June 2026

Centre for Excellence

Three Biggest Killers:

A Strategy for Humber and North Yorkshire

Tobacco

Alcohol

Unhealthy Food

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Obesity Health Alliance

ALCOHOL HEALTH ALLIANCE

ash. action on smoking and health

Foreword

Every year, thousands of lives are cut short by diseases such as cancer, heart disease, stroke and liver disease - many of them preventable and driven by three products: tobacco, alcohol and unhealthy food. Over the past 50 years, significant progress has been made in reducing deaths from smoking, though the job is far from done, with around 5.3 million people still smoking in the UK. At the same time, harm from alcohol and unhealthy foods is increasing.

The harm from tobacco, alcohol and unhealthy food does not happen by accident. They are often produced, marketed and sold in similar ways by large, profit-driven companies.

The policies that have successfully reduced smoking, such as regulation, pricing and restrictions on marketing, can and should be adapted to tackle the harms caused by alcohol and unhealthy food. This does not mean identical policies, these products carry different harms, but learning from what works to reduce the burden of ill health.

Progress at a national level has often been slow, but there is strong local appetite and ambition for change. This strategy aims to support Local Authorities and Integrated Care Boards to develop clear, coherent and effective approaches to reducing preventable harm in their communities.

Hazel Cheeseman,
Chief Executive of Action of Smoking and Health

Professor Sir Ian Gilmore,
Chair of the Alcohol Health Alliance

Katharine Jenner,
Executive Director of the Obesity Health Alliance

Message from local leaders

Across Humber and North Yorkshire, preventable ill health continues to shape lives, families and communities. Tobacco, alcohol and unhealthy food remain the biggest drivers of that harm, contributing to early death, widening inequalities and avoidable pressure on health and care services.

As Directors of Public Health, we see clearly that these harms are not inevitable. They are shaped by the environments people live in – what is available, affordable, promoted and normalised – and they fall hardest on those already facing disadvantage.

This strategy brings together strong national evidence with local understanding of our communities, providing a clear, practical framework for action. It builds on what we already know works from tobacco control, applying those lessons consistently across alcohol and unhealthy food.

Its focus is on changing the conditions that drive harm: reducing exposure, reshaping environments, and making effective support easy to access, respectful and free from stigma. When action on environments, social norms and treatment is delivered together and sustained over time, real progress is possible.

We are proud to support this collective approach and are committed to working together across Humber and North Yorkshire to reduce preventable harm, improve healthy life expectancy and create fairer, healthier places for our communities.

Jason Stamp
Chair
– Humber and North Yorkshire ICB

Peter Roderick
Director of Public Health
– City of York Council

Louise Wallace
Director of Public Health
– North Yorkshire Council

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Director of Public Health
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Contents

Introduction

There is a coherence in how the industries behind the three biggest killers operate that covers the development, sales and marketing of their products and extends to lobbying efforts to influence policy designed to reduce consumption.

Therefore, there needs to be a coherent approach to tackling the causes and effects of the sale and consumption of these products - one that is evidence-based and addresses root causes, rather than blaming individual behaviour. We can apply the lessons learnt from addressing the harms of tobacco where a united public health response has created an environment where tobacco is less available, less affordable and less attractive.

This strategy outlines the situation in Humber and North Yorkshire (HNY) and how the three biggest killers are affecting our populations, building on previous work with ASH, AHA and OHA to develop a toolkit [1] to support the development of a coherent framework to be applied at regional and local level.

It sets out coherent positions that establish a clear view and approach to tackle the sale and consumption of these harmful products. It identifies a set of comprehensive actions that local authorities can take to address these harmful products, protect the health of their populations and tackle inequalities. These actions and this approach align with national policy priorities including the 10-year plan for the NHS, and the government's approach to strengthening local and regional powers to tackle health inequalities.

Actions on specific products are underpinned by the need to advocate locally and nationally for the changes that make the biggest difference and ensure there is good governance in place to reduce industry interference.

Case study:

Our approach in HNY builds on work in the North East.

www.fresh-balance.co.uk

Fresh and Balance is a comprehensive public health programme addressing tobacco and alcohol harms across the North East of England. Fresh focuses on tobacco and Balance on alcohol, delivered through a single, integrated team. The award-winning initiative has delivered multi-strand activity since 2005 (Fresh) and 2009 (Balance).

The programme focuses on population-level approaches such as insight-led health campaigns and supporting evidence-based local action, while playing a significant role nationally.

Bringing tobacco and alcohol together within one programme has enabled a more coordinated approach to two of the leading causes of preventable harm, recognising shared risk factors and opportunities to align action. Pooled investment and joint NHS and local authority leadership have achieved economies of scale, sustained funding and supported a continued strategic focus.

