Tailored Review of Public Health England: Call for Evidence

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Response from Action on Smoking and Health

About You

Amanda Sandford
Information Manager
Action on Smoking and Health
Amanda.sandford@ash.org.uk
020 7404 0242

Action on Smoking and Health ("ASH") is a health charity that works to eliminate the harm caused by tobacco. It was established in 1971 by the Royal College of Physicians. The organisation is led by its Chief Executive, Deborah Arnott, and is governed by a Board of Trustees. Its Patron is HRH the Duke of Gloucester. ASH provides the secretariat for the All Party Parliamentary Group on Smoking and Health. Its funding is provided principally by Cancer Research UK and the British Heart Foundation. ASH has also received specific project funding from the Department of Health to support work to reduce smoking prevalence.

Q1 **What do you think should be the key priorities and primary functions of PHE?**

We consider that the work of PHE should be prioritised primarily by consideration of:

a) Evidence of the extent of harm and contribution to health inequalities caused by the public health problem that PHE is attempting to address. This necessarily means that tobacco control is and must remain a key priority.
b) Evidence that there are known policy levers, relevant to the work of PHE, that can reduce or eliminate the harm.

This necessarily means that reducing tobacco consumption is and will remain a key PHE priority.

About half of all lifelong smokers will die prematurely, losing on average about 10 years of life,[1] and smoking is a major cause of health inequalities, being responsible for half the difference in life expectancy between the most and least affluent in society.[2] Smoking in England causes more premature deaths than obesity, alcohol, road traffic accidents, illegal drugs and HIV infection combined.[3]

Most people start smoking as children. Among existing adult smokers, almost two fifths took up smoking tobacco before they were 16 years old; almost two thirds as children (i.e. under 18) and four fifths before they were 20 years old. Smoking initiation is associated with a wide range of risk

[1] Doll R, Peto R et al Mortality in relation to smoking: 50 years' observations on male British doctors *BMJ* 2004; 328

2 Jha P, Peto R, Zatonski W, Boreham J, Jarvis MJ, Lopez AD. Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland, and North America. Lancet. 2006 Jul–Aug;368:367–70.

[3] Statistics on obesity, physical activity and diet: England, 2014. Health and Social Care Information Centre, 2014. Statistics on Alcohol: England, 2014. Health and Social Care Information Centre, 2014. Reported Road Casualties in Great Britain: Main Results 2013 Dept for Transport, 2014. Statistics on Drug Misuse, England - 2012 NHS Information Centre for Health and Social Care. National AIDS Trust. Statistics, 2013

factors including smoking by parents, siblings and peers and socio-economic status. Smoking rates are higher among particularly vulnerable groups, including children in care.[4] Once smokers are addicted it is difficult to quit: the 2008/09 "Smoking-related Behaviour and Attitudes" survey found that 26% of smokers had attempted to quit in the previous year and as many as 21% of smokers had made three attempts in the previous year alone. [5] However, only about one in twelve were successful in stopping smoking for two or more years.

The policy levers known to be effective in reducing tobacco consumption include:

- Tax and price (not directly within PHE's remit, but an issue on which PHE may wish to advise and be consulted).
- Provision of effective stop smoking services, and appropriately regulated nicotine products as alternatives to smoking, such as NRT and e-cigarettes. PHE has an essential role to play in promoting such services to local authorities and other possible providers, and in advising and developing policy on alternative nicotine products, including encouraging manufacturers of suitable products to seek medicines authorisation for their products.
- The introduction of progressive restrictions on advertising, marketing and branding on tobacco products. For example, PHE will wish to use the introduction of standardised packaging from 20th May 2016 onwards as an opportunity to try to amplify the effect of the packaging in reducing the number of children and young people who start to smoke, and encouraging existing smokers to quit.
- Restrictions on those places where people may smoke, including those places where local authorities have discretion to act (e.g. parks, playgrounds and beaches). PHE has an important role to play in advising on and supporting this kind of discretionary action.
- Ensuring that action to reduce tobacco consumption is effective with those particularly vulnerable groups who may otherwise be "left behind" as tobacco consumption falls. These groups include, but are not limited to, children and young people in care, people with a mental health condition and prisoners. PHE has an important role to play in helping to develop and support specific policies to reduce smoking rates in each of these groups.
- Working to reduce the class and income gradient of smoking prevalence. Smoking is more than twice as common in the 'routine and manual' socio-economic group than in the 'managerial and professional' group. Across Great Britain, 23% of those with an annual income of less than £10,000 are current smokers, compared with 11% of those with an annual income of £40,000 or more. [6]
- Action at international, national, regional and local level to combat the illicit tobacco trade. As well as requiring work by enforcement authorities, including police, customs and trading standards, there is also a demonstrated need for co-ordination between these authorities and public health organisations, and PHE should support such co-ordination. [7]

