*This paper is intended to support those applying for Integrated Care Board health inequalities funding for regional tobacco control work. However, it can be adapted to apply for local authority funding.*

1. **Executive Summary**
   1. Smoking is the single leading cause of preventable death and is responsible for at least half of the difference in life expectancy between the least and most deprived in our area. There are currently [insert number from supporting spreadsheet, under slide 4] smokers in [the ICB region] (1): [insert comparison to populations of ICB areas e.g. “the same as the population of York”, “larger than the population of Barnsley”].
   2. Nationally, there is an ambition is to create a smokefree generation, where fewer than 5% of people smoke across all demographic groupings within society by 2030 (2), and as part of this the NHS Long Term Plan commitments for new NHS-funded tobacco dependence services to be made available across all inpatient and maternity pathways with an offer available those accessing long-term mental health care in the community (3) is being implemented locally.
   3. The independent Khan review contains significant recommendations for Integrated Care Systems (ICSs) around their commitments to tobacco control (4). An increased role for the NHS in prevention was also outlined by Minister Neil O’Brien in his speech on achieving a smokefree 2030 earlier this year (5). He encouraged Integrated Care Boards (ICBs) to work in partnership with local authorities to develop systemwide tobacco control programmes.
   4. The Hewitt review also outlined the need for ICSs to shift their focus upstream to preventative services and interventions to improve population health and reduce pressures on the health and care system (6). This includes a recommendation to increase the share of ICB funding going towards prevention by 1% over 5 years.
   5. Reducing smoking prevalence is key to meeting all four of the key aims of ICSs: to improve outcomes in population health and healthcare; to tackle inequalities in outcomes, experience and access; to enhance productivity and value for money; and to help the NHS support broader social and economic development (7).
   6. New funding intended to support the NHS response to health inequalities (the Core20PLUS5 approach) has been identified for [ICS]. Smoking is linked to all 5 clinical areas and is a driver for poor health in all the Core20PLUS5 populations (8).
   7. This paper has been written to outline the rationale and a proposal for an expansion of the ICS's work on smoking, drawing on these new resources to develop an ICS-level comprehensive tobacco control programme. This will involve building a strong partnership of NHS, local authorities, third sector and academic / national bodies working on interventions best delivered at scale, such as:
      * Mass media campaigns intended to drive down smoking prevalence.
      * Collaboration on tackling cheap and illicit tobacco.
      * Research, monitoring and evaluation
      * Advocating for national policy action on tobacco control
   8. The recommended recurrent costs and resource implications of this approach vary from 45p per head of population ([£x use costings spreadsheet to estimate spending]) and 80p per head of population (([£x use costings spreadsheet to estimate spending]) based on funding from other regional programmes.
   9. Ultimately, the aim and outcome of this work is to accelerate regional progress towards the national smokefree 2030 target, prevent avoidable harm, reduce inequalities, and save lives.
   10. **RECOMMENDATION:** The [insert relevant committee/board] are asked to approve the proposals in this paper for the development of an ICS-level Tobacco Control programme, through the allocation of [insert desired funding] in [financial year] to the Programme in addition to current Long Term Plan money.
2. **Background**
   1. Smoking is the single leading cause of preventable death, causing over [insert supporting spreadsheet for slide set] deaths and nearly [insert supporting spreadsheet for slide set] hospital admissions in our ICS area annually. Whilst smoking rates have reduced over the last decade, at least 1 in [x – calculate from fingertips prevalence data] residents in each of the 'places' within our ICS still smoke, and around 1 in [x – calculate from fingertips prevalence data] in our area with the highest prevalence ([insert highest prevalence area]) (9). Smoking is responsible for at least half of the difference in life expectancy between the least and most deprived in society. There are currently [insert number of smokers from supporting spreadsheet for slide set] smokers in [insert area] (1): [compare to populations of ICB areas where possible e.g. “the same as the population of York”, “larger than the population of Barnsley”].
   2. Smoking costs the region [£x – use supporting spreadsheet for slideset], including [£x – use supporting spreadsheet for slide set] in NHS costs, [£x – use supporting spreadsheet for slide set] in social care costs and [£x – supporting spreadsheet for slide set] due to lost earnings and unemployment (1).
