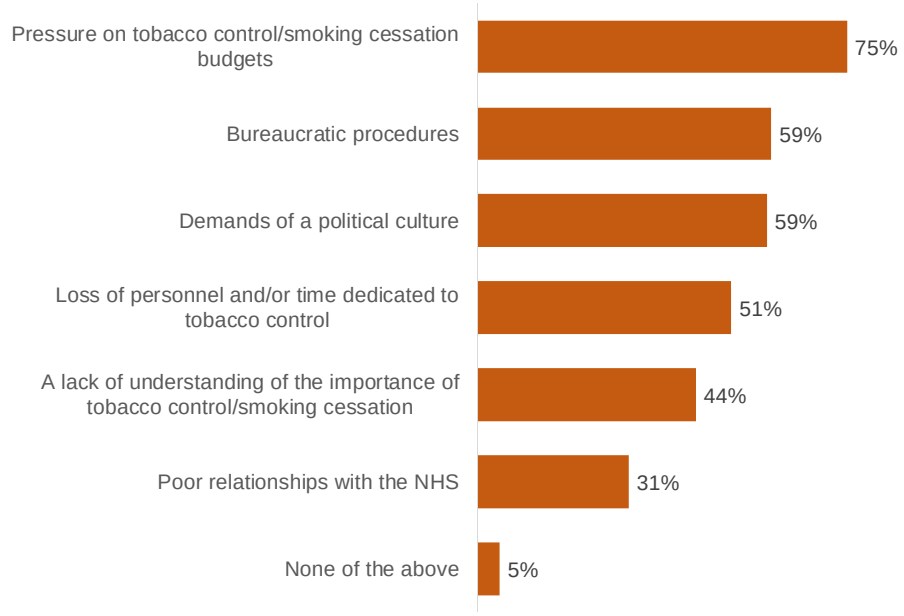
> “Engagement of elected members needs to be a constant activity to ensure personal opinions of elected members do not overshadow evidence-based strategies from officers/experts.”

> “Everything has to go through multiple boards. There’s some political interest in the money spent supporting NHS budgets rather than Council budgets.”
>
> “Only people of a certain status or seniority can make decisions that will address strategic or structural issues and this can mean slow or no progress at a strategic level for long periods of time. Currently there is very little commitment from relevant stakeholders (other than public health) to address tobacco related harm. In response to this I am working with my manager to use the CLeaR tool. I am confident that this will make it easier to make progress with the structural/strategic issues.”
>
> “The bureaucratic process to progress with work significantly adds more time to achieve things. There is at times pressure to provide interventions based on opinion and what would look good politically rather than evidence-based practice.”

Several respondents also said more about their relationships with the NHS:

> “I wouldn't say our relationship with the NHS is poor. It’s just sometimes more of a challenge to maintain and develop relationships now we're no longer an NHS service.”
>
> “There has been less engagement of GP localities than previously despite CCG leadership. GP smoking cessation performance has declined considerably.”
>
> “Relationships with GPs are still good but they are no longer contractually-obligated to us. This requires support from NHS England.”

Figure 6.2. Perceived difficulties of the local government context for tobacco control



Future prospects

Respondents were asked to indicate how they personally felt about the future of smoking cessation services and wider tobacco control work in their locality. Figure 6.3 illustrates the results. A majority of respondents felt positive about the future of both smoking cessation services (59 per cent) and wider tobacco control work (also 59 per cent).

The similarity of the two pie charts in Figure 6.3 suggests that respondents tended to feel the same way about the future of both smoking cessation services and wider tobacco control work. In fact, a

third (32 per cent) gave a mixed response to the two questions. Overall, 47 per cent of respondents were consistently positive about the future and 13 per cent were consistently negative.

There were no statistically significant associations between respondents' feelings about the future and their experience of budget cuts, though the association approached significance for tobacco control budgets: 58 per cent of those who had not experienced a cut in this budget were positive about the future compared to 38 per cent who had seen their budget cut (p=0.07). However there was a significant association between negative feelings about the future and the identification of pressure on tobacco control/smoking cessation budgets as a current difficulty of the local government context.

It was people rather than resources that clearly predicted the outlook expressed by respondents. There were significant positive associations between respondents' outlook (on both smoking cessation services and tobacco control) with active support from the leader, lead member for health and wellbeing, chief executive, director of adult social care and children's director. Only the association with active support from the director of communications was not significant (support from the director of public health was too undifferentiated across the sample to enable testing).

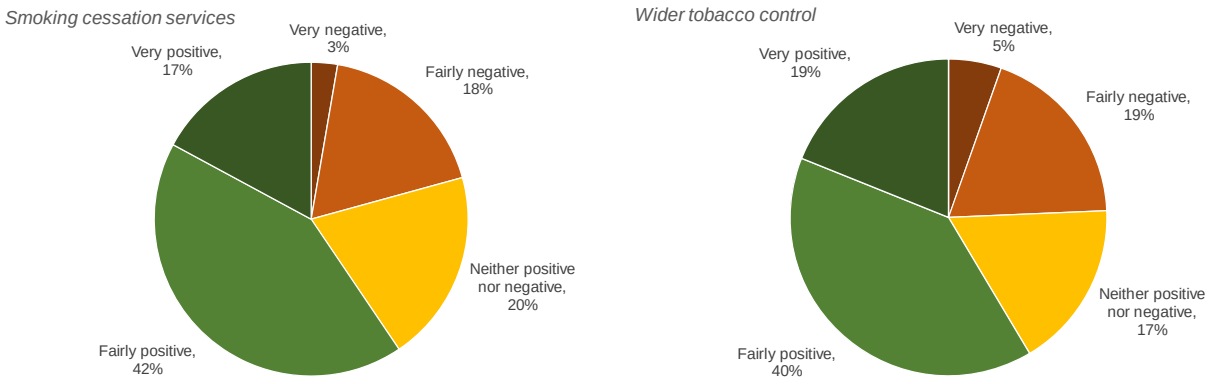
Respondents were also more likely to feel positive about the future if:

- they perceived tobacco control to have a high priority in their local authority;
- they had built constructive relationships with local authority officers in other departments; or
- they had witnessed the integration of tobacco control into the wider business of the council.