[4] Mooney A, Statham J, Monck E, Chambers H. Promoting the Health of Looked After Children, A Study to Inform Revision of the 2002 Guidance Research report by the Thomas Coram Research Unit Institute of Education, University of London, and National Children's Bureau, (for the Department for Children, Schools and Families). June 2009. Also see: Joint statement of the Smokefree Action Coalition and the Fostering Network on smoking and foster care. November 2009

[5] Lader D. Opinions Survey Report No. 40 - Smoking-related behaviour and attitudes. 2008/09 Office for National Statistics, 2009

[6] Opinions and Lifestyle Survey. Adult smoking habits in Great Britain, 2014, ONS, 2016

[7] See for example the Tackling Illicit Tobacco for Better Health Partnership

The latest NHS Five Year Forward View points out 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. 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. Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smoke… These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from 2% in west London to 28% in Blackpool."* [8] **We consider that PHE has a central to play in delivering this *"radical upgrade"* and that this requires focussed and effective action to cut smoking rates.**

Q2 **Should PHE continue to undertake all of its four main functions?**

Yes. All four core functions are important:

- protecting the public's health from infectious diseases and other hazards to health
- improving the public's health and wellbeing and reducing health inequalities
- improving population health through sustainable health and care services
- building the capability and capacity of the public health system

ASH works to eliminate the harm caused by the consumption of tobacco. This is clearly related to all four of PHE's current main functions. We are particularly concerned that tobacco control continues to be a priority for public health policy and practice, and to be fully effective this requires a "joined up" integrated approach that utilises various policy levers, including marketing and information campaigns and the provision of stop smoking services. PHE has a crucial role to play in ensuring that tobacco control is properly "joined up" across the country and across the various elements of the health system including local authorities, the DH, the NHS, and the MHRA.

We are very concerned by recent cuts in public health spending in local authorities, particularly on smoking cessation and wider tobacco control work. An ASH survey of tobacco control leads in England, published in January 2016, found that in 2015/16 smoking cessation budgets had been cut in 39% of upper-tier local authorities in England, and wider tobacco control budgets in 28%. [9] ASH is currently undertaking its survey for 2016/17 and it is expected this will find that cuts to public health budgets are continuing to feed through to reduced spend on tobacco control and smoking cessation. And this is before 2017/18 when the ring-fence on public health funding is to be lifted, which will have a significant, and variable impact on future spend by local authorities, with authorities with the highest level of social need facing the biggest cuts and therefore most likely to cut spend on public health.

Early indications are that funding cuts in mass media spend and public health budgets are already threatening to halt or reverse long-term falls in smoking prevalence. The latest data from the Smoking Toolkit Study, a monthly household survey of representative samples of approximately 1800 adults per wave (16+ years old) in England, suggests that smoking prevalence has already stopped declining and seems to be flatlining (headline figures are 18.5% in 2014 to 18.7% in 2015 with 95% confidence intervals of ±0.5%, with the latest data for 2016 showing prevalence rates of 18.5%).[10] The rise in 2015 was the first time since the survey started in 2007 there was an increase in

[8] NHS Five Year Forward View: October 2014

[9] ASH. Reading Between the Lines: Results of a survey of tobacco control leads in local authorities in England, January 2016

[10] Smoking Toolkit Study. STS 140721. Top Line Findings from the STS. May 2016.

the headline figure; prior to that the average annual decrease over the previous 7 years was 0.8 percentage points per annum.