   3. Tobacco control is integral to addressing health inequalities using the Core20PLUS5 approach. Recent data suggests that a third of smokers in England reside in the most deprived 20% of areas (10) (the Core 20 population) and smoking is the leading cause of the difference in life expectancy between the richest and poorest in society. Smoking also contributes to poverty. The average smoker is now estimated to spend £2,500 a year on smoking, approximately the same as the average energy bill. When expenditure on tobacco is taken into account, an estimated [x – use spreadsheet] households containing smokers in [ICS area] are living in poverty.
   4. Smoking is also independently associated with every indicator of disadvantage, such as homelessness, unemployment and occupational group, meaning that it will likely be a leading cause of ill health amongst the locally determined PLUS populations (8).
   5. Smoking is an important factor in each of the 5 clinical focus areas (maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension) of the Core20Plus5 approach (8). Smoking in pregnancy is the leading modifiable cause of poor birth outcomes such as miscarriage, still birth, and low birth weight. In our ICS [x% find your ICS statistics in the relevant ICS briefing here: <https://ash.org.uk/resources/smokefree-nhs/briefings-for-integrated-care-systems>] of women smoke at the time of delivery. Smoking is more common in people with severe mental illness and is the leading cause for the 10-20 years of reduced life expectancy in people with severe mental illness. In [ICS area] [x% - insert from link above] of people with severe mental illness smoke. 86% of deaths from the chronic respiratory disease, COPD, are caused by smoking. In [ICS area] [x – use link above] people die from COPD each year. Smoking is also the leading preventable cause of cancer, causing 27% of cancer deaths. Smoking causes [x – use link above] cancer deaths in the ICS each year. Finally, cardiovascular disease risk is twice as high in smokers than non-smokers. In [ICS area] [x use link above] due from cardiovascular disease caused by smoking each year (8; 11).
   6. Nationally, there is an ambition is to create a smokefree generation, where fewer than 5% of people smoke across all demographic groupings within society by 2030 (2). A [representative survey for ASH](https://ash.org.uk/uploads/Public-support-for-Government-action-on-tobacco-Results-of-the-2022-ASH-Smokefree-survey.pdf?v=1659737830) of over 10,000 people found that 74% of the public support this ambition. To help achieve a smokefree 2030, the NHS Long Term plan contains a commitment that all NHS inpatients, outpatients and those on mental health and maternity pathways who smoke will be identified during their care and offered tobacco dependency treatment by 2024 (3).
   7. In June 2022 the Government published the Khan review, an independent review into its Smokefree 2030 policies. It contains significant recommendations for Integrated Care Systems around their commitments to tobacco control (4).
   8. In response to the Khan review, Minister Neil O’Brien outlined the government’s approach to achieving a smokefree 2030 in April 2023. As part of this, O’Brien advocated for an increased role for the NHS in prevention and encouraged ICBs to work in partnership with local authorities to develop systemwide tobacco control programmes, following the example set by Humber and North Yorkshire ICB (5).
   9. Addressing smoking will also be key to government’s major conditions strategy. This aims to tackle six priority areas, namely cancers, cardiovascular diseases (including stroke and diabetes), chronic respiratory diseases, dementia, mental ill health, and musculoskeletal disorders - all conditions that can be caused or exacerbated by smoking (12).
   10. Furthermore, reducing smoking prevalence is key to meeting all four of the key aims of ICSs, which are: to improve outcomes in population health and healthcare; to tackle inequalities in outcomes, experience and access; to enhance productivity and value for money; and to help the NHS support broader social and economic development (7).
   11. The Hewitt review outlined the need for ICSs to shift their focus upstream to preventative services and interventions to improve population health and reduce pressures on the health and care system. It includes a recommendation to increase the share of ICB funding going towards prevention by 1% over 5 years (6).
   12. [£x - Insert ICB health inequalities allocation] was made available through the NHS system allocations for [insert financial year]. The new funding is intended to support the NHS response to health inequalities (the Core20PLUS5 approach), and the [insert relevant board/committee] will oversee these recurrent resources coming into the system into tackle health inequalities.
   13. This paper outlines the rationale for a low cost, high return expansion of the ICS's work on smoking, drawing on these new resources to develop a new ICS-level programme of Tobacco Control. The goal is to build a strong partnership of NHS, local authorities, third sector and academic / national bodies working at scale to accelerate regional progress towards the national smokefree 2030 target, prevent avoidable harm, reduce inequalities, and save money.
3. **Current smoking and the trajectory towards a Smokefree 2030** 
   1. An estimated [x – use spreadsheet]% of the ICS population (18+) smokes (9), [higher than/similar to/lower than] the current England figure of 13%. The following table shows the current prevalence of smoking in adults (18+) across the [x – number of local authority areas] places of the ICS compared to the English average.

