Smokefree 2030

The role of supra-local tobacco control

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ash.
action on smoking and health

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1. Background

1.1 This report

Following the announcement of Public Health England (PHE) functions transferring in August 2020 Action on Smoking and Health (ASH) identified the importance of securing a strong model for regional tobacco control delivery within a new public health infrastructure. In collaborating with the University of Nottingham they undertook research to understand the historical models for regional tobacco control and where stakeholders across the system saw the opportunities to further develop and embed these as part of an overarching strategy to secure the Government's goal of a smokefree country by 2030.

This report sets out the findings of this research and makes recommendations for the future.

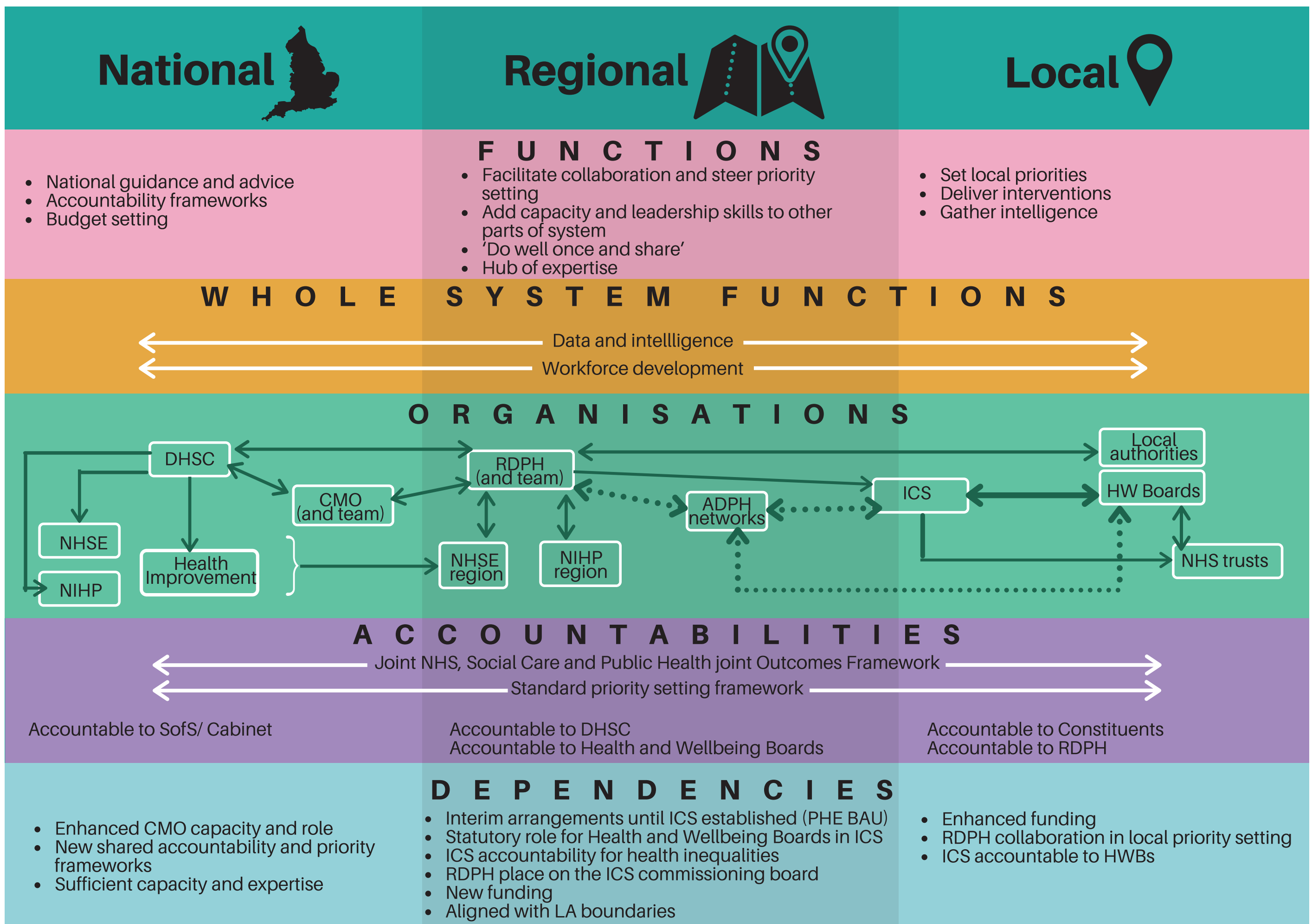
1.2 Health policy context

In August 2020, the sitting Health and Social Care Secretary Matt Hancock announced that Public Health England (PHE) would be dissolved and its responsibilities taken on by new organisations.[1] From 1st October 2021, PHE's major functions moved to the Office of Health Improvement and Disparities (OHID) in the Department of Health and Social Care (DHSC), the UK Health Security Agency (UKHSA), NHS England (NHSE), with some smaller functions taken on by other organisations.

The planned structures of integrated care systems (ICSs), which will be formalised in 2022, have become clearer. Subject to legislation, each ICS will comprise an Integrated Care Partnership (ICP, a statutory committee involving a broad alliance of organisations seeking to improve health and wellbeing) and an Integrated Care Board (ICB, a statutory organisation which brings the NHS together locally).[2]

In December 2020, Action on Smoking and Health (ASH) was asked by PHE and DHSC to run a roundtable on the future regional structure of public health, publishing its findings in February 2021.[3] These findings included a proposed regional model for a future public health system (Figure 1).

Figure 1. ASH proposed model for a regional public health structure



Specifically relating to tobacco, in June 2021, the All Party Parliamentary Group on Smoking and Health set out 12 recommendations for the upcoming tobacco control plan for England.[4] This plan is due to be published in 2022.

1.3 International regional tobacco control context

Tobacco control at subnational, supra-local level (known variously as states, provinces, and regions) has been at the heart of tobacco control efforts in federal nations. In the US, the much-admired Californian tobacco control programme works to comprehensively denormalise smoking,[5] contributing to a reduction in adult prevalence rates to 10% by 2017.[6]

In Argentina, the province of Santa Fe was the first place to enact smokefree laws,[7] which were subsequently implemented in subnational regions of Brazil and Mexico.[8 9]

In Australia, states such as New South Wales have developed strong tobacco control plans that combine support for local areas and state-level delivery.[10] In France, the Grand Est developed a regional strategy to complement national plans, working with metropolises in the region to develop comprehensive tobacco control policies.[11]

In countries with strong federal systems, tobacco control at regional level tends to be the default rather than the exception. Yet for countries with centralised systems of governance, the role of the region is less well defined.

1.4 English regional tobacco control context

In England, advocates of regional tobacco control make the case that that the "bridging" role by an intermediate level reduces duplication of effort, fragmentation of resources, under-prioritisation of tobacco issues and efforts with low population reach.[12]

Instead, the argument continues, regional focus on issues such as illicit tobacco control and media campaigns ensure national policies and evidence-based practice is implemented effectively, and local commissioners and populations benefit from economies of scale, and far greater population reach.[13 14] Regional tobacco here refers more broadly to tobacco control at subnational, supra-local level rather specifically referring to any particular method of breaking England down into regions.