Q3 **How well do you think PHE fulfils its functions?**

Our response concentrates on the role of PHE in tackling the harm caused by smoking, which remains the leading public health problem for the UK. PHE at national level has played an indispensable role in tobacco control, and we consider the work of the national tobacco team to be of high quality. However, we are concerned that leadership at national level is insufficiently linked through to implementation at PHE centre level. Furthermore that lack of expertise, capacity and resource undermines the ability of the PHE centres to effectively support delivery at local level in local authorities and the NHS. In addition we are concerned that funding cuts are likely to lead to reductions in the national tobacco team's budget and the budget for mass media campaigns, and would consider this to be likely to reduce its effectiveness in this critically important area of public health.

Q4 **Does PHE demonstrate the level of scientific/medical expertise you would expect?**

In the area of tobacco PHE has an excellent record of developing policy and activity based on the best available scientific and medical evidence. The foremost example is the role PHE has played, working in collaboration with the DH, NICE and the MHRA, in developing and promoting public policy on tobacco harm reduction. PHE has played a particularly important role in its work developing and disseminating the evidence base on the use of electronic cigarettes.

Q5 **Does PHE demonstrate the level of independence you would expect?**

We consider that in the area of tobacco control PHE has been clear and consistent in its work and activities, that it has been guided by the best available evidence and that it has not diluted or altered its approach in response to political or commercial pressure.

However, the remit letter for Public Health England says that *"PHE is the expert national public health agency which fulfils the Secretary of State for Health's statutory duties to protect health and address health inequalities, and executes the Secretary of State's power to promote the health and wellbeing of the nation".* In order to fulfil this role PHE should have done more to scrutinise the Government budget reductions for public health and to advocate for evidence-based funding levels rather than simply accepting the cuts uncritically. [11]

Q6 **Is PHE sufficiently accountable to the Department of Health, Parliament, and/or to the public, both in terms of the work it does and for the public money it spends?**

We consider PHE to set a reasonable standard for both transparency and accountability. However, we note the possible tension between accountability on the one hand to DH (and Government) and on the other to Parliament and the public, particularly over public expenditure decisions, and other Government decisions which may militate against achieving the objective of the NHS England Five Year Forward View of a *"radical upgrade in public health"*.

Q7 **Does PHE prioritise effectively?**

We are concerned that PHE's prioritisation starts from the basis of the level of funding of the constituent parts of the organisation when it was set up and that as a result tackling smoking is still not given sufficient priority or funding. Smoking in England causes more premature deaths than

[11] PHE Chief Executive, quoted in Health Service Journal, 9th December 2015

obesity, alcohol, road traffic accidents, illegal drugs and HIV infection combined.[3] Smoking is responsible for half the difference in life expectancy between the richest and poorest in society.

An NAO report published in 2010 estimated that there were 330,000 problem drug users, that the cost of illegal drugs to society was £15.3 billion and that the Government spent £1.2 billion tackling this problem of which £581 million was spent on treatment.[12] The same year it was estimated that there were 9 million smokers and the cost to society from smoking was £13.74 billion, while Government spend to tackle this was only £250 million in total (this included investment in mass media, treatment, and tackling illicit trade).