The picture in Humber and North Yorkshire

Indicator	ER	Hull	NEL	NL	NY	York	HNY	Eng
Smoking prevalence in adults (aged 18 and over) – current smokers (APS) (3 year range) (%)	10.3	17.4	17.6	14.6	9.0	7.4	11.7	10.9
Smoking attribute mortality (rate per 100,000)	181.3	419.7	282.1	250.0	179.1	170.2	218.9	202.2
Smoking attribute hospital admissions (rate per 100,000)	1,236	2,440	2,079	2,009	1,425	1,240	1,586	1,398
Alcohol-related mortality (rate per 100,000)	37.6	50.1	52.4	46.2	37.1	39.9	41.2	38.9
Alcohol-specific mortality (rate per 100,000)	10.1	16.1	21.0	19.3	13.0	11.4	13.9	13.8
Admission episodes for alcohol-related conditions (narrow) (rate per 100,000)	504	694	624	525	527	518	551	504
Admission episodes for alcohol-specific conditions (rate per 100,000)	507	939	702	600	565	809	644	612
Admission episodes for alcohol-specific conditions (under 18 years) (rate per 100,000)	14.6	18.3	27.2	14.6	25.7	29.9	21.8	22.6
Overweight prevalence in adults (including obesity) (%)	68.3	69.6	70.2	74.2	66.2	60.7	68.0	64.6
Year 6 prevalence of overweight (including obesity) (%)	36.4	42.6	39.1	39.5	34.2	34.7	37.3	36.2
Year 6 prevalence of obesity (including severe obesity) (&)	22.7	27.8	26.1	26.2	19.3	19.3	23.1	22.2
Percentage of adults meeting 5-a-day recommendation	30.3	24.1	26.3	27.1	36.5	34.6	29.9	31.4
Prevalence of type 2 diabetes among practices participating in the National Diabetes Audit (17+) (%)	7.5	7.2	7.6	7.6	6.3	5.1	6.7	6.6

Worse than England Better than England

Data source: Fingertips | Department of Health and Social Care

Tobacco remains the leading preventable cause of ill health, disability and premature death in Humber and North Yorkshire.

Smoking drives some of the most significant health inequalities in our communities, places sustained pressure on health and care services, and imposes substantial economic costs on individuals, families and the wider system. [2]

Despite long-term progress, smoking prevalence remains disproportionately clustered in certain populations and places. Rates are highest among people experiencing deprivation, those with mental health conditions, routine and manual workers, and those living in social housing. [3]

Without renewed and coordinated action, tobacco will continue to undermine our ambitions for longer, healthier lives and a sustainable health and care system.

Humber and North Yorkshire is committed to accelerating progress towards a smokefree future. This requires sustained leadership, investment and collective action across the NHS, local authorities, voluntary and community organisations, employers and communities themselves.

Hospital admissions due to smoking-related illness in HNY:

1,586

per 100,000 population

National average:

1,398

per 100,000 population

Tobacco as One of the Three Biggest Killers

Smoking is the single largest preventable cause of premature mortality in Yorkshire and the Humber, accounting for 7,400 deaths every year, with over 2,500 annually in Humber & North Yorkshire, about 50 per week. It is causally linked to major conditions including cardiovascular disease, chronic obstructive pulmonary disease (COPD), lung cancer and many other cancers, stroke, diabetes, and poor pregnancy outcomes. It significantly reduces healthy life expectancy and contributes to long-term disability. [4]

Second-hand smoke exposure increases the risk of respiratory infections, asthma exacerbations, sudden infant death syndrome (SIDS), and cardiovascular disease. Children in smoking households are more likely to experience ill health and are more likely to become smokers themselves. [5]

Across key indicators, harm from tobacco in our region is higher than the national average. [6,7]

- Smoking prevalence in adults: 12.2% (national average 10.4%)
- 11% of secondary school children in Yorkshire & Humber had ever smoked and 3% are current smokers, similar to England-wide data
- Hospital admissions due to smoking-related illnesses in HNY are more than 10% higher than England: 1,586 admissions per 100,000 population (national average 1,398), and around 18,000 hospital admissions each year in HNY.

Health Inequalities

Smoking is a major driver of health inequalities. Prevalence is substantially higher in areas of deprivation and among routine and manual occupations. People with serious mental illness smoke at much higher rates and experience disproportionate tobacco-related harm. One of the biggest predictors of smoking is your housing tenure, those in social housing are very much more likely to smoke than those who own their own property. [8]

As a result, tobacco contributes significantly to the life expectancy gap between the most and least deprived communities. Reducing smoking prevalence is one of the most powerful actions available to narrow these inequalities and move households out of poverty. [9]

Economic and System Costs
Tobacco use generates significant costs:

– Increased NHS expenditure due to smoking-related admissions, long-term conditions and treatment
– Pressure on primary care, community services and hospital capacity
– Wider productivity losses due to sickness absence, unemployment and premature mortality
– Financial strain on households, particularly those on low incomes, where spending on tobacco compounds poverty.

Data from Action on Smoking and Health estimates that smoking costs Humber and North Yorkshire £1.39bn per year. This is made up of £821m productivity costs, £502m on social care, £57.9m on health and £12.5m on fires. [10]

Reducing smoking prevalence delivers a strong return on investment, both financially and in improved quality of life.

Wider Social and Environmental Harms
Tobacco use impacts the environment from growth and curing, manufacture and packaging and then through supply chains to disposal as a non-recyclable waste item or litter. [11]

Smoking in pregnancy increases risks for babies and contributes to intergenerational disadvantage. Tobacco harms are therefore not only clinical but social and environmental.

The Tobacco Industry as a Commercial Determinant of Health
The tobacco industry continues to act as a commercial determinant of health. Its business model depends on addiction and the sustained recruitment of new users. The industry has a long history of lobbying against effective public health regulation.

Adherence to Article 5.3 of the WHO Framework Convention on Tobacco Control (FCTC) is essential as it legally obligates participating governments to protect their public health policies from the commercial and vested interests of the tobacco industry. Humber and North Yorkshire partners will ensure transparency, reject all partnerships and avoid any activity that may be considered a conflict of interest.[12] Humber and North Yorkshire partners will ensure transparency and appropriate safeguards in all interactions with tobacco companies.