However, there is significant variation in the current delivery of tobacco control at regional level. From the 2004 to the early 2010s, regional tobacco control managers were employed by the Department of Health to lead on smokefree legislation and support wider tobacco control alliances. In some areas, this evolved into broader regional tobacco control offices; Fresh North East, Smokefree North West and Smokefree South West. The offices in the North West and South West closed following a mid-year cut to public health grants in 2014/15,[3] although regional activity continues through Fresh and the Greater Manchester Health and Social Care Partnership. In Yorkshire and Humber a loser regional model has been in place throughout this period supported by the ADPH Network and PHE/ OHID and more recently ADPH Network and other regional stakeholders have come together to develop a regional tobacco control approach for London. (Table 1). Despite the areas with sustained regional tobacco control programmes seeing the greatest drop in point prevalence over the past decade (Figure 2) smoking prevalence remains highest in the North and the Midlands (Figure 3).

Figure 2: Infographic on impact of regional tobacco programmes

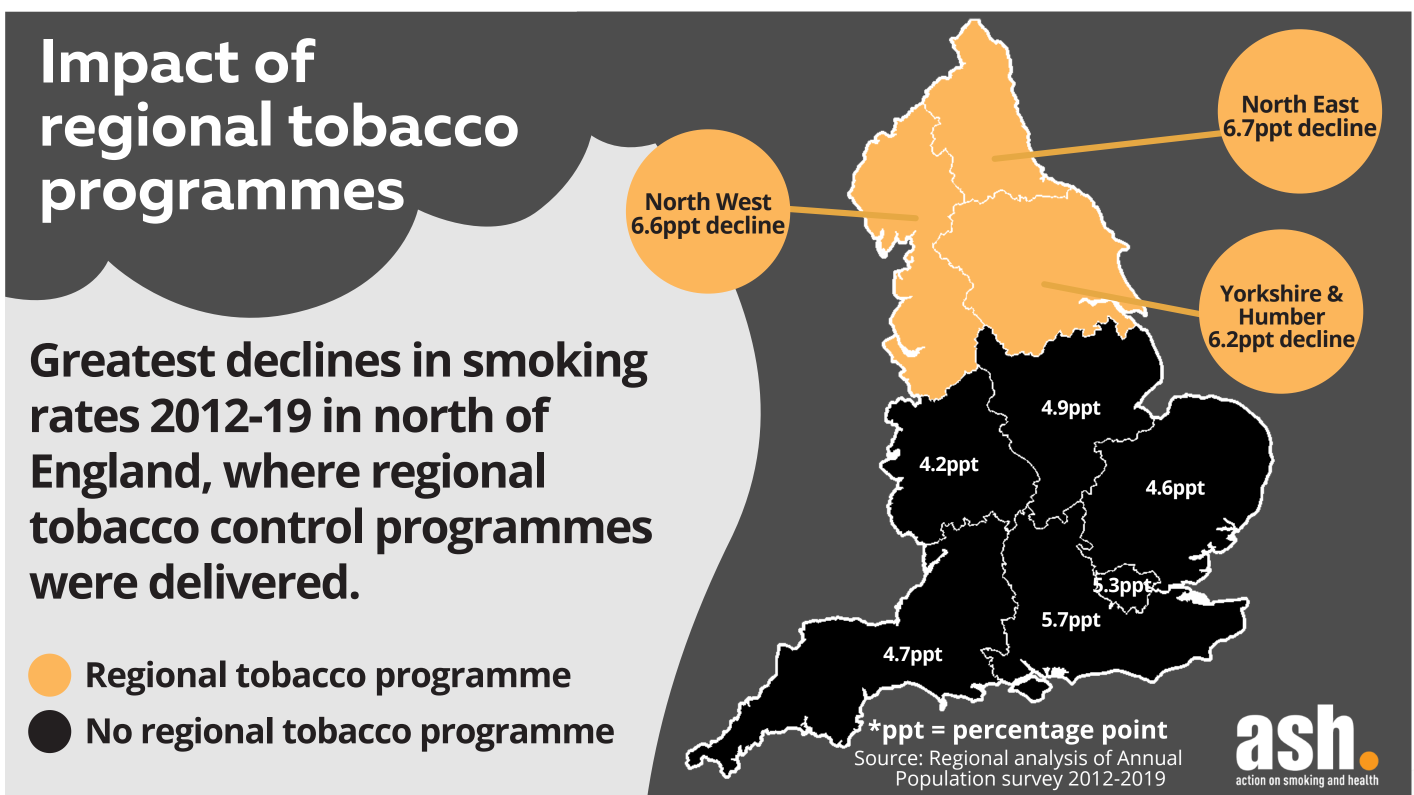
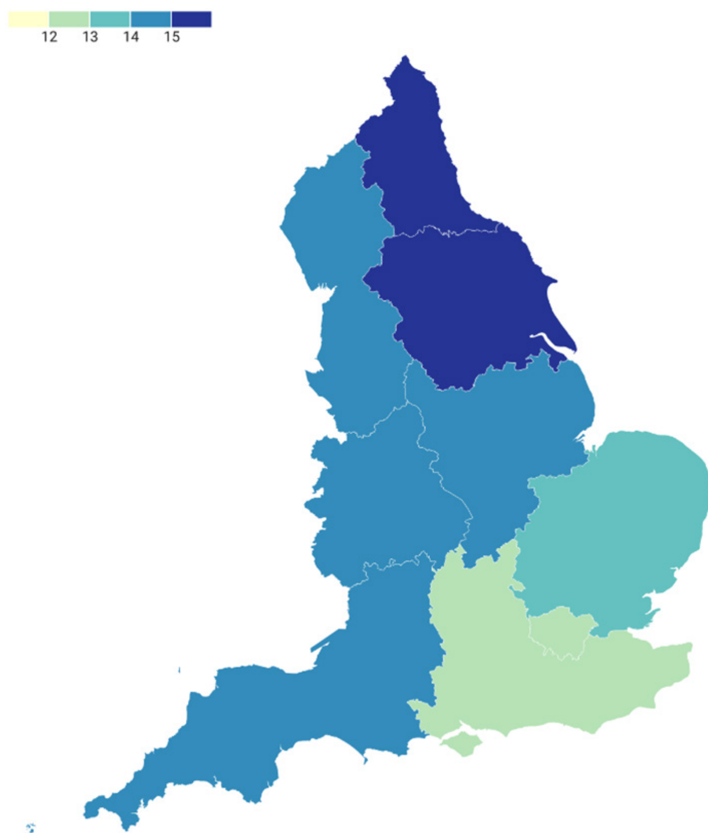


Figure 3: Adult smoking prevalence by government statistical regions, 2019[15]



From 2013-2021, PHE regional teams, based in nine regions of the United Kingdom,[16] played a role in co-ordinating and supporting local action on tobacco control. However, some teams have described the impact of COVID-19 moving tobacco control lower down a long list of priorities. The structure of PHE meant that regions had significant autonomy over priorities identified within the region and the extent to which resources were allocated to those priorities. Our research shows the tobacco control capacity of regional PHE teams varied from several staff spending more than half their time on tobacco control alongside a full-time NHS Long Term Plan lead, to one person working on tobacco control half a day a week and half an NHS Long Term Plan lead (Table 1). PHE leads described their function in tobacco control as varying, from running voluntary regional networks and sending updates, to overseeing regional campaigns and developing regional policy. Leads also described the other major regional or subregional work taking place in their area. In October 2021, these regional functions were transferred to OHID.