|  |  |  |
| --- | --- | --- |
| Area | Smoking prevalence (Annual Population Survey 2021/22) | Comparison to English average |
| England | 13% | - |
| LA 1 | 19.6% | Significantly higher |
| LA 2 | 9% | Significantly lower |
| LA 3 | 16.9% | Significantly higher |
| LA 4 | 13.3% | Not significantly different |

Select areas to compare and complete table here: <https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132885/pat/6/par/E12000004/ati/402/iid/92443/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0>

Fill table colour based on comparison to English prevalence (red if significantly higher, amber if similar, green if significantly lower.

* 1. Work led by Cancer Research UK, highlighted in the Khan Review, shows that if current trends in reducing smoking prevalence are maintained, England is due to miss its target to bring the prevalence of smoking down to 5% by 2030. It is more likely that this will happen by 2037, and for the most disadvantaged groups not until the 2040s (4). More recently, modelling by University College London using the Smoking Toolkit study, estimates that current trajectories have us reaching 5% smoking prevalence even later, in 2039 (13). The consequences of this slower pace, in terms of avoidable illness, death and costs to society, will be large.

1. **Current investment in smoking cessation and tobacco control in [ICS]**
   1. Local Authority (LA) public health teams, through the public health grant, invest a varying amount of money every year in our region in tackling smoking harm. This is reported through the LA Revenue Account process in two categories: money spent on stop smoking services (services commissioned to work directly with smokers to support them to quit) and interventions and money spent on wider tobacco control (actions taken more broadly, often at the population level, to reduce smoking prevalence and prevent harms from tobacco).

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Smoking and tobacco - Stop smoking services and interventions** | **Smoking and tobacco - Wider tobacco control** | **Total** |
| Local authority 1 |  |  |  |
| Local authority 2 |  |  |  |
| Local authority 3 |  |  |  |
| Total |  |  |  |

* 1. Research by The Health Foundation has shown that spending on tobacco control will have dropped nationally by 45 per cent between 2014/15 and 2019/20 – the biggest drop in all areas of public health provision (14).
  2. As part of the NHS Long Term Plan, an additional £[x] was provided to the ICS each year to implement Tobacco Dependency Treatment services in acute and mental health inpatient [delete if no targeted Community Mental Health pilot funding is received], maternity, and community mental health settings by 2024, with funding continuing after that as part of the ICS baseline. However in 2023/24, this funding was less than expected, meaning there is a shortfall in Long Term Plan budgets.
  3. In total, this means an estimated £[x]m will be spent in our system every year on tobacco control and stop smoking, approximately £[x] per head of population.