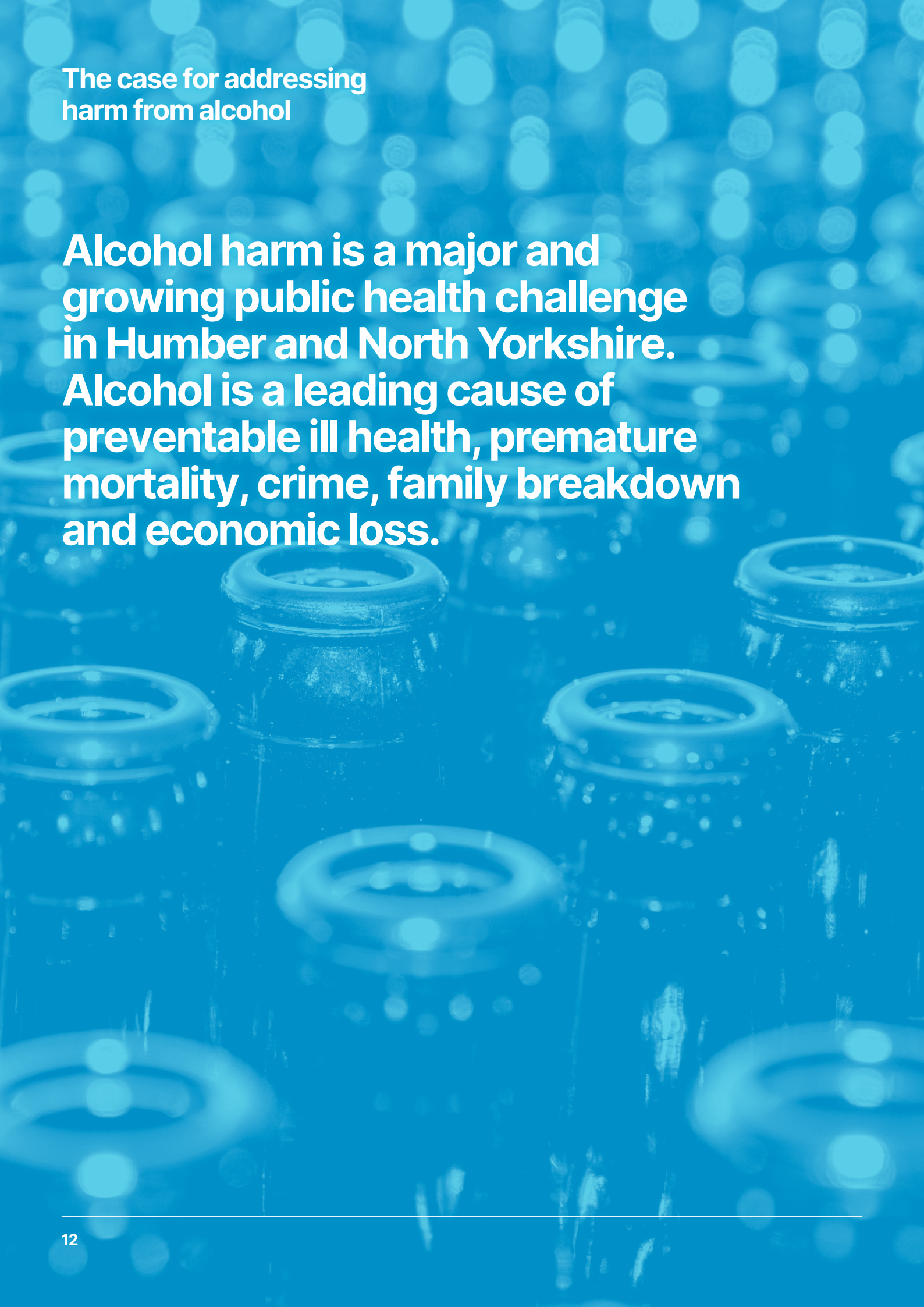
Smoking prevalence in adults in HNY:

11.7%

National average:

10.4%

Alcohol harm is a major and growing public health challenge in Humber and North Yorkshire. Alcohol is a leading cause of preventable ill health, premature mortality, crime, family breakdown and economic loss.



Alcohol contributes to a wide range of physical and mental health conditions, increased pressure on urgent and emergency care, and alcohol harm disproportionately affects communities experiencing deprivation. [13,14]

The pattern of harm is not evenly distributed: the most disadvantaged groups experience the greatest health consequences, even where overall consumption may not be highest. Along with the serious health impacts, alcohol consumption can have wide ranging effects, such as poor sleep, anxiety and the ability to function well after drinking. [15]

Hospital admissions due to alcohol-related conditions in HNY:

551

per 100,000 population

Alcohol as One of the Three Biggest Killers

Alcohol consumption in Yorkshire and the Humber region is a significant public health issue, accounting for over 2,300 deaths every year, of which around 800 are in Humber & North Yorkshire (15 per week).

Alcohol is a causal factor in more than 200 medical conditions. It is directly linked to liver diseases, heart diseases, and several different types of cancers, as well as mental health and behavioural conditions such as depression, anxiety and alcohol use disorders. Alcohol is also a major contributor to accidents and injuries, domestic abuse, suicide, and self-harm. [16] Alcohol is also a major contributor to accidents and injuries, domestic abuse, suicide, and self-harm. It plays a significant role in emergency department attendances and unplanned hospital admissions. [17]

Alcohol-related liver disease remains one of the leading causes of premature mortality, particularly among working-age adults. Across nearly all key indicators, harm from alcohol in our region is higher than the national average. [18, 19]

- Higher risk drinking in adults: 4.7% (national average 4.8%)
- 41% of secondary school children in Yorkshire and the Humber have ever drunk alcohol, compared with 37% in England. 9% consumed alcohol in the previous week versus 7% nationally
- Hospital admissions due to alcohol-related conditions are nearly 10% higher than nationally: HNY rate is 551 per 100,000 (national average 504).