Table 1: Regional tobacco control resource in PHE regions as of August 2021

PHE region	Smoking prevalence[17]	Population[15]	Staff working on tobacco control (FTE)	Share of LTP Tobacco Control Programme Manager (FTE)	Other major regional tobacco control work
Yorkshire and the Humber	15.7	5,500,000	2	0.5	Comprehensive Breathe2025 regional programme
North East	15.3	2,700,000	0.9	0.5	Comprehensive Fresh programme operating across 7 local authorities
East Midlands	14.8	4,900,000	0.4	0.5	No identified additional regional activity
North West	14.5	7,400,000	0.5	1	Comprehensive Greater Manchester Social Care Partnership tobacco control programme
West Midlands	14.1	6,000,000	Vacant	0.5	No identified additional regional activity
South West	14.0	5,700,000	0.5	1	No identified additional regional activity
East of England	13.7	6,300,000	0.1	1	No identified additional regional activity
London	12.9	9,000,000	1.8	1	London Smoking Cessation Transformation Programme
South East	12.2	9,200,000	1	1	Illicit tobacco lead based with regional Trading Standards

2. Methods

This report has been informed by the following original pieces of research.

Qualitative interviews and focus groups

ASH and the University of Nottingham conducted semi-structured interviews and focus groups of professionals with expertise in or influence over regional tobacco control. Participants were identified using a purposive sampling method (ethics reference FMHS 260-0521). Participant characteristics from interviews (n=16) and four focus groups (n=26) are presented in Table 2.

Table 2: Participant characteristics

Characteristic	Number of participants
Gender	
Female	20
Male	22
Role	
Clinician	1
Health service leader	1
Local director of public health	6
Local tobacco control	7
National public health leader	1
Local politician	7
Regional director of public health	3
Regional regulatory services	1
Regional tobacco control	8
Regional tobacco dependence treatment lead	5
Subregional tobacco control	2
Region	
National	1
East Midlands	3
East of England	4
London	4
North East	5
North West	6
South East	3
South West	3
West Midlands	2

Interviews and focus groups were transcribed by an external agency. Data was then analysed using thematic analysis as described by Braun and Clarke.[18] Transcripts were double-coded by two co-investigators to provide triangulation and enhance the credibility of the analysis. Themes were reviewed between the researchers and definitions and labels refined accordingly. Themes have been derived inductively – without reference to previous theory – and analysis took place at the latent level, identifying the underlying assumptions and ideas behind the words used by participants. Quotes and images have been provided to bring the analysis to life.

Survey of PHE regional leads

Over the summer of 2021, the 9 PHE regions were surveyed to identify a snapshot of regional resource dedicated to tobacco control, with a 100% completion rate. Results are reported in Table 1.

Literature review

With the support of the PHE library service, we conducted a systematic search of UK papers between 2000-2021 on HDAS, EMBASE, MEDLINE, HMIC, Global Health and Psychology and Behavioural Sciences Collection,* resulting in 204 citations. A hand search of the citations in the 7 most relevant papers was also conducted, producing an additional 42 citations. Relevant papers have informed this report.

Final development of report

From September to December 2021, draft findings and policy recommendations were shared and discussed with regional ADPH networks, academics working in the field of tobacco control, and several national leads for topics including tobacco, prevention, public health systems and health inequalities for the national ADPH board, OHID, DHSC and NHSE. This consultation informed the final report.

The search terms were: Region, supra-local, sub-national, subnational, multiregion*, multi region*, local*, borough*, county OR counties, Smoking Prevention, Smoking Cessation, Tobacco Use Cessation, control, programme*, approach*, intervention*, strategy, polic*, Smokers, Smoking, Cigarette Smoking, smok*, Tobacco, Tobacco Use, Tobacco, cigarette*, regional tobacco control*, local tobacco control*, service model*, UK OR United Kingdom OR Great Britain OR GB OR GBR OR England OR English OR Wales OR Welsh OR Scotland OR Scottish OR Ireland OR Irish OR Northern Ireland OR isle of man OR isle of wight

3. Results

The results section is divided into three core themes identified in the research phase, each with their own subthemes (Table 3).

Table 3: Themes and subthemes

Themes	Sub-themes
1. Key functions of RTC	Illicit tobacco
	Making the case for effective tobacco control
	Communications and campaigns
	Policy and intervention development
	Facilitating and developing local approaches
2. Wider features of effective RTC	Expertise in tobacco control
	Relationships with local and national partners
	Distinctive programme of work
3. Funding and governance of RTC	Footprint of RTC
	Consistency of RTC
	Initiating and developing RTC
	Funding RCT

3.1 Key functions of regional tobacco control

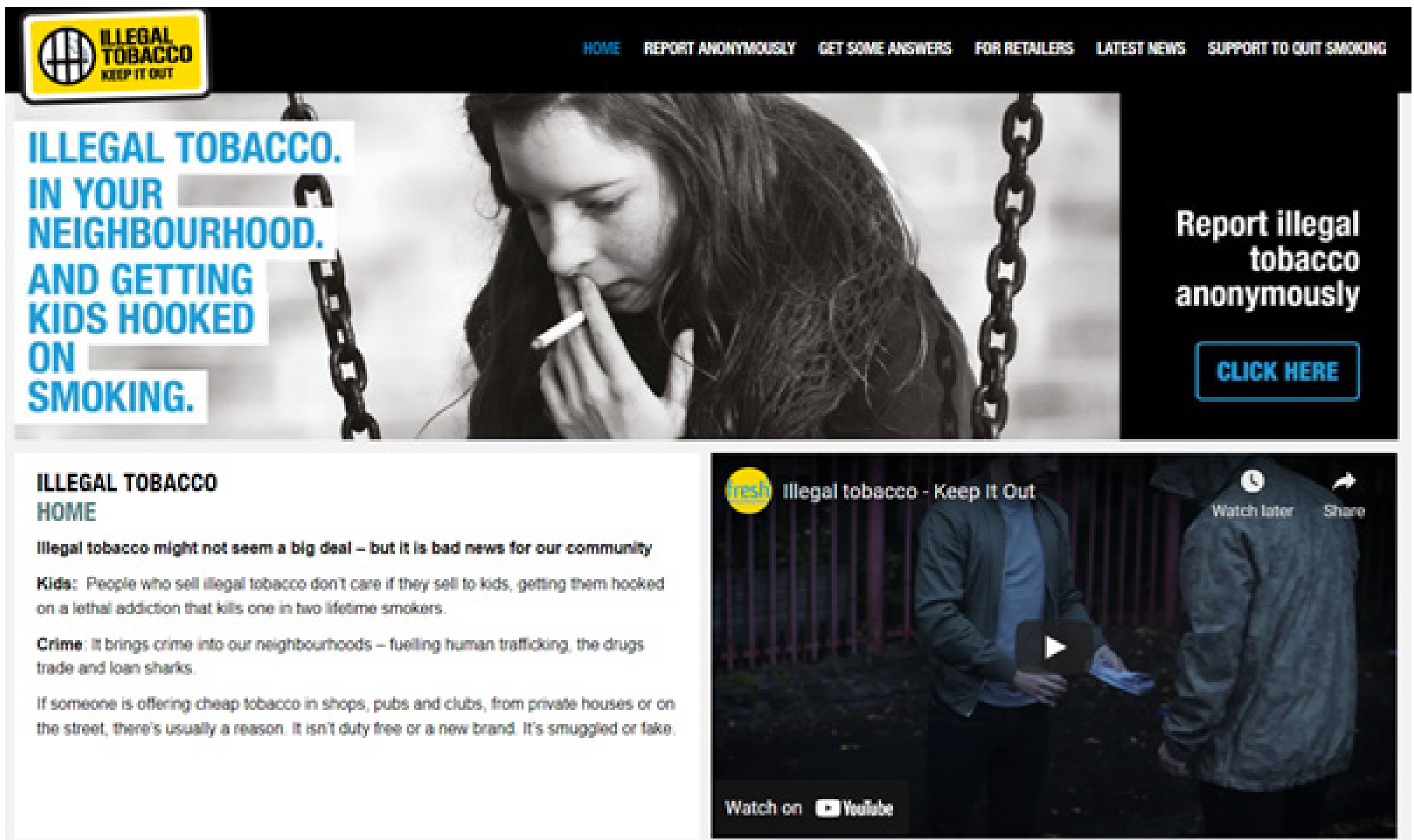
Several potential key functions for regional tobacco control were identified in the qualitative research and the literature review.

