Taking a Reading

The impact of public health transition on tobacco control and smoking cessation services in England

March 2015

A report by Action on Smoking & Health
Written by Will Anderson and Helen Asquith

Commissioned by Cancer Research UK

A report by Action on Smoking & Health
Written by Will Anderson and Helen Asquith

ash.
action on smoking and health

The report was commissioned by Cancer Research UK

CANCER
RESEARCH
UK

For media enquiries please contact:
Action of Smoking & Health on: 0207 404 0242

Cancer Research UK press office on: 0203 469 8300;
Out of hours: 07050 264 059

Contents

Summary and actions

This report presents the results of a survey of tobacco control leads in upper tier local authorities in England. The survey was conducted in June 2014 and the results provide a snapshot of the experience of tobacco control teams just over a year after their transfer from NHS primary care trusts to local government.

Overall, more respondents made a positive assessment of the impact of the transition than made a negative assessment. Although all respondents were able to identify losses and obstacles, these tended to be outweighed by the gains and opportunities:

- In regard to smoking cessation services, 41 per cent felt that the gains and opportunities outweighed the losses and obstacles compared to 16 per cent who felt the balance lay the other way
- In regard to wider tobacco control work, 59 per cent felt that the gains and opportunities outweighed the losses and obstacles compared to 12 per cent who felt the balance lay the other way

The two principal gains of transition have been, firstly, closer relationships with colleagues in the local authority and closer integration with the strategy and activity of the authority; and, secondly, greater political support for tobacco control as a result of the engagement of elected members.

The losses and obstacles reported by respondents were more diverse and included pressure on budgets and uncertainty about the future; loss of tobacco control personnel and/or the demands of other portfolios; a lack of understanding in the local authority about the importance of tobacco control; a breakdown of relationships with the NHS, especially with GPs and clinical commissioning groups; and the bureaucracy of local authority decision-making.

The time and resources available for tobacco control have been affected by the transition to local government but there is no overall direction to this impact. Among the tobacco control leads who were in post before and after transition, as many reported an increase in the time they spent on tobacco control as reported a decrease. Similarly, budgets for smoking cessation had risen as often as they had fallen (14 percent), and budgets for wider tobacco control had risen more often (22 per cent) than they had fallen (13 per cent). The ring-fence for public health budgets appears to have been widely, though not universally, respected but there is concern for the future of tobacco control when this ring-fence is removed, given the depth of local authority spending cuts.

The political culture of local authorities has created opportunities for tobacco control but it has also been a problem where political support has not been forthcoming. A quarter (26 per cent) of respondents reported that they had encountered opposition from elected members and a majority (54 per cent) did not think that the priority given to tobacco control in their local authority was high enough. Nonetheless this priority was reported to be above average or high by half (51 per cent) of respondents and two thirds (65 per cent) reported that their lead member for health and wellbeing actively advocated for tobacco control. Seventy-two per cent of respondents were aware of a tobacco control target in at least one of the local authority's core corporate documents – the Health and Wellbeing Strategy, Joint Strategic Needs Assessment or Community Strategy. In many areas the Local Government Declaration on Tobacco Control has helped to build political support with three quarters (73 per cent) of respondents reporting that their authority had ether signed the declaration or was planning to do so in the next year.

Respondents' relationships with local authority professionals have widely benefited from the physical and political reality of working for the same organisation and a majority of respondents (55 per cent) felt that the impact of transition on tobacco control alliances had been positive. However relationships with GPs, NHS commissioners and NHS intelligence officers have suffered, with a quarter of respondents (24 per cent) reporting a decline in their relationships with GPs. The effect of transition on regional support appears to

have been negative overall, with a third of respondents (35 per cent) reporting a decrease in regional support.

In general, tobacco control leads are positive about the future of tobacco control and smoking cessation services in their localities. Two thirds of respondents (67 per cent) were positive about the future including 13 per cent who were very positive. Far fewer – 14 per cent – were negative about the future. This is good news for tobacco control and suggests that, where political support is forthcoming, local government offers real opportunities to develop more strategic, community-focussed approaches to tobacco control and smoking cessation services.

However, the adverse consequences of transition reported by respondents must also be recognised, for they provide a warning that the overall positive picture could change, especially if budgets suffer following the removal of the public health ring-fence. Respondents who had experienced budgets cuts, political opposition, the demands of additional portfolios, and broken relationships with the NHS had reason to be wary of the future of tobacco control in their local authorities. Looking to the long term, a tobacco-free future will be difficult to achieve without the support of local authority officers and the engagement of all local authority members.

Table of actions

Action(s)	To be taken by
If tobacco control is to thrive in the long term in *all* local authorities, there needs to be clear national leadership as well as local political will.	Public Health England Department of Health Local authorities
The funding for tobacco control and smoking cessation services must be secured both before and after the removal of the public health ring fence.	Public Health England Department of Health Local authorities LGA
The experience of tobacco control teams within local authorities should be monitored on a regular basis, with special attention paid to budgets, political support and relationship with the NHS.	Public Health England Civil society Support from national local government organisations, e.g. LGA
There is scope for sharing good practice in making the case for tobacco control and smoking cessation to elected members and other stakeholders within local authorities.	Local tobacco control teams LGA Civil society Public Health England
We need to develop a shared understanding within tobacco control of how the opportunities of local government can be fully exploited, including building relationships with professionals who have not traditionally been involved in tobacco control and smoking cessation activity.	Local tobacco control teams Civil society Public Health England Other statutory partners including police, fire authorities, HMRC etc
Regional or supra-local collaborative tobacco control activity must be supported throughout England.	Public Health England Local authorities Other statutory partners, e.g. HMRC (illicit trade)

Tools available to support local action:

- **CLeaR** – a self and peer-assessment improvement tool designed to support councils to develop a balanced tobacco control strategy https://www.gov.uk/government/publications/clear-local-tobacco-control-assessment
- **Local Government Declaration on Tobacco Control** – A statement of a council's commitment to ensure tobacco control is part of mainstream public health work and commits councils to taking comprehensive action to address the harm from smoking http://www.smokefreeaction.org.uk/declaration/index.html

- **The NHS Statement of Support** – this supports the Local Government Declaration and is a set of commitments for NHS organisations on their role in tackling tobacco http://www.smokefreeaction.org.uk/declaration/NHSstatement.html
- **Local Toolkit** - a set of resources for local tobacco control professionals http://ash.org.uk/localtoolkit/
- **NICE guidance on tobacco** – there is a wide range of public health guidance from NICE on tackling smoking http://www.nice.org.uk/guidance/lifestyle-and-wellbeing/smoking-and-tobacco
- **NCSCT** – the National Centre for Smoking Cessation and Training have a range of resources to support local service improvement http://www.ncsct.co.uk/

1. Introduction

In April 2013, English public health teams left the NHS and started work in their new homes in upper tier local authorities. This new working environment, with its distinctive political culture, was bound to present both challenges and opportunities for professionals who were used to working within the NHS. All public health professionals, including those working in smoking cessation and tobacco control, had to face these challenges and opportunities and chart a new way forward.