Health Inequalities

Alcohol-related harm follows a steep social gradient. People living in more deprived communities are more likely to experience hospital admissions and premature death related to alcohol, even when overall levels of consumption are lower than in more affluent groups. Reducing alcohol harm is essential to narrowing inequalities in life expectancy and healthy life expectancy. [20]

Higher risk drinking in adults in Yorkshire and Humber:

4.7%

Economic and System Costs
Alcohol places substantial pressure on services across the system including emergency and acute care, primary care and mental health along with social care and safeguarding systems. Alcohol-related admissions and complex multi-morbidity cases increase bed occupancy and length of stay. Alcohol also places significant strain on policing and the criminal justice system, with alcohol frequently linked to violent crime, anti-social behaviour and demand on custody and court services. [21]

The economic impact extends beyond public services to families and communities, including lost income, debt, housing instability, unemployment, and poor mental health, which all increase system complexities and costs. Employers also lose out with productivity losses due to sickness and poor performance.

A 2024 analysis by the Institute of Alcohol Studies (IAS), supported by Balance, the North East alcohol programme, estimated that alcohol harm costs society in England £27.44 billion each year. This figure reflects the "external" costs of alcohol - the burden placed on wider society by drinking, excluding the personal costs experienced by individuals themselves. In Yorkshire and the Humber the costs of alcohol harm are £2.87 billion, equivalent to £524 per head of population across the region. This is one of the highest costs per head in the country, after the North East (£562) and North West (£538). [22]

Wider Social Harms
Alcohol use can contribute to domestic abuse and family breakdown, anti-social behaviour and violence, road traffic collisions and community safety issues. Office for National Statistics (ONS) data from the Crime Survey for England and Wales found that victims perceived offenders to be under the influence of alcohol in approximately 4 in 10 violent incidents. In addition, alcohol may exacerbate or escalate domestic abuse. [23]

Secondary school children that have ever drunk alcohol in HNY:

41%

The cost of alcohol harm per head of population in HNY:

£524

Poor dietary patterns and excess weight, caused by unhealthy food and drinks are among the most significant drivers of preventable ill health in Humber and North Yorkshire.

Poor dietary patterns and excess weight, caused by unhealthy food and drinks are among the most significant drivers of preventable ill health in Humber and North Yorkshire.

Diet-related disease is a leading cause of premature mortality, reduced healthy life expectancy, along widening health inequalities due to systemic inequalities in food access, affordability and exposure to marketing. [24]

Less healthy food and drink, particularly products high in fat, salt and sugar (HFSS), are widely available, heavily marketed and often more affordable than healthier alternatives. This environment shapes behaviour and normalises excess consumption. [25]

Childhood obesity at Year 6 in HNY:

23.1%

National average:

22.2%

Unhealthy Food as One of the Three Biggest Killers

Poor diet is a leading modifiable risk factor for ill health in England and contributes to a wide range of chronic conditions.

Diet-related disease in Yorkshire and the Humber accounts for 1,670 deaths aged under 70 each year. [26] Humber & North Yorkshire this is around 530 deaths in each year, close to 10 per week.

Poor diet is directly linked to cardiovascular disease and stroke, type 2 diabetes, at least 13 types of cancer, liver disease, musculoskeletal disorders, poor oral health and poor mental health. Excess weight significantly increases the risk and severity of these conditions.[27,28,29,30,31] Childhood obesity increases the likelihood of obesity in adulthood and is associated with earlier onset of long-term disease.[32]

Across many indicators, diet-related harm in our region is worse than the national average.[33]

- Adult excess weight prevalence: 68.0% (national average 64.6%)
- Childhood obesity at Year 6: 23.1% (national average 22.2%)
- Type 2 diabetes prevalence: 6.7% (national average 6.6%)
- Decayed tooth extraction episode rate per 100,000 population: 504/100,000 (national average 250/100,000).

Health Inequalities

Diet-related disease follows a strong social gradient. People living in more deprived communities are more likely to experience obesity, type 2 diabetes and cardiovascular disease. [34]

Contributing factors include a higher density of fast-food outlets in deprived areas (also known as food swamps), lower access to affordable fresh food (also known as food deserts), financial pressures and food insecurity, and greater exposure to marketing of unhealthy products. [35]

Reducing diet-related harm is essential to narrowing inequalities in life expectancy and healthy life expectancy.

Economic and System Costs

Dietary related ill health places substantial pressure on the health and care system. These pressures include rising rates of hospital admissions, increased prescribing costs, demand for services. The economic impact extends beyond public services to families and communities, including lost productivity, sickness absence, financial strain and reduced quality of life.

In England, obesity is estimated to cost the NHS around £11 billion each year, [36] with wider societal costs estimated at more than £125 billion annually due to ill health. [37]

Furthermore, research by the University of Sheffield has also estimated that a 10% reduction in spend on confectionery would result in a £389 million boost and almost 7,000 new jobs. [38]

Prevention of dietary related ill health and associated obesity offers one of the most significant opportunities to reduce long-term demand on the system.