Illicit tobacco

Price and availability of illicit tobacco increases accessibility for children and reduces the effect of tax rises on quit rates. Fresh, in the North East, reports that its programme, based on regional quantitative and qualitative research, was associated with reductions in the illicit market share.[19] External evaluation of wider programmes in the North found they have increased public acceptability of reporting illicit tobacco and improved community awareness of illicit tobacco[20] and the National Audit Office has highlighted the approach as an exemplar.[21]

In focus groups and interviews, there was universal participant support for some level of regional tobacco activity on illicit tobacco, even from the minority of participants who highlighted their concerns with a regional approach. Some participants reported that in the North, regional organisations play an important role in tackling the demand for illicit tobacco by understanding and changing community norms on buying illicit tobacco (Figure 4), which complement the supply-side approach taken by enforcement agencies. Trading Standards operate nine regional offices across the country on the government region footprint.

Figure 4: Keep It Out campaign website from North of England Tackling Illicit Tobacco for Better Health Programme



> **"Criminals don't stop at local authority borders, they certainly don't care about local authority borders, so if we're tackling criminals you have to tackle at that bigger footprint."** — Trading Standards

> **"I think the sort of enforcement aspects of tobacco control, so working with retail around whether it's counterfeit tobacco or smuggled tobacco, all of that work, I think the local council footprint doesn't make as much sense to the police and other bodies. So obviously the police do operate to an extent on a borough footprint that work like that is often done better on a regional or sub-regional level."** — ICS board member

Making the case for effective tobacco control

One of Fresh's key successes, mentioned by several participants, was its role in supporting local organisations and members of the public to make the case for a comprehensive smoking ban that would not exempt "wet pubs", which did not serve food, from the legislation. Its advisory board presented the scientific evidence behind this to Parliament and 18% of the responses on the government consultation came from the North East, an area with 5% of the population.[22] Regional organisations have also contributed to policy development on standardised packaging[23] and on smoking in private vehicles carrying children.

Many participants reported that a role clearly setting out evidence to policymakers of what would reduce harm from tobacco was a priority for development in other regions. There was an acknowledgement that the degree to which this role could be best adopted regionally depended on the structure of regional offices. A regional tobacco control office jointly funded by a number of organisations and hosted by a local organisation could have a strong mandate for drawing together local voices to make the scientific and ethical case for evidence-based

tobacco control to a range of professionals and policymakers. Some participants reported that, despite some weaknesses in public health advocacy, tobacco control advocacy had been strong and regional organisations were a key part of this coalition.

> **"I think there's always been a really strong advocacy role and I don't see that changing... So in terms of the health outcomes that were there pre-pandemic and still exist, yeah, we need our Public Health people and our politicians to speak up, and our population to speak up. We need those kind of grassroots movements don't we of people speaking up for themselves – smokers and non-smokers and ex-smokers."** — Regional Tobacco Control

> **"There's something to be done around advocacy. We're pretty s*** as a Public Health community around advocacy, in an organised way. We all do bits of it, bits of it here, bits of it there, but it's all absolutely it's hodgepodge and it's all a bit unorganised and often underwhelming because we're not coordinated and connected. So I do think there's something that we could do in a regional way in that space."** — Director of Public Health

Communications and campaigns

A number of participants made the case that the regional level is an effective place to run communications campaigns to support changing social norms, especially across footprints that mirrored those of regional news outlets. Some of those working in local authorities reported they did not have the budget to run a successful campaign locally.

> **"I think, you know, we've obviously lost a lot of funding over the years for proper modern, high quality campaigning... even if we're going to have some of that sitting at national level, which I do think makes sense in terms of heft and firepower, again I think we've learnt an awful lot through Covid about localised communications and there needs to be some scope to be able to do that. So again, I think that's something where it does make sense to have that done on a kind of regional footprint. It's probably bigger than an ICS level, you know, so that we'd be very keen on."** — Director of Public Health

> **"So mass media campaigns is probably the big one, that have a local and a regional feel."** — Clinician

A minority of participants believed multimedia campaigns were better done at either national level or local level, citing national media reach for the former and hyper-targeted messaging for the latter.

> **"I just think in terms of cost-effectiveness I think (national) would be the most useful in terms of getting the message across. It also helps ensure that there's a universal provision or a universal offer around campaigns."** — Regional Tobacco Control

There is some support in the literature for regional approaches to media campaigns. An evaluation of a London marketing campaign seeking to increase quit attempts found an increase quit attempts in London by almost 10 percentage points compared to pre-campaign – and whereas quit attempts rose in London, they fell in the rest of the country.[24] A month-

long campaign on e-cigarettes as a quit aid carried out regionally by Greater Manchester was associated with an increase in smoker motivation to quit, although the impact on e-cigarette awareness was more mixed.[25] Regional campaigns have found that digital media combined with TV advertising drives higher qualitative engagement.[26]

Media campaigns in California and Massachusetts (with a population similar to many English regions) were associated with significant decreases in smoking prevalence compared to the rest of the USA.[27]

Figure 5: Greater Manchester You Can campaign

Policy and intervention development

Policy development at regional level will include supporting and enabling local areas in developing their own approaches, but many participants also discussed the value of policies that can be rolled out across the region, for example on e-cigarettes (Figure 6) or smoke-free hospital policies. A common point was that regions could have the population scale and resources to develop a policy idea well, but greater flexibility and adaptability to regional circumstances than a national team with the ability to secure local buy-in. Participants also discussed the role of regional tobacco control in working with other partners operating at supra-local level like ICSs to understand the impact of smoking on the health of their populations, and in developing concrete actions that could be taken at greater than local level.