This report presents the results of a survey that explored the impact on tobacco control teams of the transition of public health to local government. It was conducted with tobacco control leads in June 2014, just over a year after the move from the NHS, and so provides an early snapshot of how tobacco control teams and smoking cessation services are faring under their new political masters.

Among the many work streams of public health, tobacco control was arguably one of the best placed to benefit from the move to local government because of the established role of local authorities as partners in tobacco control alliances. Trading standards and environmental health officers have long been key players in monitoring and enforcing legislative changes that reduce the harm of tobacco. Local authorities also have a direct interest in tobacco control because of the burden that smoking imposes upon local communities, including significant economic and social care costs. However, local authorities have broad interests beyond health, so there was always a risk that tobacco control would not enjoy the same level of support in local authorities as it did in the NHS.

Overall, the results of the survey are positive: the benefits of the transition appear to outweigh the losses and a majority of respondents are positive about the future of tobacco control and smoking cessation services in local government. However this is not the universal experience: there is a minority experience of decline and political opposition that provides a warning for the future. Tobacco control and smoking cessation services have been protected – in most places – by the ring-fence of the public health budget. The key question for the future is whether the optimism described in this report can survive the removal of this ring-fence and the impact of on-going local authority budget cuts.

2. Methods

The aim of the survey was to obtain a snapshot of the impact of the transition of public health from NHS primary care trusts to local government on tobacco control and smoking cessation services. The sampling frame was all upper tier local authorities in England. The respondents were tobacco control leads within public health teams, or individuals with comparable roles.

The questionnaire was developed by ASH and piloted online with ten tobacco control leads in March 2014. The finalised questionnaire was sent to all tobacco control leads in May 2014. The survey was principally

conducted online, using Survey Monkey, though respondents could also request paper copies of the questionnaire. Tobacco control leads who did not respond were followed up by telephone. All respondents were made aware that their responses to the survey would be anonymised. The survey closed at the end of July 2014, at which point 111 tobacco control leads had completed the survey. Seven respondents answered for more than one local authority due to joint public health arrangements. Overall, data was obtained from 80 per cent of upper tier local authorities.

Analysis was conducted in Excel. Correlations were explored using the chi square test of goodness of fit. Most questions in the survey had fixed choice answers but respondents had the opportunity to respond to key questions using free text. Free text answers were quantified using thematic content analysis.

Respondents were asked to identify their role in tobacco control in their local authority using the list shown in Table 2.1. A majority of respondents ticked more than one option. Three fifths (61 per cent, n=68) of respondents had been the primary care trust lead on tobacco control and/or smoking cessation prior to the transfer of public health to the local authority.

Table 2.1 Respondents' roles (including multiple roles) within their local authority

Strategy lead on tobacco control and/or smoking cessation	75 (68%)
Commissioner of smoking cessation services	70 (63%)
Coordinator of tobacco control and/or smoking cessation	55 (50%)
Consultant in public health with responsibility for tobacco	10 (9%)
Other	11 (10%)

3. The culture of local government

Key Findings

- 51% of respondents felt that the priority given to tobacco control by their local authority was above average or high; 15% said it was below average or low

- 54% felt the priority given to tobacco control was not high enough

- 65% of lead members for health and wellbeing advocate for tobacco control

- Tobacco control was much more likely to be perceived as a priority where the lead member for health and wellbeing advocated for tobacco control

- 26% of respondents had encountered opposition to tobacco control from elected members

- 72% of respondents were aware of a tobacco control target in at least one of the core corporate documents (the Health and Wellbeing Strategy, Joint Strategic Needs Assessment or Community Strategy)

- 73% of local authorities have either signed up to the Local Government Declaration on Tobacco Control or are likely to sign up in the next year

Priorities

Respondents were asked how they perceived the level of priority given to tobacco control in their local authorities. Figure 3.1 illustrates their responses. Half of respondents (51 per cent) felt that the priority given to tobacco control was above average or high priority, a third felt that the level of priority was average and 15 per cent felt that tobacco control was given below average or low priority.

Respondents were also asked whether they thought the priority given to tobacco control in their local authority was high enough. Over half (54 per cent) said it was not high enough, leaving 41 per cent who felt it was high enough and 5 per cent who did not know. Four fifths of those who said tobacco control was

given average priority felt that this was not high enough, as did two fifths of those who said it was given above average priority (and all of those who said the priority was low or below average).

Figure 3.1 Respondents' perceptions of the priority given to tobacco control in their local authority
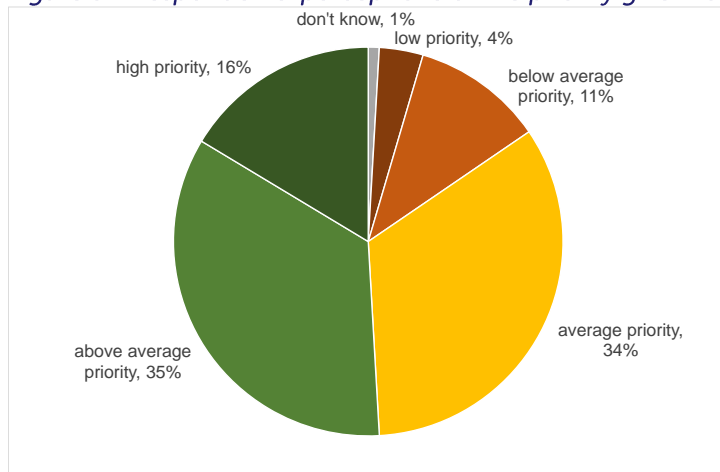

Leadership

Respondents were asked to identify which individuals within their local authorities actively advocated for tobacco control and/or smoking cessation. Figure 3.2 illustrates their responses. Three respondents were unable to identify anyone who advocated for tobacco control in their local authority.

The two principal figures who advocate for health in local authorities are the Director of Public Health and the lead member for health and wellbeing (or comparable role). Most respondents (88 per cent) said that the Director of Public Health advocated for tobacco control, though nearly one in eight did not, and only two thirds (65 per cent) of lead members for health and wellbeing advocated for tobacco control.

There was a clear relationship between leadership on tobacco control and the level of priority given to tobacco control in the local authority. In local authorities where the lead member for health and wellbeing advocated for tobacco control, respondents were much more likely to perceive the priority given to tobacco control to be above average or high compared to those authorities where the lead member did not advocate on this issue ($p<0.005$).