1. **What works for smoking cessation and tobacco control**
   1. The broad evidence-based approach to tackling the harms associated with smoking, endorsed by the World Health Organisation, is known as Tobacco Control. Tobacco Control includes:

* Provision of quality stop smoking support
* Bespoke media, communications and education campaigns which underpin population wide behaviour change
* Building local infrastructure, skills/capacity to deliver tobacco control
* Reducing exposure to second-hand smoke
* Reducing availability and supply of illicit and legal tobacco
* Reducing tobacco promotion
* Tobacco regulation
* Research, monitoring and evaluation
* Advocacy and influence to support tobacco reform.
  1. Delivered and coordinated at scale, these strands of activity create the conditions through which whole population level prevalence decline takes place; trying to quit is made to feel normal and achievable.
  2. The Tobacco Control Plan for England, published in 2017, set out national ambitions to create a *smokefree* generation (when smoking prevalence is at 5% or below) (15). The Khan review makes four key recommendations:
  + Increased investment of an additional £125 million per year in smokefree 2030 policies, with an extra £70 million per year ringfenced for stop smoking services
  + Raising the age of sale from 18 by one year every year, until eventually no one can buy a tobacco product in this country
  + Promotion of vapes as an effective “swap to stop” tool to help people quit smoking
  + Improving prevention in the NHS so smokers are offered advice and support to quit at every interaction they have with health services (4).
  1. Other recommendations include a tobacco licence for retailers to limit availability; a rethink of the way cigarette sticks and packets look to reduce their appeal; and a mass media campaign to encourage smokers to quit (4).
  2. In April 2023, in response to the Khan review, minister Neil O’Brien confirmed that the government would be rolling out “swap to stop”, alongside a package of financial incentives for pregnant women and enhanced funding to tackle underage vape sales and illicit tobacco (5). However, the announcement stopped short of increasing investment to the levels outlined in the Khan review and did not take action on age of sale or increase funding for mass media campaigns.

1. **Regional Collaboration on Tobacco Control**
   1. Another approach with an emerging evidence-base is regional collaboration. In 2021 Action on Smoking and Health (ASH) produced a report on developing [regional models for tobacco control](https://ash.org.uk/wp-content/uploads/2022/04/Regional-report-2022.pdf) based on expert interviews, desk research and survey data. This report found:
   * Regional programmes have good evidence of impact and a majority of stakeholders would welcome programmes being more widely established
   * The functions of a programme that experts broadly agreed on include: action on illicit tobacco, communications campaigns, making the case for tobacco control, policy and intervention development and supporting local implementation.
   * In addition to key functions there are wider characteristics that determine success these include: staff team with expertise in tobacco control and the ability and mandate to lead, effective relationships with local and national partners and a distinctive programme of work
   * Footprints need to be determined based on local infrastructure and with consent of local government. But they must also have regard to networks important to the function of regional tobacco control such as trading standards and TV regions (16).
   1. Current examples of working at a regional level on tobacco are designed around aggregated programme work, and benefit from economies of scale by operating across a bigger geography. This though in itself is not enough, as regional working that is transformative has clear leadership and a distinctive independence from funding organisations allowing it to:
   * Lead from the front and move the agenda forward
   * Identify opportunities for action regionally that are being missed nationally
   * Build momentum and commitment across very different organisations and provide ‘glue’ within the system
   * Be nimble and responsive to changing circumstances and agendas

It is these characteristics that lift regional approaches from being merely effective programmes to something that can inspire change.

* 1. The longest-running dedicated regional tobacco programme in the UK is [Fresh](http://www.freshquit.co.uk/) (now Fresh-Balance) in the North East. Since its launch in 2005, the North East has seen the largest fall in smoking prevalence in the country, with rates reducing from 29% to 15.3% in 2019. Meanwhile Greater Manchester’s [programme](https://makesmokinghistory.co.uk/our-strategy/) has been associated with a higher than average rate of quit attempts.
  2. [insert any existing collaboration across the region here]