> **"I think also there probably needs to be – well there does need to be – common (policies) because you can cross the street and you're in another county, or across a road. Some of our communities, particularly the rural communities, will look to other county areas rather than the one that they currently sit in."**
> — Councillor with responsibility for public health

The BabyClear trial, and intervention to improve referral and treatment of pregnant smokers conducted in the North East of England, is one such example of how a new policy can be

implemented at scale and be fully evaluated on a regional footprint.[28]

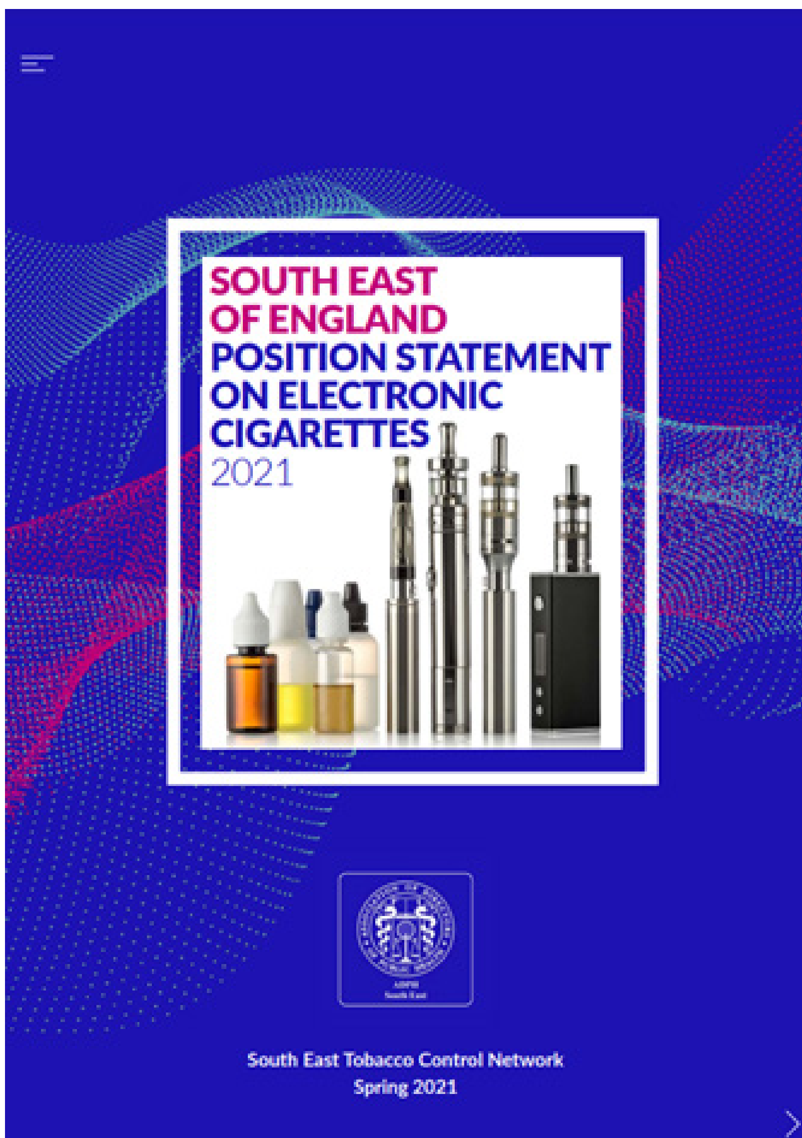
> **"But what you have at the (place) level is that ability to coordinate and to support and to ensure that (number of) localities are all potentially doing something similar and you get the scale don't you about the learning and sharing together. I think that's really quite an important and useful way forward and I think certainly in (place) the figures suggest they're quite effective."** — Director of Public Health

Participants also raised the risk of a regional approach creating a culture of **"death by update"** (local authority tobacco control) if there was not a more proactive strategic role in overseeing policy development and delivery.

However, a small number of participants did not feel that a regional approach in their area would add value to policies that could already be done locally or nationally, and that it instead might introduce added bureaucracy and opportunity costs. These were not areas that currently have an additional regional model in place.

> **"Well, a local authority doesn't need to speak to anybody else in a region to introduce a smoke-free policy, neither does any NHS organisation."** — Director of Public Health

Figure 6: South East of England Position Statement on Electronic Cigarettes, 2021



Facilitating and developing local approaches
Participant perceptions varied in their views on the degree to which regional tobacco control should be involved with the development of smoking cessation services.

Some participants noted the danger of regional teams being set up purely around supporting smoking cessation services, although the general consensus was that regional approaches supported localities to look beyond the commissioning and delivery of smoking cessation services.

> **"The other thing to note I think about the regional element is that for [place] it mainly seems to be focused on smoking cessation and not really the wider tobacco control agenda."** — Regional tobacco control

Some participants saw a role for regions in standardising and improving the approaches to accessing services, particularly with services becoming available for a great number of NHS patients through the NHS Long Term Plan delivery.

> **"Those relatively rare moments where someone wants to make a change, you want to remove as many barriers as possible and an inconsistent approach to how you offer support to people I think creates an additional unnecessary barrier and there may well be some economies in terms of commissioning things like smoking cessation over a [place 2] footprint rather than a borough or small number of boroughs."** — ICS board member

Some participants advised against regional teams taking on the role of performance management in scrutinising delivery of local services, citing negative impacts on relationships between regional and local teams.

> **"The bit that they didn't like previously through that network was the degree of scrutiny and stuff around performance that came very strongly from the NHS kind of leadership of that."** — Regional tobacco control

However, there was widespread discussion of a greater role for regions in a more supportive "performance development" function pulling together and disseminating data on service delivery and tobacco control from across their area and sharing best practice. One participant described this tension as "a bit of a fine line between data collection evaluation and performance monitoring" (DPH).

The views on where the balance should lie were varied regardless of role. Some regional leads thought the region should be purely facilitative, whereas some local leads welcomed more open sharing of local data and scrutiny.

Findings from the ASH annual survey of local authorities shows there is a relationship between local priority on tobacco control and the presence of an established regional programme (Table 4).

Table 4. Local authorities where the priority of tobacco control was perceived to be high or above average (n=114)[29]

Region	Surveyed local authorities responding	Priority of tobacco control perceived to be high or above average
North East	8	7 (88%)
Yorkshire and Humber	12	7 (58%)
North West	16	8 (50%)
South East	14	6 (43%)
London	24	8 (33%)
East of England	10	3 (30%)
West Midlands	10	3 (30%)
East Midlands	7	2 (29%)
South West	13	3 (23%)

3.2 Wider features of effective tobacco control

Expertise in tobacco control

Participants generally made clear they felt regional teams must possess up-to-date expertise on tobacco control. Stakeholders who placed greatest value in their regional teams cited their deep expertise in tobacco control, and, along with consistency of postholders, this was cited as a key factor in trust in the regional function.

> **"[Name] has always been the linchpin of that and has done so exceptionally ably over many, many, many years. [Name] has the go-to on all things tobacco control for the region."** — Director of public health

> **The risk of regional teams possessing only generic skillsets could lead to partners feeling like they are working with people who can "tell you what you already know".** — Director of public health

Many participants felt regional tobacco control offices require leadership who deeply care about the impact of tobacco. This enables leaders to be driven to influence others by "a sense of...social justice in terms of the impact that tobacco has on families and communities". (regional tobacco control).