Figure 3.3 Local authority stakeholders who actively advocate for tobacco control
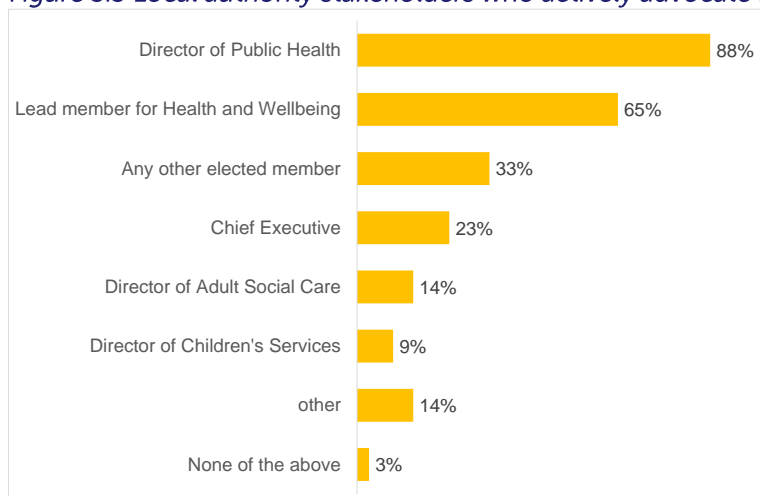
Opposition to tobacco control

Respondents were asked if they had encountered any opposition to tobacco control and/or smoking cessation from elected members or officers. Two thirds (66 per cent) of respondents had not experienced any opposition from elected members but a quarter (26 per cent) had encountered some form of opposition (7% did not know). Similarly, a majority (73 per cent) had not experienced opposition from officers but 17 per cent had some experience (10 per cent did not know). Respondents who had experienced opposition were asked to describe in their own words what form this took.

Opposition from members typically had a personal or political motivation, including resistance from members who were smokers themselves, or who felt that smoking was a personal freedom, or who felt that tobacco control was an expression of the 'nanny state'. Some respondents reported a lack of knowledge among members about the benefits of tobacco control and the cost-effectiveness of stop smoking services, or a resistance to paying for a service where the benefits accrued to the NHS. There was also opposition in a few cases to creating a fully smokefree workplace. Some respondents noted that opposition only came from one member but that this could be enough to cause a problem.

"The Leader objects to the 'nanny state' and perceives smoking cessation to be nannying"

Opposition from officers was predominantly described either as a general reluctance to engage – "What has smoking got to do with the local authority?" – or as specific opposition to new policies. Several respondents described opposition to extensions of smokefree policy, including specific policies on smokefree homes, cars and parks. Opposition had also been encountered to electronic cigarettes and to standardised packaging of cigarettes.

"It is more of a reluctance to engage rather than overt opposition"

Plans and targets for tobacco control

Respondents were asked to identify which corporate documents, if any, contained targets for tobacco control and/or smoking cessation. Figure 3.3 illustrates the results.

As might be expected, targets for tobacco control were most often set within local tobacco control plans. Such plans were not, however, universal: only 69 per cent of respondents had an active tobacco control plan. Targets were less common in corporate documents with a wider brief. Nonetheless, 72 per cent of respondents were aware of a tobacco control target in at least one of the core corporate documents – the Health and Wellbeing Strategy, Joint Strategic Needs Assessment or Community Strategy.

The presence of targets for tobacco control in corporate documents was not associated with leadership by the lead member for health and wellbeing. Nor were targets correlated to respondents' perceptions of the priority given to tobacco control: the presence of a target for tobacco control in any of the three core corporate documents – the Health and Wellbeing Strategy, JSNA and Community Strategy – was no more likely in an authority where the priority given to tobacco control was perceived to be above average than in an authority where the priority was perceived to be below average.

Looking across all the relevant documents in each local authority, Figure 3.4 describes the number of documents in each authority that contain targets for tobacco control or smoking cessation. In one in eight local authorities (12 per cent), there are no active documents that set targets for tobacco control.

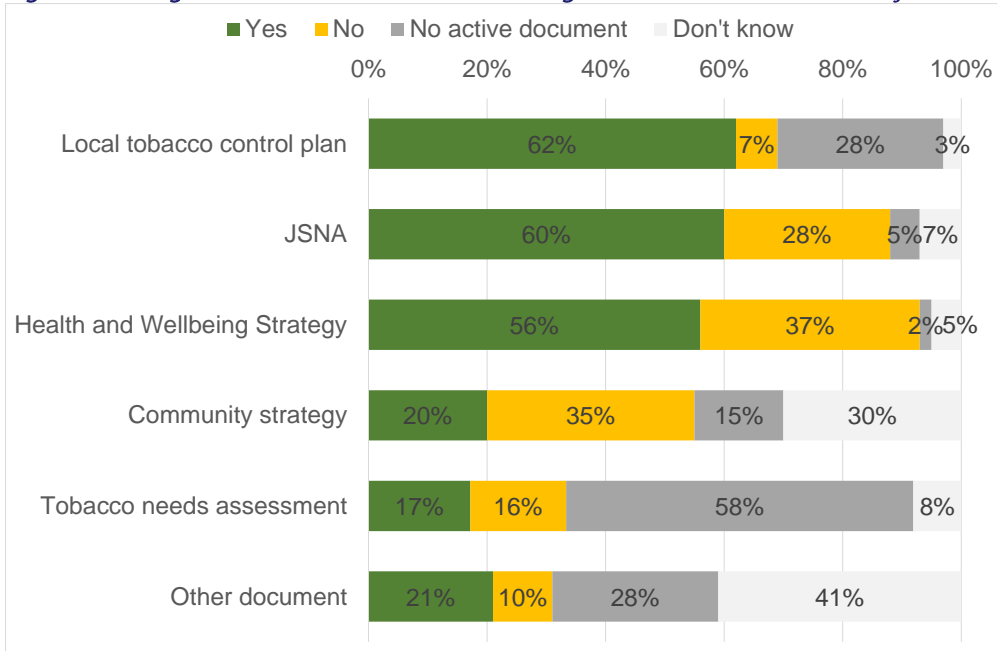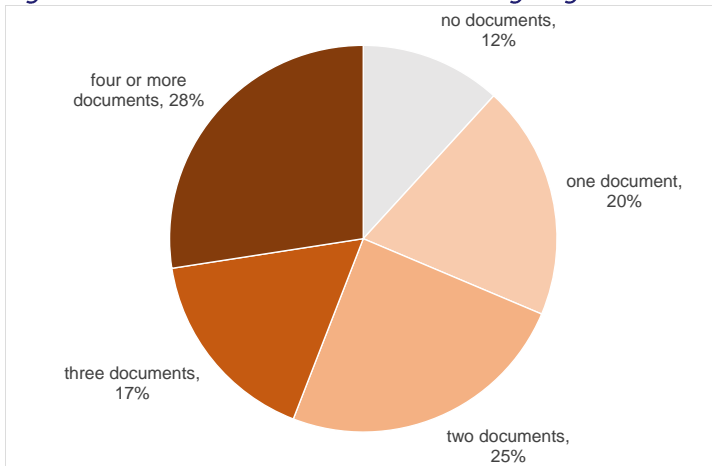*Figure 3.3 Targets for tobacco control/smoking cessation in local authority documents*

Figure 3.4 Number of documents including targets for tobacco control/smoking cessation

The Local Government Declaration on Tobacco Control

Respondents were asked about the interest of their local authority in the Local Government Declaration on Tobacco Control, and specifically whether the authority was likely to sign up to the declaration in the forthcoming year. Nearly three quarters of respondents (73 per cent) said that their authority had either signed up already (46 per cent) or was likely to sign up in the next year (27 per cent). Thirteen percent said that the authority was unlikely to sign in the next year and 14 per cent did not know.