Adult excess weight prevalence in HNY:

68.0%

National average:

64.6%

How Change Happens: A Whole-System Approach

The sustained reductions in harm from tobacco, alcohol and unhealthy food required to improve health in the region will not be achieved through single interventions.

While the specific interventions differ across tobacco, alcohol and food, progress depends on the interaction between mutually reinforcing components of a comprehensive strategy, as shown in the framework for action on three biggest killers (see p36).

1. **Action on Environments:** Shaping Environments and Use to Reduce Availability, Visibility and Normalisation.

   The environments people live in strongly influence behaviour. Effective action requires policy and system-level approaches that reduce the availability, visibility, affordability and normalisation of harmful products, while making healthier choices easier and more accessible.

   Across tobacco, this includes enforcing measures such as smokefree legislation, restrictions on advertising and promotion, licensing and taxation along with local action to reduce illicit supply. For alcohol, it includes action on licensing, pricing, marketing, availability and the density of licensed premises. For food, it includes planning and retail policies, restrictions on the promotion and placement of HFSS products, healthier catering schemes, procurement standards and improving access to affordable nutritious food.

   These upstream approaches are particularly important for reducing inequalities because they do not rely solely on individual agency, knowledge or motivation.

2. **Action to support individuals:** Providing effective and compassionate support and treatment.

   Alongside population-level measures, many people require structured support to reduce harm and improve health outcomes. This includes accessible, evidence-based services delivered in ways that are inclusive, non-stigmatising and responsive to different communities.

   Across the three areas, this may include smoking cessation services, alcohol treatment and brief interventions, NHS and community weight management programmes, diabetes prevention support, maternity and early years interventions, and specialist services, including medication and bariatric surgery for people with complex needs or severe obesity.

   Healthcare professionals and frontline practitioners play a critical role, and training is essential to ensure support is effective, engaging and equitable.

3: Action on Social Norms: Communicating Health Messages to Drive Demand and Legitimacy.

Communication, including how we communicate and tell a compelling story about the impact harmful products have on our lives, along with public engagement can help build awareness, legitimacy and support for policy action. In smoking particularly, effective communication campaigns and frontline brief advice normalise quitting and reinforce that smoking is not a routine or inevitable behaviour. In alcohol, evidence based communication can increase awareness of health risks and Balance North East have demonstrated this can be achieved at a regional level, shifting public attitudes towards drinking and policies to tackle harm. Furthermore, brief advice across a range of settings helps reinforce consistent messages.

However, communication alone is insufficient to drive population-level change, particularly when it comes to healthy eating. Awareness campaigns are most effective when combined with wider environmental and policy measures that support healthier behaviours and reinforce changing social norms.

Local declaration

Humber and North Yorkshire is committed to reducing harm from alcohol, tobacco, and unhealthy food and drink through a comprehensive, whole-system approach. This requires coordinated action across prevention, regulation, early identification, treatment, and recovery support.

We call for:

- A strengthened partnership approach to reducing harm across alcohol, tobacco, and unhealthy food and drink
- Sustained investment in prevention, treatment and recovery services
- A focus on reducing inequalities in health harms
- Clear leadership, governance and accountability across the system.

By accelerating progress to reduce harm from tobacco, alcohol and unhealthy food and drink, we can:

- Improve healthy life expectancy
- Reduce health inequalities
- Relieve pressure on health and care services
- Strengthen our local economy
- Improve the wellbeing of individuals, families and communities.