This was linked to a view that effective regional tobacco control was a clear, well-evidenced method of reducing health inequalities and wider inequalities, which has strong links to the Government's levelling up agenda.

> **"We're going to be in recovery and restarting building back fairer and better and we need to ensure that there's policy advocacy for tobacco cessation, especially as a driver of inequalities."** — Regional DPH

Relationships with local and national partners

Some participants advocated for the ability to set regional priority and strategy which was truly regional, rather than simply for a regional tobacco control programme. These participants heavily emphasised the exceptional skills in building and maintaining relationships and coalitions of the willing this required; for merely keeping relationships ticking over was not enough to create change.

> **"It's been years since we all sat down together and mapped out collectively a regional tobacco strategy and carve out, so it's not just seen as [name], it needs to be NHS contribution, this is the [name] contribution, this is local authority's – and that's I think what we're missing and I think you've probably got more of that to an extent happening in Greater Manchester because they were able to come up with a five year strategy."**

Participants reflected that strong relationships would be necessary with DPHs, LAs, ICSs and local politicians, articulating that regional teams should be able to bring partners together and amplify the voice of tobacco control alliances. Partnership working is the future opportunity most commonly identified by local tobacco control leads;[30] a regional team could play an important role in convening this on a larger footprint.

An ethnographic study of Fresh found that "by talking about success stories elsewhere in the world, by greeting advisory panel members warmly, by phoning them to ask their advice on particular issues, the SFNE office staff were following the American Cancer Society's exhortation to be "sparkplugs", "visionaries" and "movement builders".[31] A social network analysis of tobacco control networks in the US found that programmes with greater connectivity between partners and flatter structures had better-rated networks.[32]

Participants also described building relationships with policymakers and national organisations, participating in policymaking meetings and contribute to the evidence base on consultations and guidance e.g. NICE. This mirrors the description of the Royal College of Physicians of regional teams playing a "bridging" role between national and local, reducing duplication of effort, fragmentation of resources, under-prioritisation of tobacco issues and efforts with low population reach.[12]

Some participants discussed building strong relationships with groups who represent or are in close contact with populations more likely to smoke, with examples given including trade unions, large routine and manual employers, housing associations, mental health service providers, maternity providers and LGBTQ+ groups.

> **"In some ways I think the office approach has been able to address those better, so for example, around maternity.... I remember [name] and I speaking to the Clinical Director of the Maternity Network who at the time didn't really appreciate how effective and cost-effective interventions for smoking cessation were in pregnancy."** — DPH

Distinctive programme of work

Most participants recognised that tobacco control programmes could not operate in isolation. Many participants recognised the links with other behavioural public health issues, also termed the commercial determinants of health, and with disease prevention programmes.

> **"So this is where I think we do need to get it back on the agenda and it needs to be at the forefront of the agenda and we need to link it with things like CVD, obesity and all the other things that we know it links to, but make sure it's the number one priority still."**
> — Local authority tobacco control

One participant reported that tobacco control could no longer work as a standalone programme, because of changing views of its importance.

> **"I think maybe, you know, a lot of people see tobacco control as done and dusted... I personally still think it is, but I think that a lot of people aren't as interested in tobacco control as they were and I don't think there will be a lot of appetite for putting a lot of money into it, to be honest."** — DPH

However, a commonly-held view was that, whereas regional tobacco control programmes needed to make links with other strategies and programmes, it would be most effective where it retains an identity as an important programme and priority of its own. As a uniquely harmful product, tobacco control programmes can maintain clarity of message that can be diluted or confused by other public health priorities.

> **"But I think to have something which focuses on tobacco is really helpful ... I don't know if you've spoken to anybody in the [place] yet ... it is interesting that they've kind of (tobacco and alcohol) as separate... and I think that's kind of the right thing to do because I think once you then associate it with people's drinking habits, you know, it just automatically leads people to think well, this is just the nanny state telling us how to live our lives. I think on tobacco I think the public view is that amongst smokers' it's on its way out and steps we can do to help smokers to quit and stop children from taking it up in the first place is going to get a degree of support. As soon as you say 'well, you also need to be drinking less and eating more healthily', I suspect people will switch off."** — Regional DPH

Participants discussed a range of skills that an ideal regional tobacco control team or network would possess, or at least be able to draw upon. This included project management and delivery skills, which linked with the view that regional teams should be involved in delivery and not just facilitation. Many participants ranked communications skills highly, given views on the importance of multimedia campaigns. Some participants expressed support for team members with experience of trading standards or environmental health to support legislative work. Data analysis and evaluation skills were discussed as a function that could sit within a regional team or could be drawn on from wider intra- or extra-organisational teams.

> **"I think that you need expertise in that to head it, so you need someone that knows the networks and can get going. I think that you need communications and PR expertise to create noise and to have those skills. I think that you probably need project management skills... and I think you'll probably need a sort of data skill somehow to understand the data and present that data back to local areas".**
> — Regional tobacco control

3.3 Funding and governance of regional tobacco control

Footprint of regional tobacco control

The populations of the pre-existing regional healthcare structures vary considerably across England (Table 5).

Table 5: Populations and numbers of ICSs within regional structures in England

	Regional area[15]	NHS region	Number of ICSs
North East	2,700,000	8,200,000 (NE and Yorkshire)	1
Yorkshire and the Humber	5,500,000		3
North West	7,400,000	7,400,000	3
East Midlands	4,900,000	10,900,00 (Midlands)	5
West Midlands	6,000,000		6
East of England	6,300,000	6,300,000	6
London	9,000,000	9,000,000	5
South East	9,200,000	9,200,000	6
South West	5,7000,000	5,7000,000	7

The research elicited mixed views on regional footprints from participants, which is likely reflective of diverging approaches to regional and subregional governance across England through devolution deals, strengths of less formal networks and significantly varying ICS footprints.

Some participants did not perceive single ICSs to be a natural footprint for wider tobacco control. Reasons given included a footprint often fragmented across smaller populations (for example, West Midlands contains 6 ICSs for an area with a population of 6 million) and without coterminosity with Trading Standards footprints, ADPH networks or media outlets, three frequently named major tobacco control partners.

> **"I'm not sure, [place 1] is only a population of [number] people and I'm not sure that's a big enough footprint for what you need to do on reginal tobacco control. It doesn't give you enough bite…I don't think that is a big enough vehicle to do what needs to be done on tobacco control."**
> — Councillor with responsibility for public health

> **"The ICS is…generally based around acute footprints and so it's hard to see the logic of doing stuff at that sub-regional level."**
> — ICS board member

The former government office regional footprints were perceived by some interviewees as the optimum level for tobacco control. These participants reported good recognition, ease of data collection, pre-existing relationships and coterminosity with other networks as strengths.