Among those who said their council was unlikely to sign, most cited some form of local political sensitivity as the reason for this. This included opposition from specific members, unwillingness to make a commitment at a time of budget pressure and issues with pension investments.

Discussion

Given the extraordinary harm caused by tobacco to local communities, tobacco control ought to be a high priority for local authorities, who are now charged with protecting and promoting the health of their local populations. It is therefore encouraging that, one year in, over half of the respondents to the survey perceived tobacco control/smoking cessation to be an above average or high priority within their local authorities. Yet there are many local authorities where the importance of tobacco control has not been fully recognised or, worse, has not been understood at all.

In the political culture of local government, political support for tobacco control is crucial: tobacco control/smoking cessation was much more likely to be perceived as a priority in local authorities where the lead member for health and wellbeing advocated for tobacco control. In contrast, if the power of elected members is set against tobacco control, this can be disabling, as a significant minority of respondents reported. It only needs one member to be personally or politically opposed to tobacco control to obstruct progress.

The Local Government Declaration on Tobacco Control (www.smokefreeaction.org.uk/declaration) has evidently been important in gaining political support for tobacco control and smoking cessation in some local authorities. The declaration was first proposed and signed by the City of Newcastle in May 2013. It sets out the responsibilities of local authorities within the World Health Organisation Framework Convention on Tobacco Control including Article 5.3, which requires parties to protect public health policy from the vested interests of tobacco companies.

"The Local Government Declaration on Tobacco Control has put tobacco control on the map for our elected members"

It is encouraging that nearly three quarters of the local authorities represented in the survey had a target for tobacco control in one of their three core documents: the Health and Wellbeing Strategy, JSNA or Community Strategy. However the lack of any correlation between the presence of such targets and either political leadership or corporate priority on tobacco control is notable. Corporate targets are clearly important but, on this evidence, should not be used on their own as an indicator of political commitment to tobacco control.

Overall, these results suggest that we need to be cautious in celebrating the success of the transition of public health to the political environment of local government, as others have done[1]. Although there is evidence here that many tobacco control teams are flourishing, there is also evidence that others are struggling, especially where political support is not forthcoming.

4. Time and resources

Key findings

- The time respondents spent on tobacco control had increased almost as often (30%) as it had decreased (32%)
- 14% of smoking cessation budgets had increased and 14% had decreased but, in addition, 13% of smoking cessation budgets had absorbed unexpected NRT costs
- 22% of tobacco control budgets had increased and 15% had decreased
- 7% of tobacco control teams had experienced a cut in budget due to a cut in a ring-fenced public health budget

Time for tobacco control

Three fifths (61 per cent, n=68) of respondents had been the PCT lead on tobacco control/smoking cessation prior to the transfer of public health to local government in April 2013. These respondents were asked if the amount of time they personally spent on tobacco control and smoking cessation had changed since 2012-13, prior to the transition. Figure 4.1 illustrates the results.

The near-perfect symmetry of these results is striking. Overall, 30 per cent of respondents who had remained in post over the transition said the time they spent on tobacco control had increased including 15

---

[1] Local Government Association (2014) *Public health – one year on.*

per cent whose time had increased a lot. Similarly, 32 per cent said the time they spent on tobacco control had decreased including 16 per cent whose time had decreased a lot. In the middle, 38 per cent said their time spent on tobacco control had stayed the same.

The 22 respondents who said their time for tobacco control and smoking cessation had decreased were asked to identify the reasons for this. Most (19 out of 22) indicated that they were now responsible for additional portfolios. Nine cited pressure on the capacity of the public health workforce as a whole and four said that there had been a strategic shift to more generic public health roles.

There was no relationship between changes in respondents' time for tobacco control and their perceptions of the priority given to tobacco control in the local authority. Those who thought that tobacco control had an above average or high priority were no more likely to be putting more time into tobacco control than those who felt that the priority of tobacco control was below average.

Figure 4.1 Changes in respondents' time spent on tobacco control post-transition
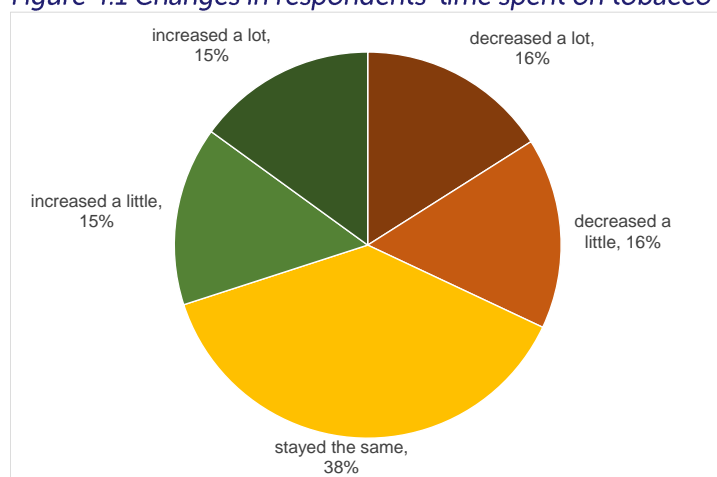
Changes to budgets

Respondents were asked if their smoking cessation and tobacco control budgets had changed since 2012-13, prior to transition. The most common answer, in both cases, was that the budget had stayed the same (Figure 4.2). This is consistent with the protection offered by the public health ring-fence. However this was far from a universal experience.

Budgets for smoking cessation, excluding nicotine replacement therapy (NRT) had decreased as often as they had increased. Of the 15 respondents who reported a cut in their budget, 8 had seen a cut of more than 3 per cent. Budgets for wider tobacco control had fared better with more budgets rising than falling. Of the 14 respondents who reported a cut, 9 had seen a cut of more than 3 per cent. Nearly a quarter of respondents (23 per cent, n=25) had experienced a cut in one of these budgets but only four respondents (3.5 per cent) had seen a decrease in both budgets.

Smoking cessation budgets were most often cut because of cuts in the public health budget, cited by 6 respondents, or changes in priority within the public health budget. The other reasons given for reductions in spend included pressure on the overall council budget and the need to make savings, reduced demand and specific service cuts. Similarly, the most common reason for a cut in the tobacco control budget was a cut in the overall public health budget, also cited by 6 respondents. Overall, 8 respondents (7 per cent) reported a reduction in one or both of these budgets due to a cut in a supposedly ring-fenced public health budget.

Some smoking cessation teams have been coping with reduced resources due to problems with the transfer of NRT budgets. In order to compare like with like, NRT costs are specifically excluded from the comparative results in Figure 4.2 as they were not paid for by tobacco control teams in PCTs. However two thirds (68 per cent) of councils now have to pay for NRT. In the majority of these cases, NRT costs had been included in the calculation of the transition budget but in 13 per cent of all councils the costs are now being paid despite their omission from the transition calculation.