Both drug treatment and smoking cessation treatment are highly cost-effective by comparison with NICE standards that interventions with an ICER of less than £20,000 per QALY gained are considered to be cost effective.[13] However, smoking cessation treatment is significantly more cost-effective than, for example, treatment for heroin use. Treatment in clinic for heroin users with methadone was estimated to cost £15,805 per QALY (oral methadone) and £10,945 per QALY (injectable methadone).[14] Smoking cessation treatment by comparison comes in at £4,400 per QALY for a pharmacy based treatment service and £5,400 per QALY for a specialist group support service.[15]

Smoking cessation treatment is also highly cost-effective for those already diagnosed with smoking-related diseases. About 900,000 people in England have been diagnosed with COPD out of a total estimated number of sufferers of around 3 million.[16] Around 25,000 people die a year from COPD and in 2010/11 the NHS spent £720 million on treatment for COPD. This is a disease which is almost entirely preventable, smoke is the cause of more than three quarters of COPD cases and in England the exposure to smoke is primarily through smoking. Clearly it is better to prevent COPD through provision of smoking cessation treatment to help smokers quit before develops. However, even after onset of COPD smoking cessation can help improve quality of life and is highly cost-effective compared to other treatments. The cost per QALY for smoking cessation treatment for people with COPD is estimated to be £2,000 per QALY while the costs of drug treatment for those with COPD range from £5,000 per QAL at the bottom end to £187,000 per QALY for triple therapy.

Yet the spend on smoking cessation treatment from 2000 to 2009 was estimated to be only £400 million saving an estimated 70,000 lives[17], less than one year's expenditure on treatment for illegal drug users. And while around 80,000 adults die a year in England and Wales from smoking, the total number of deaths from drug misuse each year is less than 2,000.

There is no sign that since the transfer of funding responsibilities to local authorities the disparity in funding of drug misuse and smoking cessation treatment has changed significantly, and smoking cessation is further disadvantaged by a lack of the statutory responsibility for its delivery which is in place for drug misuse treatment.

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[12] Report by the Comptroller and Auditor General. Tackling problem drug use. HC 297 Session 2009-2010. National Audit Office. March 2010

[13] NICE. Developing NICE guidelines: the manual. October 2014

[14] Byford S. Barrett B. Metrebian N. Groshkova T. Cary M. Charles V. Lintzeris N. Strang J. Cost-effectiveness of injectable opioid treatment v. oral methadone for chronic heroin addiction The British Journal of Psychiatry Nov 2013, 203 (5) 341-349; DOI: 10.1192/bjp.bp.112.111583

[15] Boyd, KA & Briggs AH Cost-effectiveness of pharmacy and group behavioural support smoking cessation services in Glasgow Addiction 2009; 104 (2): 317–325. DOI: 10.1111/j.1360-0443.2008.02449.x

[16] NHS Choices. Chronic Obstructive Pulmonary Disease. Accessed 4th July 2016.

[17] Department of Health Press Release: 70,000 lives saved by the NHS Stop Smoking Services. 2009.

PHE needs to put more effort into helping redress the disparity in spend at local level, through its own investment in tobacco control. It is not possible to identify the relative spend on drug treatment and tobacco from PHE's accounts but it is clear that the spending imbalance at national level was not addressed when PHE was set up and has still not been addressed to this day.

Q8 N/A

Q9 N/A

Q10 N/A

Q11 **PHE works at the international, national, regional and local levels. In your opinion, are these tiers necessary for PHE to perform its functions effectively?**

Given the need for tobacco work from national right through to local level, (see also our answer to Q3) we are concerned that leadership at national level is insufficiently linked through to implementation at PHE region and local centre level. It is not apparent how the PHE "region" level supports the national or local level leadership and engagement on this agenda except perhaps in London where an integrated region and centre may create additional capacity. Furthermore lack of expertise, capacity and resource undermines the ability of the PHE local centres to effectively support delivery at local level in local authorities and the NHS. If PHE local centre resource cannot be strengthened it might be more effective for the national tobacco team to work directly with local authorities and local and regional tobacco-focused organisations rather than to work through the PHE centres.

Such working exists very effectively in a number of regions, in particular the northeast, Yorks and Humber and the northwest, and until very recently the southwest where the tobacco function has been funded at regional level by local authorities. Indeed it should be noted that in the northeast and Yorks and Humber the local authority funded tobacco function supports the PHE centre tobacco function in an unpaid capacity, providing additional expertise and resource to PHE and working directly with the national tobacco team as appropriate. Regional funding and coordination of tobacco control have been found to be highly effective and cost-effective in increasing the rate of decline in smoking prevalence above the national average, and for that reason they are included in the NICE return on investment tool for tobacco control. [18] The work they do is highly innovative, for example they have run successful paid for mass media campaigns backed up by intensive media advocacy, as well as campaigns to reduce the supply of, and demand for, illicit tobacco.