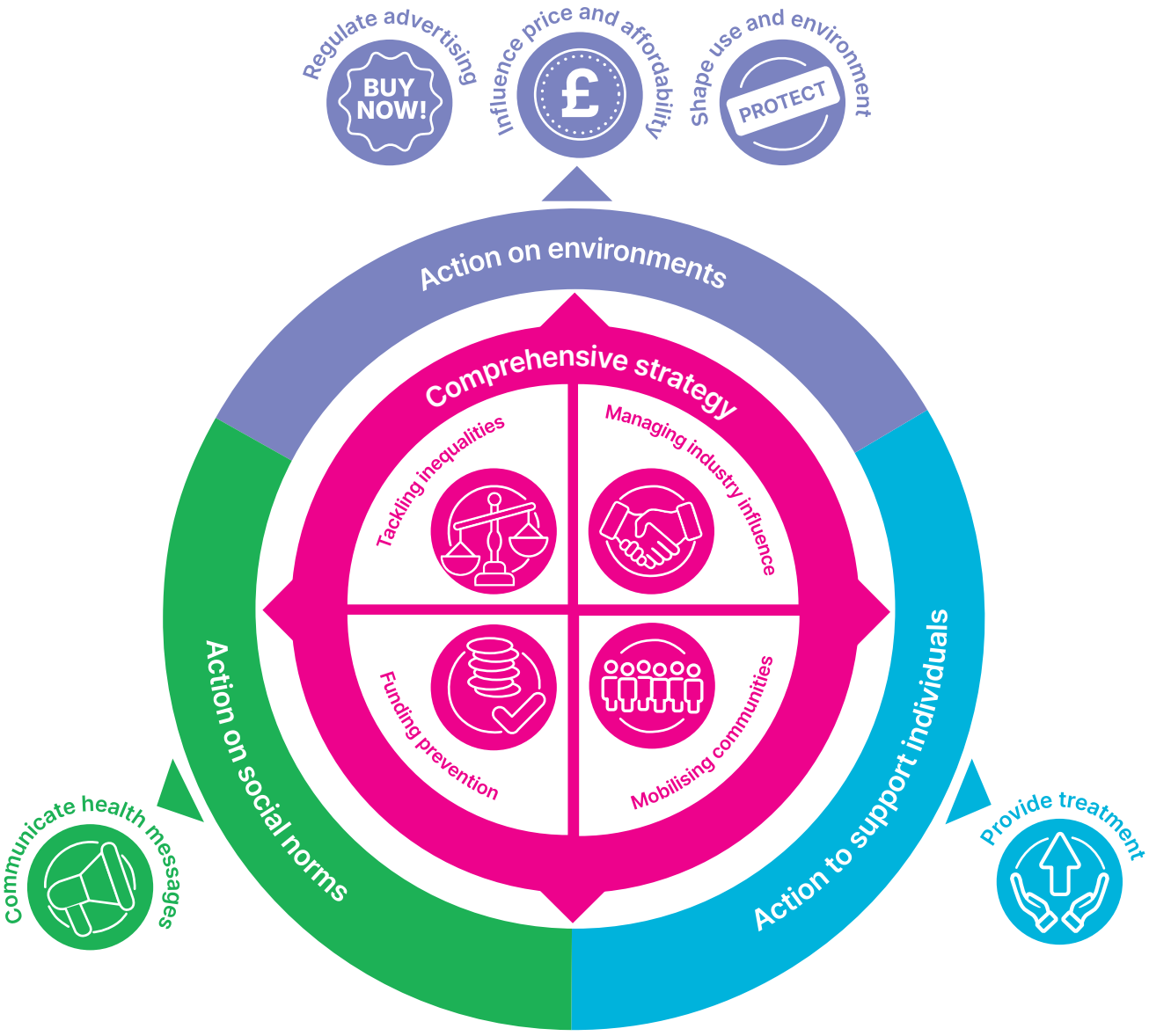
Addressing these key drivers of preventable ill health is fundamental to delivering our shared ambition for a healthier, fairer and more sustainable Humber and North Yorkshire.

Roadmaps

The roadmaps have been developed to set out the evidence informed actions and interventions that can be delivered at a local level as part of an ambitious, comprehensive strategy. Rather than a menu of options, the actions work together in a whole system approach to create healthier local environments and sustained treatment support.

Actions are organised around a framework developed by ASH, OHA and AHA and adapted for regional use through an iterative process of feedback from stakeholders from across the Humber and North Yorkshire and Greater Manchester ICB areas. It takes the elements of an effective local approach to tobacco, and applies this to alcohol and unhealthy food and drink, recognising that the same basic principles apply.

Figure 1: A regional framework for action on the three biggest killers



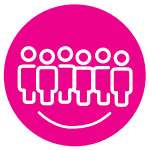
Source: Addressing the three biggest killers on a regional and local level. https://ash.org.uk/uploads/Three-Biggest-Killers-Regional-Toolkit.pdf

At the heart of the framework is a comprehensive strategy – this should be agreed at a regional level to guide an overarching approach. The strategy should be enabled by:

Tackling inequalities
Take action on diseases with a social gradient, tackle industry tactics targeting the most vulnerable in society, and develop interventions with a 'proportionate universalism' approach.

Funding prevention
Ringfenced, long-term funding to enable prevention efforts to reduce impact of harmful products.

Managing industry influence
Ensure that vested commercial interests do not undermine evidence-based policies designed to reduce the impact of harmful products, nor limit an organisation's ability to protect, promote and improve the health of its population.



Mobilising communities
Amplify the voices of those affected by the problem to rally support for action.

The following high impact actions are core to achieving the goal of reducing the harm caused by the three biggest killers. Each has been successful in reducing harm from tobacco, and lessons can be learnt for alcohol and unhealthy food and drink.

Regulate advertising
Use proportionate regulation of advertising and marketing across different media forms, to prevent promotion of unhealthy products.

Shape use and environment
Reduce access to harmful products, particularly by children, and regulate the environments they can be used in to prevent harm to individuals and those around them.

Influence pricing and affordability
Advocate upwards for taxes to raise prices of harmful products to reduce use or encourage product reformulation, and/ or levies to fund prevention activities and use local levers to improve the affordability of healthier options.

Communicate health messages
Use evidence-based communications to raise awareness and inform people about the risks of harmful products and the benefits of engaging in healthy behaviours.

Provide treatment
Provide treatment services to those at risk of harm from these products to improve health and prevent further harm.

Tobacco roadmap

Actions to take	Why they are important	Leaders and partners	How to evaluate
Influence price and affordability			
No applicable local levers – national policy required.			
Shape use and environment			
Create an environment where smoking is less visible and normative. Reduce exposure to indoor secondhand smoke in houses. Introduce smokefree places and ensure compliance with smokefree regulations. – Enforcement of smokefree regulations – Smokefree public spaces (parks, pavements, licensed areas) – Smokefree NHS estates – Smokefree social housing policies – Smokefree workplaces and anchor institutions.	Making environments smokefree helps to lead by example and reinforce messages about the harms of smoking. As well as building compliance and enforcement with regulations, local authorities can look for opportunities to build smokefree environments with priority groups. Working with social housing providers to introduce local swap to stop schemes can help save money and reduce fire risk as well as provide health benefits.	Public health and environmental health for building compliance and enforcement. Partners can include social housing providers, employers, NHS acute and mental health trusts, licensing teams and community groups.	Spot checks on places known to be smoking areas including monitoring smoking related litter. Regular surveys of acute trusts. Number of employers with smokefree policies in place. Number of people taking part in local swap to stop schemes.
Make tobacco less accessible. Retail regulation and good trading practice. – Restrictions on tobacco outlet density – Minimum distance from schools and youth facilities – Preparation for retail licensing schemes – Enforcement and promotion of good trading practice – Retailer compliance with age of sale and display regulations.	Reducing the accessibility of tobacco makes it more difficult to get hold of. This can help people who have stopped smoking from relapsing. It can also help create an environment where tobacco is seen as less normative and acceptable. Building compliance and enforcement with regulations can help stop children and young people from buying tobacco.	Trading Standards, public health and licensing teams lead retail regulation and trading practice. Working together to address this through a health harms approach helps to regulating the environment. Partners include retailers, bars, restaurants and cafes.	Density of outlets selling tobacco. Distance from schools for tobacco outlets. Percentage of businesses compliant with trading regulations.