There was no correlation between changes in budgets and the perceived priority of tobacco control. Those respondents who reported an increase in budget were no more likely to feel that the priority given to tobacco control in the local authority was above average or high than respondents who reported a decrease in their budgets. There was also no correlation between changes in budgets and leadership on tobacco control by the lead member for health and wellbeing.

Figure 4.3 Changes to budgets for smoking cessation (excluding NRT) and wider tobacco control budgets, 2012-13 to 2014-15.
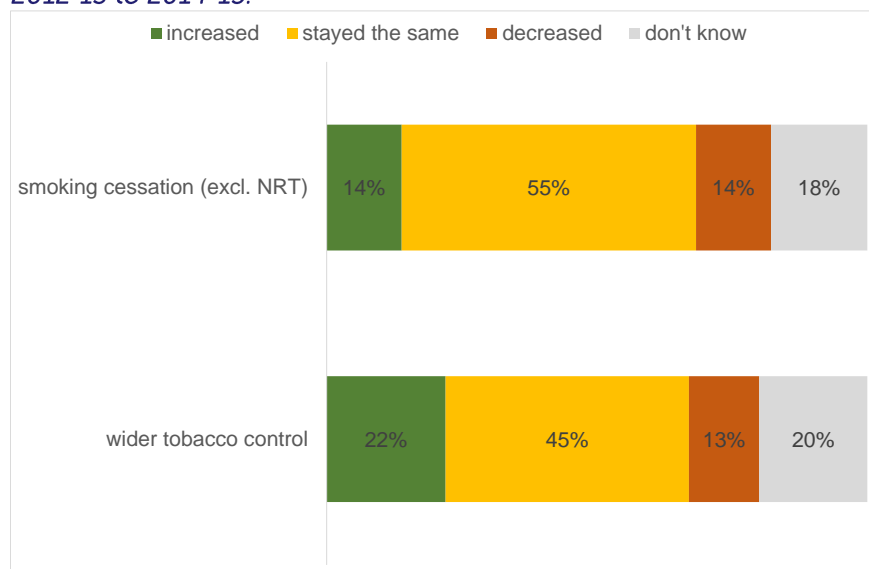
Discussion

The budget results presented here are based on respondents' own assessments of the changes in tobacco control and smoking cessation budgets from the year before transition (2012-13) to the second year of public health within local government (2014-15). The actual budgets for these areas of work have not been compared. However the findings provide a useful insight into the impact of the transition. They demonstrate that, in the great majority of cases, the public health ring-fence has been respected for tobacco control work.

Nonetheless, the minority experience is important: according to the respondents to this survey, tobacco control or smoking cessation budgets had been cut in 7 per cent of local authorities due to cuts in a ring-fenced public health budget. This is a warning to set against the generally positive picture. For if public health budgets can be cut when they are protected by a ring-fence, there is clearly a risk that many more budgets may suffer when this ring-fence is removed.

"Public health budgets are likely to be raided to reduce cuts in other areas, despite the 'ring-fence' badge. If the ring fence is removed more cuts will follow."

The diverging experience of tobacco control teams can also be seen in the time that respondents had for tobacco control before and after transition. It is encouraging that the majority of respondents have maintained or increased the amount of time they spend on tobacco control but it is of concern that nearly a third have seen a reduction in the time they spend on tobacco control including around one in six whose time has decreased a lot, mainly because they have had to take on additional portfolios.

There is a risk that many more tobacco control professionals will have to take on other briefs as local authorities look for ways to save money in the years ahead. Modelling by the Local Government Association suggests that a gap between local government expenditure and funding will begin to open up in 2015/16 and could reach £12.4bn by 2019/20[2]. In this context, the pressure on public health teams to do more with less is likely to be significant.

---

[2] Local Government Association (2014) Future funding outlook: Funding outlook for councils to 2019/20.

5. Changing relationships

Key findings

- Relationships with local government officers have widely improved
- 24% of respondents have experienced a decline in their relationships with GPs
- 27% of respondents have experienced a decline in their relationships with NHS commissioners
- 55% of tobacco control alliances have benefited from transition

Professional relationships

Respondents were asked to describe how their relationships with a range of professionals and service providers had changed since 2012-13, prior to transition. Figure 5.1 illustrates the results, with the most improved relationships first.

Overall, the move to local government appears to have had a beneficial effect on professional relationships, with far more relationships improving than declining. However there is a clear divide between relationships with local government services, all of which have improved more often than they have declined, and relationships with NHS services, where the picture is more mixed. For example, relationships with trading standards officers, environmental health officers and children and young people's services have widely improved (for 51 per cent, 42 per cent and 41 per cent of respondents respectively) and have rarely declined. However relationships with GPs have improved for only 9 per cent of respondents and declined for a quarter (24 per cent). A net negative impact was also seen for relationships with NHS commissioners (27 per cent reported a decline, 10 per cent an improvement) and NHS intelligence officers (14 per cent reported a decline, 9 per cent an improvement).

For all the improvements in relationships described by Figure 5.1, these data also indicate that there is still great scope for tobacco control professionals to exploit the opportunities of the local government setting. In each case, less than a third of respondents reported improvements in their relationships with adult social care services, recreation services, housing services and planning officers, and some respondents have no relationship with these key local government functions.

Figure 5.1 Changes in relationships with key professionals and service providers since 2012-13
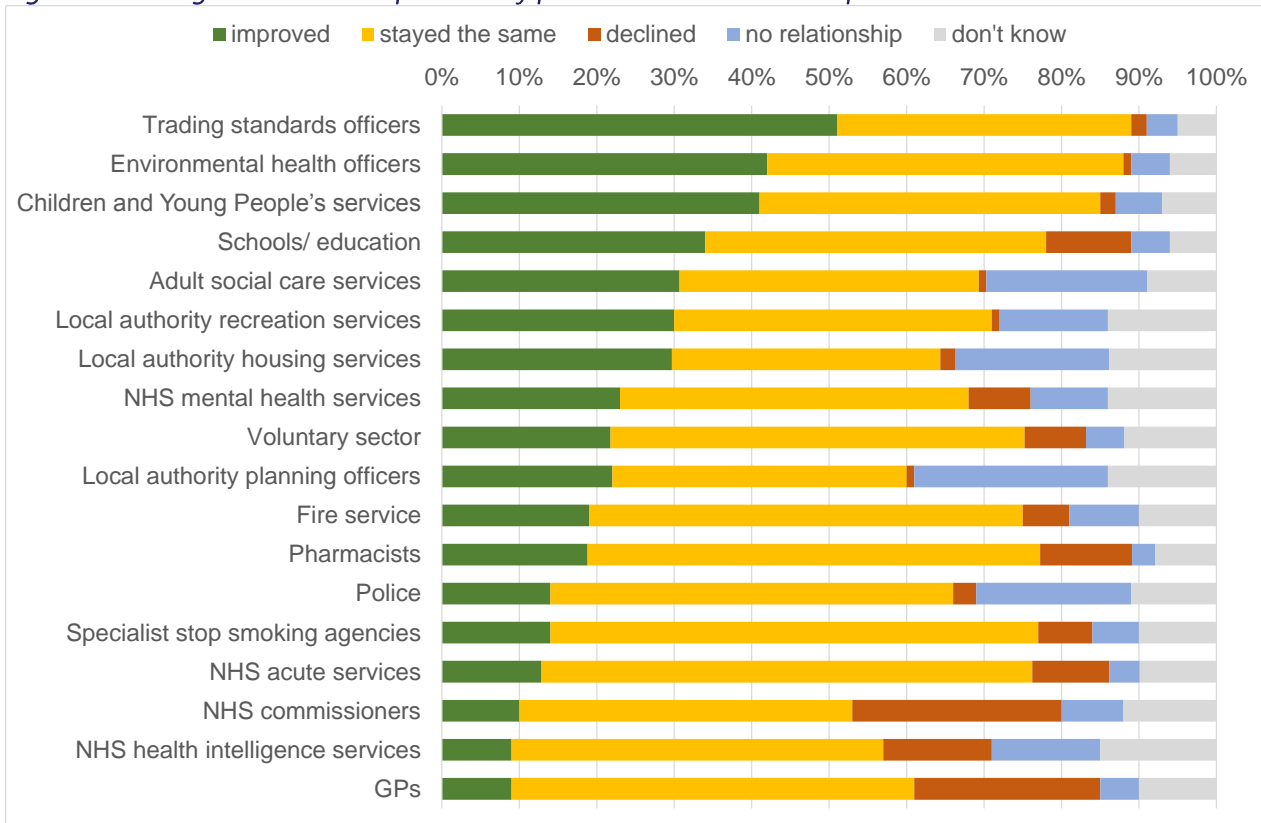
Tobacco control alliances