The regional office in the southwest has now had its funding terminated. Funding for this function in the other regions, all areas of deprivation with high smoking rates, are also under threat. Three local authorities in the northwest terminated funding for 2016/17 due to budgetary constraints. We consider that these cuts threaten the future of regional tobacco control work, and will make "joined up" tobacco control policy much more difficult, and existing tobacco control policies less effective.

Q12 **Specifically in relation to its work to improve public health, how well does PHE balance national priorities with the differing needs of local areas?**

There are very wide variations in council spending on reducing smoking. Using local authority revenue expenditure and financing for 2015 to 2016, ASH has calculated the intended spend per smoker by

[18] NICE. Tobacco return on investment tool

each local authority for the last financial year.[19] The average intended spend was £21 per smoker and the range is from £4 per smoker to £49 per smoker (excluding City of London and Isles of Scilly). There is no strong correlation between local authority areas with high rates of smoking and their spending on reducing smoking. The average spend among the ten authorities with the lowest rates of smoking is £21 per smoker (ranging from £11 to £31). Among the ten authorities with the highest rates of smoking the average spend is actually lower at £19 per smoker (ranging from £6 to £38).

There is obviously only a limited amount that PHE can do about this obvious imbalance in spending and its failure to match measurable public health needs. However, PHE does have a responsibility to draw to the attention of local authorities and central government the consequences for public health of such a manifest spending imbalance, and as far as possible it needs to balance its own work and spending to reflect the level of underlying need (as measured in this case by local prevalence rates). It is also essential that PHE evaluates use of the public health grant by localities and publicly challenges examples of poor use of the grant.

Q13 **PHE has to work effectively with partners both nationally and internationally to meet its objectives. How well do you think PHE influences and supports other bodies?**

We consider PHE to be effective in its partnership working, and we very much value our engagement with PHE as being mutually helpful in developing effective implementation of evidence-based tobacco control policies.

Q14 **How well does PHE communicate and engage with the full range of its stakeholders? What, if any, changes would you like to see to PHE's approach with stakeholders? Does PHE act on stakeholder views and feedback? How effective is engagement with the public and wider stakeholders?**

Communication with stakeholders on tobacco policy is generally good. Executive leadership for the programme sits under Professor Kevin Fenton, with the primary government department policy interface led by Rosanna O'Connor, Divisional Director for Alcohol Drugs and Tobacco (ADT), supported by Martin Dockrell. There is a Tobacco Control Implementation Board which meets quarterly, and which is chaired jointly by Rosanna O'Connor and Professor John Britton of the UK Centre for Tobacco and Alcohol Studies. However, given the importance of mass media and marketing strategies in reducing smoking prevalence it is of concern that the marketing team do not appear properly integrated into this process. Often they are not present at the quarterly meetings and when they are it is not clear that they are responsive to expert input on the evidence-base from academics and practitioners.

Q15 **How effective is PHE at operating within, and supporting, the rest of the health and care system?**

The costs of tobacco consumption to society in England were quoted at £12.9 billion in HM Treasury's consultation document on a possible tobacco levy.[20] The headline figure can be broken down as follows:

- £2 billion cost to the NHS of treating diseases caused by smoking
- £3 billion loss in productivity due to premature death

[19]Smokefree Action Coalition, Letter to the Chancellor, 26 Nov 2015

[20] HM Treasury. Tobacco Levy: consultation document. December 2014.

- £5 billion cost to businesses of smoking breaks
- £1 billion cost of smoking-related sick days
- £1.1 billion of social care costs of older smokers
- £391 million cost of fires caused by smokers' materials.