Actions to take	Why they are important	Leaders and partners	How to evaluate
Influence price and affordability			
Make tobacco less affordable by reducing the supply of illicit tobacco. Control of illicit tobacco and illegal vapes. – Control of the supply of illicit tobacco and illegal vapes – Regional collaboration and intelligence sharing – Enforcement against illegal supply chains – Demand-side action to reduce illicit use – Protection from tobacco and vape industry interests – Communication campaigns on the community harms of tobacco to lower acceptability.	Increasing the price of tobacco through tax is one of the most effective and cost-effective ways to reduce tobacco consumption.[39] The price increase helps to stop people smoking and prevent people starting and the money goes back into the government. Illicit tobacco undermines this by making cheaper tobacco available. And instead of money going to the government, it funds organised crime.[40] Reducing acceptability of illicit tobacco helps to increase reporting and decrease purchasing.[41]	Public health teams, trading standards and communications. Police and HMRC at a local and regional level. Partners include retailers who can help build reporting. Community groups and health and care staff working with those in the community and provide valuable insights and intelligence.	Number and size of seizures. Campaign reach and opinion or behaviour change post campaign. Number of news stories on illicit tobacco seizures.

Tobacco roadmap

Actions to take	Why they are important	Leaders and partners	How to evaluate
Communicate health messages			
Raise awareness of the harms of smoking. System wide communications to drive quit attempts. This can include the following: – Online, social and mass media quit campaigns – Local targeted and tested campaigns for high prevalence groups – Proactive PR and earned media – Communicating hope and normalising the annual quit attempt – Communications aligned to policy moments (e.g. smokefree, licensing).	Mass media quit campaigns are associated with an increase in quit attempts.[42] Campaigns can help people think about quitting and, for those who want to stop smoking, can help communicate the most effective methods to try.[43] Broader communications can help provide frequent prompts and reminders about stopping smoking.	Public health, smoking cessation providers, and communications teams. NHS primary and secondary care and independent vape stores can help amplify campaigns such as Stoptober or No Smoking Day.	Campaign reach and awareness. Number of people contacting stop smoking services. Number of people using digital support.
Give people information to help prompt them into stopping smoking. Everyday communication through public services and professionals. – Communication and engagement through all council services – Professional–client communication in routine encounters – Normalising quitting support as standard care – Communications supporting smokefree environments – Communications promoting smokefree homes and families.	Giving smokers multiple messages about stopping smoking increases their chances of a successful quit.[44] Local authorities, statutory bodies and health services can play an important role if they lead by example. Smokers have multiple interactions where the benefits of stopping smoking can be communicated. These can be linked to messages about finances, secondhand smoke, fire or other secondary harms of smoking.	Public health, smoking cessation providers and communication teams. Partners can include fire services, housing and healthcare organisations. Non-government organisations, for example Citizens Advice Bureau.	Number of partner organisations with communications. Number of people accessing stop smoking services mentioning these organisations.
Make sure that smokers are informed and aware of the relative harm of tobacco and nicotine. Clear, evidence-based communication about quitting support. – Communication about quitting aids, including e-cigarettes/vapes – Harm reduction messaging to counter misinformation on vapes and nicotine – Promotion of medicines and combination therapy – Signposting to local and national support offers – Reinforcing confidence in treatment effectiveness.	There is a strong evidence base about the most effective ways to stop smoking.[45] However, despite this there are often misconceptions about the harms of nicotine[46] and vapes.[47] These mixed messages lead to confusion about what might help someone to stop smoking and reduces their chances of a successful quit. Making sure that there are consistent, clear and accurate messages is an essential part of helping smokers to quit.	Public health, smoking cessation providers and communications teams. Partners include professionals working in primary and secondary health care including pharmacy, GPs, mental health teams and acute services.	Number of people accessing stop smoking services. Percentage of successful quits.