Respondents were asked if a tobacco control alliance existed in their locality and what the impact of transition had been on their alliance. Three quarters (73 per cent) of respondents said they had a tobacco control alliance. Of these, over half (55 per cent) felt that the impact of transition had been positive, including 17 per cent who said it had been very positive. A quarter (26 per cent) said that the impact had been neither positive nor negative and 13 per cent said that the impact had been negative.

Discussion

The transfer of public health from the NHS to local government was predicated on the idea that local authorities would be a better place to promote population health due to their links with local communities and influence over the broader determinants of health. The findings from the survey support this idea: many tobacco control professionals are building or improving relationships with people whose work takes them to streets, shops, homes, parks, schools, youth centres, care homes and much more. This ought to create many new opportunities for promoting smoking cessation services and pursuing wider tobacco control interventions including smokefree environments.

"Positioning within the local authority has enabled a wider outlook for local tobacco control"

It is, however, early days and further research will be needed to explore whether these budding relationships are effectively exploited to deliver real improvements in smoking cessation and tobacco control interventions. This will require political leadership and effective partnership, so it is encouraging that over half of respondents are positive about the impact of transition on their local tobacco control alliances. A challenge will be to move beyond relationships with officers who have an established role in tobacco control, such as trading standards officers[3], to build relationships with

---

[3] See Trading Standards Institute (2014) Tobacco Control Survey England 2013/14: A report of council trading standards service activity

other local authority stakeholders, such as planners, who have no traditional role in tobacco control but who could play an important role in the future.

Although the findings here are largely positive, there is a downside: the significant decline in respondents' relationships with their GPs. GPs have an absolutely central role to play in smoking cessation as they are perfectly placed to 'make every contact count', both by providing brief interventions to smokers themselves and by referring patients to specialist stop smoking services. At a time when GPs are reporting increasing work pressure and a squeeze on their budgets[4], a decline in their links with tobacco control professionals could have serious consequences for smokers who seek their advice. The net decline in relationships with NHS commissioners is also of concern, as Clinical Commissioning Groups provide a vital link to secondary care and mental health services.

6. Beyond the local

Key findings

- 35% of respondents reported a decrease in regional support since transition; 11% an increase
- 56% are satisfied with the level of regional support available to them
- 39% are satisfied with national support from Public Health England and other statutory bodies

Regional support

Respondents were asked if the level of regional support they received had changed since 2013, prior to transition. Figure 6.1 illustrates the results. Here the overall impact of the move to local government is negative: far more respondents (35 per cent) reported a decrease in regional support than an increase in support (11 per cent).
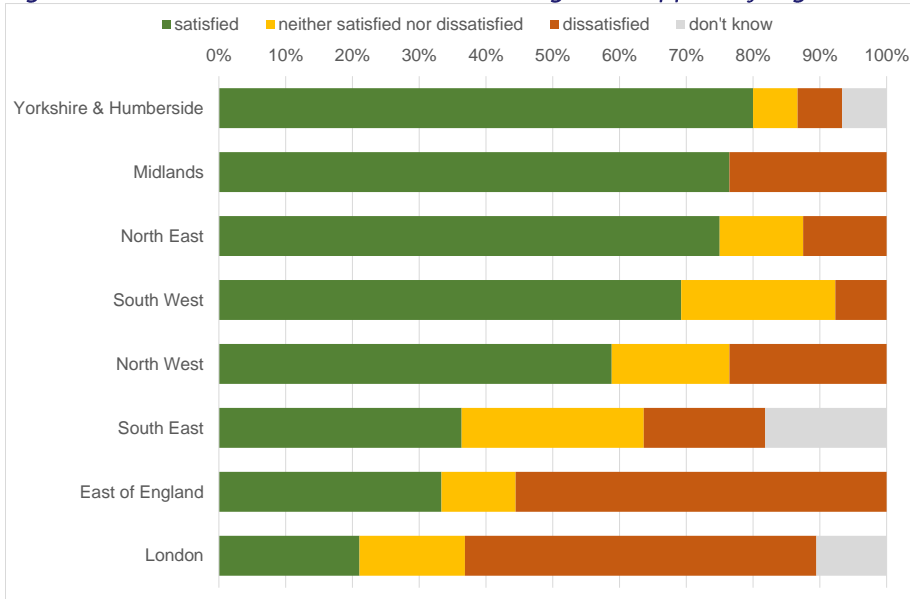
Respondents were also asked if they were satisfied with the current level of regional support for tobacco control in their area. Here the overall picture is more encouraging with a majority of respondents (56 per cent) saying they were satisfied with the regional support available to them. However levels of satisfaction vary considerably by region (Figure 6.2).