We also note that the future sustainability of the NHS has now been explicitly linked by NHS management and the Government to major improvements in public health, including continuing falls in smoking prevalence. PHE has a vital role to play in delivering these improvements, but it cannot be expected to do this effectively if it is not properly funded, and if it is working in a system (particularly at local authority level) that is facing progressively more extensive cuts to funding. It is also not clear that PHE is working effectively with the NHS to ensure that its public health responsibilities continue to be met.

Q16 **PHE has a key role in influencing public attitudes and behaviours to support health improvements. To support this it has a significant marketing function. How effective is PHE's marketing function at delivering such change?**

Mass media campaigns to reduce smoking are proven to be highly cost-effective, if properly funded. In the United States, the Centers for Disease Control (CDC) made a best practice recommendation in 2014 for spending on 'mass reach health communication interventions', and costed this at $1.69 per capita. This equates to around US$90 million for England, more than ten times the amount spent in 2015-6. Studies carried out in England in the past few years have found that mass media campaigns have been effective in triggering quit attempts and have been responsible for a significant proportion of the reduction in smoking prevalence,[21] and that the freeze on mass media campaigns was associated with a reduction in quitting activity.[22] A systematic review of economic evaluations of mass media campaigns noted that all of these found mass media campaigns to be cost effective.[23] However, there is a threshold level for mass media campaigns which need to have sufficient intensity and be sustained over time in order to translate into population reductions in smoking.[24]

The cost per quality adjusted life year (QALY) of the recent FDA campaign *Tips from Former Smokers* was calculated to be US$383[25], way below the £20,000 threshold below which NICE consider interventions to be cost-effective.[13] In a UK context, Stoptober, a TV led mass media campaign backed up by digital media, was estimated in 2012 to have generated an additional 350,000 quit attempts in England and saved 10,400 discounted life years (DLY) at less than £415 per DLY in the modal age group.[26]

[21] Sims M, Salway R, Langley T. et al. Effectiveness of tobacco control television advertising in changing tobacco use in England: a population-based cross-sectional study Addiction. 2014 109 (6): 986-94

[22] Langley T, Szatkowski L, Lewis S et al. The freeze on mass media campaigns in England: a natural experiment of the impact of tobacco control campaigns on quitting behaviour. Addiction 2014: 109: 995-1002

[23] Atusingwize E, Lewis S, Langley T. Economic evaluations of tobacco control mass media campaigns: a systematic review Tobacco Control 2015: 24: 320-327

[24] Durkin S & Wakefield M. Commentary on Sims et al. (2014) and Langley et al. (2014) Mass media campaigns require adequate and sustained funding to change population health behaviours. Addiction 2014: 109: 1003-1004.

[25] Xu, Xin, et al. Cost-Effectiveness Analysis of the First Federally Funded Antismoking Campaign. American Journal of Preventive Medicine. 2014; 48 (3): 318–325.

[26] Brown J, Kotz D, Michie S, Stapleton J, Walmsley M, West R. How effective and cost-effective was the national mass media smoking cessation campaign 'Stoptober'? Drug Alcohol Depend. 2014 Feb 1;135:52-8. doi: 10.1016/j.drugalcdep.2013.11.003. Epub 2013 Nov 20.

Yet despite all the evidence since 2009-10 funding of mass media campaigns has been erratic and in overall decline. So although we recognise the quality of PHE's marketing communications, they are insufficiently funded and sustained to be fully effective. Furthermore the most recent feedback to the PHE Tobacco Control Implementation Board seemed to indicate further cuts to the budget for 2016/17 and a discontinuation of the highly effective 'health harms' campaigns.

Financial year [27]	Media Spend (£m)
2008-09	23.38
2009-10	24.91
2010-11	0.46
2011-12	3.16
2012-13	8.21
2013-14	7.64
2014-15	6.92
2015-16	5.3

Last but not least, the oversight of marketing campaigns by the Cabinet Office, and sign off on a case by case basis, prevents development and implementation of a strategic plan for marketing and communications. Instead campaigns have to be developed and implemented on an ad hoc and short-term basis with a lack of any long-term clarity about timing, funding and implementation.