They were additionally *less* likely to feel positive about the future if they identified the demands of a political culture as a problem of the local government setting or felt that there was a lack of understanding in the local authority of tobacco control and smoking cessation.

Respondents' positivity about the future has declined since the 2014 survey, when the question was asked about smoking cessation services and tobacco control combined. Then, 67 per cent of respondents were positive, 14 per cent were negative and 18 per cent were neither positive nor negative.

Figure 6.3. Respondents' feelings about the future of smoking cessation services and wider tobacco control work in their locality



Discussion

The benefits of the local government context described by respondents to the 2014 survey were largely confirmed by the quantitative measure used in the 2015 survey. The only benefit to have

largely lost its salience was ‘increased funding for tobacco control’. As discussed in Section 4, tobacco control leads are making the most of the opportunities of local government by building relationships with their colleagues in other departments and seeking to integrate tobacco control in the wider business of the organisation. This integrative approach, which extends to the community that the local authority serves, may yet help to sustain the work of tobacco control and smoking cessation if budget pressures increase further.

Further budget cuts were clearly a concern for survey respondents, as 75 per cent identified pressure on tobacco control/smoking cessation budgets as the leading difficulty they face, far more than the minority of respondents who actually reported budget cuts. This is perhaps not surprising, given the in-year cut in the national public health budget, which was announced not long before the survey was launched, the loss of the public health budget ring-fence, and the outlook for local authority budgets as a whole. The result is consistent with the earlier LGA opinion survey of lead members for health and wellbeing, three fifths of whom identified insufficient resources as the main barrier to their council achieving better public health outcomes over the next two years[13].

Although most tobacco control leads enjoy the political support of key members and senior officers, they also acknowledge the difficulties created by a political culture, not least its attendant bureaucracy. Arguably, such difficulties are perennial: a necessary price to be paid for local accountability. However the other commonly-identified difficulties – loss of personnel time, lack of understanding of tobacco control, and poor relationships with the NHS – can all potentially be overcome.

Respondents’ views of the future of smoking cessation and tobacco control suggest that current pressure on budgets has not dampened the opinion of many that the local government context is a good place to deliver outcomes for smoking cessation and tobacco control. There has, however, been a fall in the number reporting a positive outlook since 2014, increasing the size of the minority whose outlook is negative. When a quarter of tobacco leads feel negative about the future of tobacco control in their area, there is cause for concern.

7. Conclusion

The results presented in this report are drawn from a survey of tobacco control leads in upper-tier local authorities in England. As such, they reflect the views and perceptions of these individuals and not the outcomes of their actions. The aim of this study is to inform the work of tobacco control professionals, not to evaluate their impact. Given the survey response rate of 87 per cent, the results provide a representative picture of the current experience of tobacco control leads in their relatively new local government homes.

There is a clear, if not precisely drawn, divide in the results between local authorities where political support for tobacco control is forthcoming, and those where this support is limited or non-existent. In the former, tobacco control professionals are likely to be thriving and feeling positive about the future, whereas in the latter they are more likely to be struggling and feeling negative about the future. Political support from key members and senior officers was the one factor in the survey that most often predicted positive results elsewhere.

[13] Local Government Association: *Public Health Opinion Survey*, February 2015.

A key challenge for the future is therefore to persuade all local authority decision-makers of the vital importance of tobacco control and smoking cessation services to the health and wellbeing of the populations they serve. In part, this requires that tobacco control professionals make the links between tobacco control and the other interests of local government, such as the health of children who are exposed to tobacco smoke, the impact on young people of smoking uptake, and the adverse effects of smoking on elderly and disabled clients.

The results from this study suggest that this integration of tobacco control with the broader interests of local authorities is, to date, the primary success story of tobacco control's short life in local government. Tobacco control leads are building new relationships, creating new alliances, devising new initiatives and bringing tobacco control to the table in wider policy discussions. The reach of local authorities, deep into local communities, offers excellent long-term opportunities for tobacco control and smoking cessation services.

As well as describing new initiatives made possible through the local government setting, many respondents also described changes to existing services, especially smoking cessation services. Here there is cause for concern, given that some of these changes are not evidence-based. In particular, the shift to delivering smoking cessation support as part of an integrated 'lifestyle' offer, described by a fifth of respondents, is not consistent with either NICE guidelines or with the best available evidence of what works. Great care is needed not to confuse a desire to pursue a social or holistic approach to health with a rejection of tried-and-tested specialist services that are known to be effective in helping smokers quit.

The cloud that looms over the generally positive outlook expressed by respondents to the survey is the threat of significant budget cuts. Many tobacco control leads have already experienced cuts and many more are worried about how their work will fare in the face of cuts to local authority budgets and the national public health budget. The next two years are likely to be critical. The results here suggest that tobacco control is likely to be most vulnerable to these cuts in those local authorities where active political support is lacking. However the financial pressure is considerable and tobacco control leads everywhere may have to be resourceful in sustaining their vital local contribution to the long-term goal of ending the smoking epidemic.