Figure 6.1 Changes in regional support post-transition

increased, 11%

don't know, 17%

no change, 37%

decreased, 35%

---
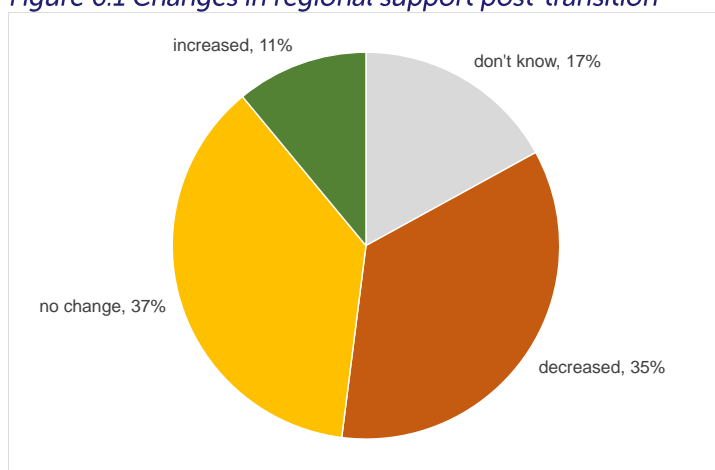
[4] Mark Gould (2014) GPs braced for shutdown after 'toxic mix' of loss of funds and high demand, The Guardian, 16th April 2014.

Figure 6.2 Satisfaction with current level of regional support by region


National support

Respondents were asked if they were satisfied with the current level of national leadership from government, Public Health England and other statutory bodies on tobacco control. Figure 6.3 illustrates the results. Here, the level of satisfaction is lower: overall, 39 per cent were satisfied and 31 per cent were dissatisfied.

Respondents were also asked to identify any issues for which they would welcome a clearer national policy position. There were 36 responses to this free text question. The two issues mentioned most frequently were electronic cigarettes and standardised packaging. Respondents also mentioned smoking in cars, smokefree public places, regional support, harm reduction and smoking in pregnancy.

Figure 6.3 Satisfaction with current level of national leadership from government, Public Health England and other statutory bodies
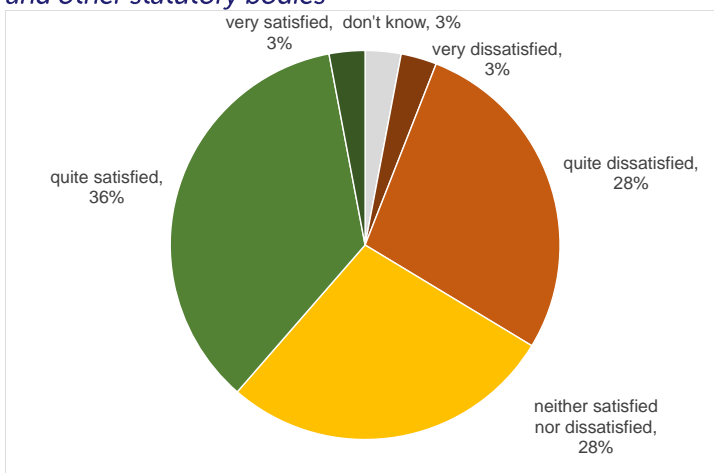
Discussion

There is a strong case for supra-local collaborative action in tobacco control, for example in mass media work, tackling illicit tobacco sales, capacity-building and research. The variability in regional tobacco control activity across England has been, and remains, an obstacle to comprehensive action on tobacco control. The diversity of respondents' answers to the questions on regional support is likely to reflect diversity in their experience of regional support before as well as after transition. Central funding for

regional programmes was cut in 2010 and while funding in the northeast has been maintained, the level of investment in the northwest and southwest has been reduced.

Tobacco control professionals in London, the southeast and the east, where there is no regional support, are clearly unhappy that their local efforts are not complemented by broader action at the regional level. Public Health England (PHE) may yet make an important contribution to regional tobacco control. At the time of the survey, PHE had only begun to build a regional presence.

The relatively low level of satisfaction with national support from statutory agencies is also of concern. Since the survey was conducted, PHE's tobacco control capacity has increased significantly. Nonetheless the fact that public health no longer sits under the national umbrella of the NHS but is now accountable to local politicians means that the powers of Public Health England to ensure standards are maintained in tobacco control across the country may be limited.

7. Past, present and future

Key findings

- 41% of respondents felt that the impact of transition on smoking cessation services had been positive compared to 16% who felt that it had been negative

- 59% of respondents felt that the impact of transition on wider tobacco control work had been positive compared to 12% who felt that it had been negative

- The principal gains of transition have been improvements in relationships with local authority colleagues and increased political support for tobacco control

- The losses and obstacles of transition include pressure on budgets, diminished time for tobacco control, poor understanding of public health by members, breakdowns in relationships with NHS partners, lack of buy-in from CCGs and local government bureaucracy

- 67% of respondents are positive about the future of tobacco control and smoking cessation in local government

Overall impact of transition

Respondents were asked to make an assessment of the overall impact of the transition of public health from the NHS to local government both on smoking cessation services and on wider tobacco control work. They were asked to judge if the gains and opportunities of transition outweighed the losses and obstacles (a positive response) or if the losses and obstacles outweighed the gains and opportunities (a negative response).Figures 7.1 and 7.2 illustrate their responses.

Overall, the balance of responses is positive. Two fifths (41 per cent) of respondents felt that the impact of transition on smoking cessation services had been positive compared to 16 per cent who felt that it had been negative. This difference is more pronounced in respondents' assessments of the impact on wider tobacco control work where 59 per cent felt that it had been positive compared to 12 per cent who felt it had been negative.

Figure 7.1 Respondents' assessment of the impact of transition on smoking cessation services
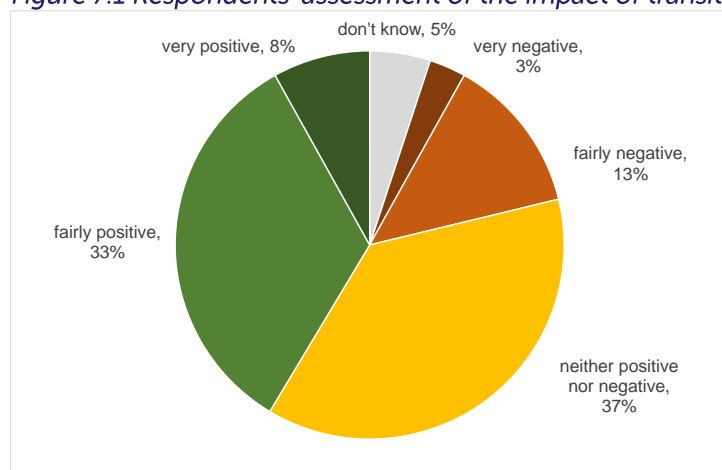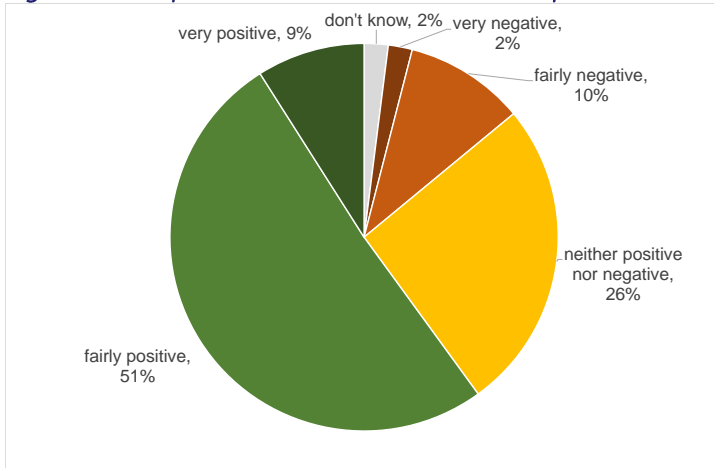
Figure 7.2 Respondents' assessment of the impact of transition on wider tobacco control work

Respondents were asked to identify the top three gains or opportunities for tobacco control, and the top three losses and obstacles, following the transition from the NHS to local government. The responses offer insight into the diversity of the experience of tobacco control teams in their new local authority homes.