Q17 **Are there any measures you believe PHE could take to deliver further efficiencies from within its agreed budget (whether reduced costs, spend to save proposals, or improved use of resources)?**

One option which could and should be considered by Public Health England is removing the regional level. From our experience in the area of tobacco control this adds a layer of bureaucracy without improving the efficiency or effectiveness of the organisation's health improvement function.

Q18 **Is PHE sufficiently strategic and forward-looking in its approach?**

We recognise that PHE has tried to be a strategic organisation that has worked hard and effectively to develop public health strategy across England, and that it has a good understanding of its key priorities. However, the political environment it works within makes it impossible for it to be sufficiently forward-looking and strategic. For example in 2015-16 it faced a £100 million in-year cut followed by further cuts announced in the Spending Review. How in such circumstances is it possible to be strategic?

PHE is unable to have a long-term strategic plan for its marketing activity because of the control placed on this area by the Cabinet Office (see answer to Q.16).

Furthermore, the erosion of data on public health outcomes and lack of continuity seriously threaten PHE's ability to measure and evaluate its effectiveness. The PHE Strategic Plan 2016[28] describes planned activity for PHE for the coming year much of which is dependent on the maintenance of high quality national and local data sources and ensuring these are appropriately analysed and disseminated to DH, NHS England, local authorities and others. Historically England has had some of

[27] Source: Hansard: Citation: HC Deb, 3 May 2016 http://bit.ly/1W6RCxa and HC Deb, 3 April 2014, c799W http://bit.ly/1UyijYs

[28] PHE. Strategic plan for the next four years: Better Outcomes by 2020. April 2016.

the best data in the world on smoking prevalence, something that has enabled us to track progress of tobacco control policy, better understand the impact on youth smoking and other sub-populations and identify priority areas for action such as smoking among pregnant women and smoking in routine and manual populations.

However, we are concerned that budget reductions are already threatening this strategic approach. In the area of tobacco control, we believe that has already been "data erosion", leading to less understanding of the nature and distribution of tobacco consumption in England. One example of the reduced data collection capacity, are changes to the surveys for youth smoking. The decision to drop the Smoking Drinking and Drug Use Among Young People in England (subsequently there has been a commitment to carry it out every other year) means that there is no reliable youth prevalence data for 2015. Yet this is the the year in which the Tobacco Control Plan ended which included a Government ambition to "reduce rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015"[29], an ambition with no data to measure whether it had been achieved.

It is important that other decisions in relation to national data sources are taken in a way that best supports the strategic role of PHE. The PHE Strategic Plan 2016 notes that PHE has a role in supporting development of a new Tobacco Control Plan, ensuring that local authorities have the data to make planning decisions and are enabled to better close the gap in health inequalities and that the NHS is equipped with the information to plan services effectively and identify variation in performance.

All the national surveys which currently record smoking prevalence are currently being consulted on and could change, risking undermining the ability to track smoking at a national level consistently over time. In addition, no national survey is currently providing data of sufficient granularity to support local planning and performance around tobacco, particularly on target sub-populations such as routine and manual smokers. Proposed changes to local measures to include smoking rates from Quality and Outcome Framework or GP Patient Survey are also unlikely to provide the quality of information needed locally.

It is vital that long running national data sources are maintained to ensure that the progress of future tobacco policy and strategy can be assessed nationally. In addition, as part of its strategic role, PHE must also identify how it can better support the delivery of local data. There are opportunities through working with NHS England to improve the recording of information in minimum data sets which, while it would be no substitute for national tracking of smoking prevalence, could improve local information. Furthermore, we think it would be timely for PHE to take the lead in a cross-Government review of the surveillance of smoking at all levels in collaboration with external experts and stakeholders to ensure that it can fulfil this strategic role in the future and the delivery of the next Tobacco Control Plan.

[29] DH. Healthy Lives Healthy Futures. A Tobacco Control Plan for England. HM Government. 2011