1. **Proposal for a future expanded tobacco control programme** 
   1. Based on the above, the proposal is that we build a strong partnership of NHS, local authorities, third sector and academic / national bodies working at scale across the ICS, using a global evidence-based approach to drive down smoking prevalence.
   2. It is anticipated that this programme would follow the three pillars of regional collaboration outlined by ASH:

|  |  |  |
| --- | --- | --- |
| *Pillar 1* | *Pillar 2* | *Pillar 3* |
| **Coordination across the ICS** for tobacco control including:   * A supported network across NHS, Local authority (LA) public health, other LA functions, police, fire, HM Revenue and Customs etc * Shared priorities * Action at place coordinated and amplified across the system | **Effective delivery**   * An agreed set of functions to be delivered across the ICS (with scope for wider partnership within the region) * Functions which deliver economies of scale * Amplification locally but not replicated | **Inspiring change**   * Give leaders a voice to champion action across the system * Champion action needed nationally * Empower local communities through engagement with smokers |

1. **Timescales for the expansion of this programme**
   1. The following outline timescales are proposed for this work:

*[Dates]:*

* + - * Discovery period with workshop and round table events
      * Early strategy development

*[Dates]:*

* + - * Establishment of the ICS tobacco programme including core staffing
      * Regional communications and media campaigns

*[Dates]:*

* + - * Full operation of the ICS tobacco programme model.

1. **Resource Implications**
   1. Based on funding for similar regional models we propose a funding model between 45 pence per head (funding level for the Humber and North Yorkshire Centre of Excellence for tobacco control) and 80 pence per head (peak funding level for Fresh in the North East).
   2. For [this ICB], a range of costings based on indicative pence per head is given below:

45pph [insert from costings spreadsheet]

60pph [insert from costings spreadsheet]  
80pph [insert from costings spreadsheet]

* 1. It is proposed that the [x] per head value ([x]) is funded through the ICS allocation of Health Inequalities funding for our population for the full delivery of the programme.
  2. In the first year, while the core model is being established, a lower sum of [X] is proposed.
  3. Proposed costings are given in the table below, with those for 2024/25 indicative at present. [insert based on calculations from budget calculations spreadsheet illustrative budget for 80pph for population of 1.4m people below].

|  |  |
| --- | --- |
| 80 pence per head | Annual budget |
| Project team |  |
| B8c Associate director | £85,432.00 |
| B7 Illicit Tobacco Programme Lead | £55,328 |
| B7 Project manager | £55,328 |
| B3 Admin | £28,629 |
| B7 Comms lead | £55,328 |
| Running costs |  |
| Common operational costs | £30,000 |
| Activity |  |
| Communications and mass media campaigns | £485,973 |
| Monitoring and evaluation | £48,597 |
| Illicit tobacco programme | £113,394 |
| Flexible project funding | £161,991 |
| Total budget | £1,120,000.00 |
| Total allocated | £1,120,000.00 |
| Surplus/deficit | £0.00 |

1. **Conclusion**
   1. For the ICS to meet many of its objectives, including improved cancer mortality and early detection, reduced cardiovascular disease incidence, improved respiratory health, better maternity and child health, and of course reducing health inequalities through a Core20PLU5 approach, we need to eliminate smoking from our region, as fast as possible. Addressing smoking will also lift households out of poverty and increase local productivity and economic prosperity, resulting in a positive feedback loop on health inequalities. The above is proposed as a way for us to move at a greater pace, with a highly favourable cost-to-benefit ratio.
   2. The proposal also optimises the value of acting at system level, bringing together those operating at place, system and other geographies across different sectors (e.g. public health, trading standards, housing services, education, social care, community care and the NHS) around a shared common objective of reducing smoking, the impact of which will have far reaching benefits for local health and economic systems.
   3. It is important to state that the intention is for ICS funding to be additive to Local Authority public health investment in tobacco control, not replace it – though local authority funding decisions are of course not under the remit of the ICS directly. [These proposals have been and will continue to be produced in conjunction with DsPH and LA tobacco control leads, in order to ensure they enhance and enable work happening at place.]

**RECOMMENDATION**

The [relevant committee or board] are asked to approve the proposals in this paper for the development of an ICS-wide centre for Tobacco Control, through the allocation of [£x] to the Programme.

*Paper developed by Peter Roderick, Humber and North Yorkshire ICB, updated and adapted by ASH.*

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