Two strong themes dominated respondents' accounts of the gains and opportunities of transition. Firstly, respondents valued the closer relationships they had with local authority colleagues and the opportunities they had to integrate tobacco control into the work of the local authority. As well as their closer relationships with enforcement officers in trading standards and environmental health, respondents also appreciated stronger links with schools and youth centres, adult social care, and partners beyond the local authority such as the fire service and the voluntary sector.

"The tobacco control agenda has integrated well into the local authority"

Secondly, respondents valued the political support and leadership they had gained through greater local authority buy-in to tobacco control. For many, the support of elected members had given a new impetus to tobacco control and brought new life to tobacco control alliances. Several respondents cited the signing of the Local Government Declaration on Tobacco Control as a key achievement and an indicator of the increased political support for their work.

"Increased support for local tobacco control initiatives from members"

Other benefits that were cited by respondents included improvements in commissioning, secure or increased budgets, the support of good communications teams, and participation in the CLeaR assessment process.

The losses and obstacles identified by respondents were more wide-ranging than the gains and opportunities they had described. The following were all common concerns:

"Funding going forward is reducing for the whole public health portfolio"

- Pressure on current and future budgets and general uncertainty about the future
- Loss of personnel and/or time dedicated specifically to tobacco control, often because of competing agendas
- A lack of understanding within local government, including among elected members, about the purpose of public health and the role and importance of tobacco control
- A breakdown in relationships with the NHS including GPs and secondary care

"We're further away from influencing maternity commissioning"

- A lack of buy-in from CCGs
- The bureaucracy and politics of local government procurement and decision-making and an associated loss of autonomy

Respondents identified various other losses ranging from a loss of local intelligence data to losses in momentum and strategic direction, regional support, and national leadership. Other obstacles identified by respondents included the non-mandatory nature of stop smoking services, confusion about who pays for what, the commissioner/provider split, and the difficulty of agreeing appropriate performance outcomes and indicators.

"Slow governance procedures mean implementing anything takes a long time"

The future of tobacco control

Respondents were asked how they personally felt about the future of tobacco control and/or smoking cessation in their local area. Figure 7.3 illustrates the results. Two thirds of respondents (67 per cent) were positive about the future including 13 per cent who were very positive. Far fewer – 14 per cent – were negative about the future.

Figure 7.3 Respondents' assessment of the future of tobacco control/smoking cessation services in their area
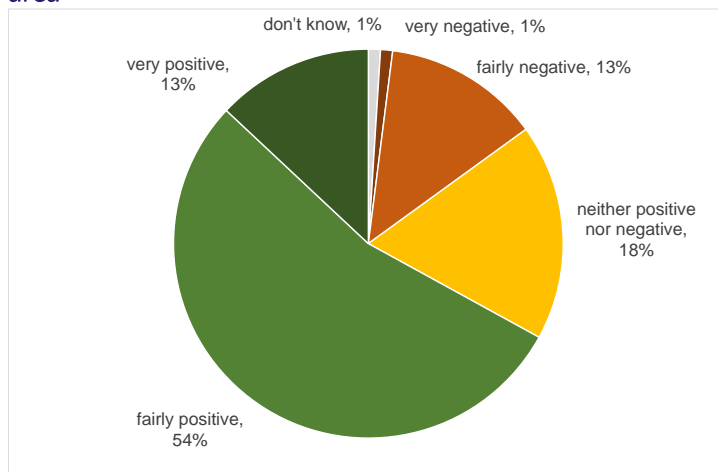
Discussion

It is encouraging that two thirds of respondents felt positive about the future of the tobacco control and smoking cessation services in their localities despite the many losses and obstacles they had identified. The survey questions which asked for an assessment of the impact of transition on smoking cessation and tobacco control work were couched in terms of the trade-off between gains/opportunities and losses/obstacles. The results suggest that although there are many issues on both sides of this trade-off, the overall impact of transition has been more often positive than negative.

This is good news but we must be careful not to interpret these results as a simple vote of confidence in the future of tobacco control and smoking cessation services in local government. Firstly, there is a significant minority of local authorities where the trade-off has not been positive, with respondents facing real difficulties in sustaining tobacco control work and smoking cessation services. Secondly, many respondents expressed their concern for the future should the ring-fence be removed from the public health budget at a time of severe cuts in local government. Thirdly, there is a real risk of fragmentation of tobacco control work across the country as different local authorities go their different ways. National leadership will be needed to avoid this outcome.

Beneath the headline results, it is the diversity of local experience which is striking. On every issue, respondents report disparate, even contrary, experiences. For example, whereas one respondent reported positively that the "good evidence base for tobacco control makes the local authority very receptive to

supporting tobacco control programmes", another despaired of the "unwillingness of elected members to engage to gain knowledge and understanding". A key challenge for the future will be to monitor the impact of this divergence of experience on the quality, scope and reach of all tobacco control and smoking cessation services.

Conclusion

The findings of the survey conducted by ASH in June 2014 indicate that the impact of the transition of tobacco control teams from the NHS to local government in 2013 has been positive more often than it has been negative. In general, tobacco control leads are positive about the future of tobacco control and smoking cessation services in their localities. Being based in local authorities has created opportunities for tobacco control teams to build new relationships and gain greater political support for their work. Where they have this political support, tobacco control teams should be well-placed to develop new service models that fully exploit the many links that local authorities have with local communities.

However, throughout this report there has been a note of warning that an overall positive result should not disguise the experience of the minority that is suffering adverse consequences from the move to local government. These consequences include cuts in tobacco control budgets, reductions in the time available for tobacco control due to expanding professional portfolios, political opposition and broken relationships with the NHS. There is also a danger that the removal of the ring-fenced public health budget at a time of severe local authority budget cuts could have serious consequences for tobacco control and smoking cessation services. The human cost of smoking to local communities remains huge, so now is not the time for local authorities to neglect their responsibilities to protect and promote the health of these communities.

In the months and years to come, a careful watch needs to be kept on key indicators of the health of tobacco control and smoking cessation services. These include budgets, staff time, the political priority given to tobacco control, changes in smoking cessation service provision and relationships with key partners.

Tobacco control is at an important historical juncture: the remarkable achievements of the last two decades have made possible a discussion of a future that is tobacco-free. This is a real long-term possibility but it is only achievable if we maintain our current commitment to denormalising smoking and helping smokers quit. Local authorities will have a central role to play in this future, so it is vital that politicians and officers in *every* local authority recognise the importance of tobacco control and smoking cessation services to the future health of the communities they live in.