> **"I think that the regional government offices were probably as good as anything else. They're big enough to manage but to make economies**

> **of scale and work with colleagues without being too small or too big.”**
> — Regional tobacco control

> **“Certainly in the [region], you know, there is quite a strong history of working on the [region]. It’s been strengthened by Covid…so you know, I think within the region we could work really well on the [region] footprint”** — DPH

Others felt that tobacco control should operate on different footprints depending on the specific local or sub-regional set ups, such as city regions, combined authorities or larger ICS footprints.

> **“So then it’s like right, what’s the next level up? For us it’s [place 1]. In [place 2] I think it’s the whole of [place 2] potentially or it’s at a [place 2] level but it’s those localities, the coalition of the willing ones within that, which is what we tried but again it just didn’t have enough oomph and funding and support.”** — DPH

Consistency of regional tobacco control
Many participants felt that their area or region would benefit from a stronger regional approach to tobacco control. Often citing regional models in the North East and Greater Manchester, these participants argued for a more consistent approach to regional tobacco control across the country.

> **“Where we’ve fallen down and possibly one of the reasons why our prevalence rates have not really gone down significantly when you compare it to other parts of the country, which you know, historically had higher rates but probably have less than we have now. So I think there is something to be said for the regional approach and a sustained regional approach.”** — Local authority tobacco control

> **“It is not uniform enough. So having worked in [place 1] and [place 2], we don’t have equivalents and that’s a real gap and so I think the big question for me is how could we get some of that infrastructure capability back in place and how do we resource some of that? Then structurally where and who does that sit with? It kind of feels to me like we’re at a bit of a turning point where we kind of know what we haven’t got, we know what works but we’ve got a bit of a way to go to build back some of that and build it back in on a kind of more universal footprint, you know, universal coverage across the country really.”** — DPH

A minority of participants felt not every region or area would necessarily benefit from regional tobacco approaches and there would not be appetite for developing structures in their area.

> **“If you start building a whole structure around a region, we don’t react well to that regional influence.”**
> — Councillor with responsibility for public health

Initiating and developing regional programmes
Participant views on how regional programmes should be instigated were varied. At one end of a spectrum, a small number of participants felt any form of regional collaboration should be organically determined by local areas based on local circumstances.

> **"I think it needs to operate at lots of different levels… we've got the (nth) biggest ICS in the country, so I think people will probably see that as really, really big… you could take forward lots of different initiatives within different areas within regions".** — DPH

A number of participants felt that the national centre should set clear guidance that regional working is desirable, and set out why, but that it should be down to local areas to determine the exact footprint that this work should take place at.

> **"I think it should probably be left to local areas to decide because it will vary…it may be locally, politically more acceptable to kind of reinvent it and rearticulate it at that kind of sub-regional level I described. So I think I wouldn't mandate it but I would in national guidance, you know, give a strong push for regional work in the definition that you gave previously so, you know, above a single local authority area level and articulate very clear the advantages of doing so."** — Regional DPH

Other participants felt that without clear national action to kickstart regional working, the status quo would persist, with areas with existing strong collaboration continuing to be strong and other areas continuing to persist with fragmented models. This is borne out to some extent by experience, as the 2011 national Tobacco Control Plan contained exhortations to regional working,[14] but was succeeded by a decrease in number of regional tobacco programmes.

> **"I think until we get that real understanding and commitment from a high level to say yes, tobacco control functions should universally be run, you know, have a regional output, these are going to be the regional areas and this is how we're going to do it, I think we'll struggle potentially to get buy-in in those places that don't see the value, whereas others will continue to thrive."** — Regional tobacco control

> **"I think that needs to be fairly clear national guidelines. I mean the problem for the [place 2] is that we are a self-contained area but actually we get millions of visitors every year, so there does need to be some consistency for those people coming down from the [place 13] and the [place 14] and [place 15] into the area. So, you know, whilst we would like flexibility, and I think the flexibility has to come in terms of messaging and all that, I do think there needs to be some pretty clear national guidance."**
> — Local authority tobacco control

Funding regional tobacco control

Participant views on how regional tobacco control should be funded were mixed. Many participants described the difficult financial situation of local authority public health departments and how this had, and may continue to be, a barrier to funding regional tobacco control work.

> **"Well I think the perennial difficulty is resourcing and funding. Local areas that are under increasing financial pressure find it difficult to justify contributing funds to activities that are not entirely focused on the local area."** — Regional DPH

One idea raised by multiple participants was a shared funding model, with central government, local authorities and NHS partners all contributing money to a regional team. The articulated benefit was of shared ownership and securing buy-in from those who would otherwise be

reticent to contribute. In-kind contributions from local authorities and ICSs were raised as a possibility for this model.

> **"I think you need it for buy-in, so I do think it's important local authorities contribute. I think it's important the NHS contributes. I think it's important OHP national government contributes. I think that way you get better buy-in because everyone feels it's their money. Nothing like your own money to give you some focus and attention to a problem."**
> — Regional DPH

An economic modelling of tobacco control in England found that supplementing local programmes with sub-national tobacco control programmes can result in significantly improved health outcomes and avoidance of disease for the public, with resultant financial savings for the local health sector and wider economy.[33]

Participants articulated the need for longer-term funding to build stability in networks and activity.

> **"Over the years we've had some absolutely brilliant regional support but the problem I think was always down to funding. They were fixed term contracts for about three years, so they'd just really get going, you know, really knowledgeable, really get us all motivated and be doing loads of coordinated activity and then the funding would run out and then we'd have six months or something where we had no regional support, or very little."** — Local authority tobacco control

ASH has previously set out estimates for the funding required at national, regional and local level to achieve the goals of Smokefree 2030. At its peak in 2009, Fresh, the regional approach with greatest longevity, was funded at 64 pence per capita. Uprating in line with inflation to 2020 would equal 89 pence per capita in 2020. However, a large portion of this budget would be allocated for mass media behaviour change campaigns. Expenditure in this area will vary depending on the level of national investment in mass media. Without national spending at appropriate levels for a population of 5 million best practice mass media campaign spend would be around £2.3 million. With higher levels of national spend this could be reduced but it remains important that communications activity is undertaken at regional level and led by teams within the region. Being able to tailor approaches to local circumstances, partnerships and populations is a key success factor and this cannot be done with best effect at national level.

The example in Table 6 draws on intelligence from pre-existing regional and subregional programme costings. It presents how an area with a population of 5 million might use its annual investment, excluding mass media spend.

Table 6: Illustrative example of regional annual expenditure to achieve Smokefree 2030 goals

Activity	Spend
Illicit tobacco programme	£500,000
Data analysis and evaluation	£400,000
Policy development	£250,000
Staffing	£1,000,000
Total	£2,120,000

This example sets out potential core functions of regional work. Other elements, such as support for the Long-Term Plan delivery of cessation services for large patient and staff populations, the local stop smoking service offers, and large-scale programmes such as an enhanced digital offer would require separate funding streams. ASH's Smokefree 2030 Fund brief has more details.[34]

4. Policy recommendations

4.1 Principles of regional tobacco control

- **There should be longevity and stability of any new regional funding arrangements.** There are clear economic benefits of regional working, but in order for these to be realised, regional approaches need sustained backing to build programme momentum and trust with local stakeholders.

- **There is a central role for a regional convenor.** This should be a named senior person within a region who takes on responsibility to bring together local and regional partners to collaborate on tobacco control.

- **There are clear areas of tobacco control that are especially effective when delivery by a supra-local, subnational level of tobacco control.** This include but are not limited to:
    - tackling illicit tobacco
    - communication and campaigns
    - making the case for effective national tobacco control
    - policy development
    - facilitating and developing local approaches

- **The regional function should possess expertise in tobacco control.** Participants expressed the need for regional functions which understands the evidence base and politics behind tobacco control

- **Supra-local, subnational tobacco control will look different in different parts of the country.** This research has highlighted that different parts of England are developing quite different forms of governance, based on historical working relationships, the presence of combined authorities and city regions, the geographies of ICSs and NHS/OHID footprints. This will influence the form and function of regional development.

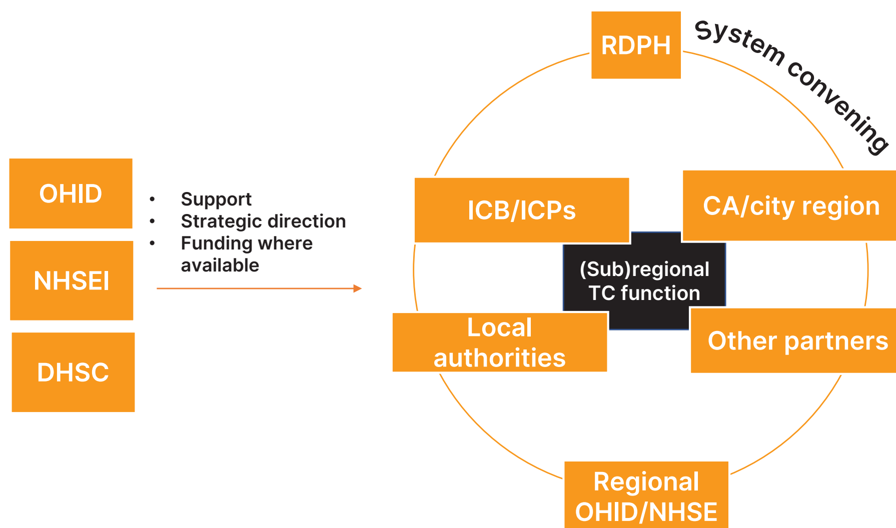
- **There is a role for national leadership in supporting regional working, but this should be informed by the principles of subsidiarity.** Structures imposed on regions will not gain local traction if they are not linked and formed by existing partnerships and will likely be counterproductive. However, past experience shows that successful regional work has combined national support for regional work with a strong local appetite for delivery.

- **Any regional approach must include a wide range of partners taking on specific roles supporting the function.** This is outlined in Table 7.

4.2 Organisational roles in regional tobacco control

Following data collection and analysis, several models of regional tobacco control were developed and tested with a wide range of stakeholders over a period of months. We found that each model had its own strengths and weaknesses, but the degree to which the strengths outweighed weaknesses varied significantly from region to region. As has been reported, there is no fixed model that can be cut-and-pasted across the country. A visual representation of one of many possible models is shown in Figure 7. The model shown is not a blueprint, but rather a demonstration of how subregional and regional models might fit together in a particular set of supra-local circumstances.

Figure 7: Example model of regional tobacco control in England



In this illustrative example, one subregion with an established mayoral combined authority has chosen to take develop a supra-local tobacco control function which takes on the specific role of bringing together partners to develop policies on smoking cessation pathways and facilitating networks for the area. The second subregion chooses not to develop a subregional function, because each local authority works closely with a single ICS. On a cross-regional footprint, all partners across both subregions contribute to a regional function delivers large-scale behaviour change campaigns, works with enforcement agencies to tackle illicit tobacco, and makes the case for effective national tobacco control policies.

Here, the regional director of public health takes on the convening role, sharing the vision for regional tobacco control and encouraging partners to contribute their time and resources to develop its functions. Local authorities and ICBs contribute resources to the shared regional function and other partners, such as the police, housing providers and Trading Standards, work with the regional function on specific issues.

Table 7 highlights the different roles organisations might play to maximise the potential of regional tobacco control.

Table 7: Potential organisational roles in regional tobacco control

Organisation	Potential role in regional tobacco control
Office of Health Improvement and Disparities (OHID)	• Reference regional tobacco control in national plans and describe standards for functions that are effectively delivered (sub)regionally • Ensure that regional approaches are included in a fully costed Smokefree 2030 fund, financed by a levy on the tobacco industry
Local authority public health teams	• Consider contributing funding and in-kind support to a consistent regional approach • Support development of regional strategies • Consider hosting regional tobacco control functions
NHS England (NHSE)	• ICS prevention plans and CORE20Plus5 include a wider, system approach to tackling tobacco dependence • Recognise regional tobacco control as mechanism to join up focused programmes for tobacco dependence treatment with wider system work
Regional Directors of Public Health	• Play independent convening role to bring together local partners to support regional tobacco control
Regional OHID	• In some areas, may be best placed to host regional tobacco control functions • Provide expert advice and support to regional tobacco control functions and local areas
Regional NHSE	• Provide support to ICSs and NHS trusts contributing to regional tobacco control approaches
Integrated Care Boards/ Partnerships	• Consider funding regional and subregional tobacco control approaches as crucial way of achieving plans on reducing health inequalities and embedding prevention • Consider hosting regional tobacco control approaches through NHS trusts if best option for region • Participate in existing tobacco control networks and approaches led by public health teams
Combined authorities/city regions	• Involve elected representatives as advocates for wider tobacco control • When subregional tobacco control exists, consider working with the wider region where this is likely to be beneficial e.g. running communications campaigns on a bigger footprint that matches media footprints
Trading Standards	• Expert contribution to and delivery of regional working on illicit tobacco and other business-related tobacco control
Police services/ Police and Crime Commissioners	• Consider contributing to illicit tobacco function of regional work, which can effectively reduce demand as well as tackle supply

5. Conclusions

Given the impact of subregional and regional tobacco control approaches in the North East, Greater Manchester, Yorkshire and the Humber and London, it may be tempting to conclude that these offices should be strategically established by national bodies across the country to create a consistent network of regional tobacco offices on regular footprints.

However, the sharply increasing complexity of subnational governance in England renders this undesirable. Instead, local areas should look to develop models that complement existing governance structures, take on specific delivery functions and are supported by local government, ICSs, Trading Standards and other key local partners.

Regional tobacco control will look slightly different in each part of the country, but there will be commonalities. Regional tobacco control functions can offer cost-effective approaches ways of delivering tobacco control and create inspiring visions that bring together a wide range of partners. They are particularly effective at delivering on reducing harm from illicit tobacco, running communications campaigns, making the case to decision-makers on evidence-based approaches to tobacco control and facilitating networks of local actors.

To achieve a Smokefree 2030 in England, local, regional and national partners all have significant roles to play. The regional role has perhaps been the least well understood to date, particularly in areas with a less established regional presence. Using the existing literature and new research involving interviews and focus groups with those best placed to influence tobacco control, this report has set out the key functions and features that are required for regional tobacco control to be effective. It shows that, despite clear challenges in governance and funding, these barriers can be overcome, and that complex subnational systems can be navigated to deliver effective regional tobacco control.

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