Actions to take	Why they are important	Leaders and partners	How to evaluate
Provide treatment			
Give smokers as many opportunities as possible to access support to stop smoking. Train people in different parts of the health and care workforce in Very Brief Advice (VBA). Set up referral pathways and interventions in different settings. – Very Brief Advice in GP and Primary Care – VBA in neighbourhood health services – VBA in dental services – VBA in community pharmacy – Clear referral routes into stop smoking support.	Very Brief Advice (VBA) is a behaviour change intervention with a strong evidence base.[48] Across the health and care system there are multiple opportunities to identify and offer a referral for stop smoking services. However, if these conversations are not handled with care, then they can be counterproductive. Providing training, including refresher training, can help make sure that people have the right skills to help people get the support they need.	Public health teams and smoking cessation providers. Partners can include health and care providers in the community, and in primary and secondary care.	Number of organisations with a training offer. Percentage of the workforce that has been trained. Number of referrals into stop smoking services.
Make sure that smoking is not seen as a 'lifestyle choice'. Treat tobacco dependency as standard NHS care. – Opt out pathways in acute care, including lung screening – Opt out pathways in maternity services – Opt out pathways in mental health services and community mental health settings – Clear referral routes into stop smoking support.	Given the devastating health effects of smoking, smokers use NHS services more than non-smokers.[49] These interactions provide valuable 'teachable moments'[50] for treating tobacco dependency as a core part of their health assessment. The systems and pathways must be in place and based on evidence[51] to make sure that the healthcare system provides the treatment that smokers need to address tobacco dependency.	Public health teams, ICBs, maternity and mental health providers and stop smoking service providers are all lead partners in commissioning and providing these services. Partners can include pharmacists, GPs and other health and care providers.	Number of smokers identified. Percentage of smokers referred.
Help people to stop smoking. Accessible, comprehensive and sustained stop smoking support. – Specialist stop smoking services – Pharmacological support and vapes – Telephone, app and online advice – Community based support (job centres, libraries, food banks, social housing) – Incentives, relapse prevention and support for smokefree families.	Most people will make multiple attempts to stop smoking before they stop for good.[52] Having a comprehensive offer helps to make sure that people can choose the support they want and access it in a way that best suits them.[53] People might choose different levels and methods of support through their quitting journey.	Public health teams and stop smoking service providers. Partners in the community can include food banks, people working with homeless or other priority groups, employers and libraries.	Number of people accessing stop smoking support. Percentage of successful quits. Number of partner organisations.

Alcohol roadmap

Actions to take	Why they are important	Leaders and partners	How to evaluate
Regulate advertising			
Reduce exposure to positive messages and images on alcohol. Restrict advertising, sponsorship and marketing of alcoholic drinks. – Restrict advertising on council owned spaces and public transport – Restrict marketing at council events and encourage other organisations like universities and community events to do the same – Restrict alcohol sponsorship to council events and encourage other organisations like universities and community events to do the same – Consider including low and no alcohol products in restrictions to address alibi marketing.	Alcohol advertising, marketing and sponsorship help to increase consumption and create an environment through repeated exposure where alcohol is seen as normal and acceptable. There is a strong association between alcohol marketing and underage drinking.[54] Alcohol advertising and marketing is noticed more by people who have, or are at risk of, alcohol problems.[55] The positive images and messages about alcohol can cause additional challenges for people in recovery.[56] Some local authorities have introduced restrictions which include low and no-alcohol to prevent alibi marketing.[57]	Public health leadership. Key partners to get onboard are transport and teams responsible for advertising procurement.	Regular review of policy implementation to ensure compliance and address issues. Spot checks in local areas. Where resource is available, academic evaluations can be commissioned to review exposure to advertising, including target groups and purchasing of alcohol. Qualitative evaluation with children and young people and people in recovery.

Actions to take	Why they are important	Leaders and partners	How to evaluate
Shape use and environment			
Reduce alcohol-related harm in high-risk areas. Use licensing policies to address risks of health harms in licensing powers and approach. – Alcohol licensing matrices – Cumulative Impact Zones – Late Night Levies and Early Morning Restriction Orders.	Using data which includes the wider alcohol-related harm on communities, such as crime, public safety and child welfare, can help public health and licensing teams to identify areas at high-risk of community harm. Strong licensing policies and approaches, including cumulative impact zones are associated with lower alcohol-related hospital admissions.[58]	Public health and licensing teams in local authorities. Partners can include the police and social care teams. Wider community partners can include local retailers.	Number of matrices and cumulative impact zones. Alcohol-related admissions. Number of license refusals. Reduction in number of late night premises.
Reduce alcohol-related harm in pubs and nightclubs. Implement training and use licensing to make the environment safer and less prone to over drinking. – Train server staff in legislation and responsibilities – Enforce existing legislation – Mobilise communities and raise awareness of legislation – Replace glassware with suitable alternatives.	Pubs and nightclubs are places where heavy levels of alcohol are consumed with the associated risks of injury. Implementing changes to these environments can reduce the risk to people drinking and those around them. Replacing glassware with safer alternatives is recommended in good practice for licensing.[59] The 'Drink less, enjoy more' initiative in Liverpool focused on not selling alcohol to people who were already intoxicated and was associated with a reduction in sales and increased awareness of the law.[60]	Public health and licensing teams to lead. Key partners include the police and nightlife venues.	Number of venues using safer alternatives to glassware. Number of venues participating in training. Levels of awareness of legislation among staff in venues and people drinking in venues. Number of refusals of service because of intoxication.
Reduce the social acceptability of alcohol. Make alcohol free events the norm. – Make all council events alcohol free – Work with partners in the community to remove alcohol from events – Work with schools and community organisations to remove alcohol as prizes for raffles and tombolas – Encourage alcohol free work social events – Ensure communications that talk about alcohol are considerate and evidence-based.	Local authorities can lead by example by making events alcohol free and encouraging partners to do the same. Schools and other environments with children can be alcohol free to support an alcohol-free childhood. This includes removing alcohol as prizes from raffles and tombolas. Alcohol free events and prizes are more inclusive. People who do not drink for religious reasons or people in recovery might not want to go to places where alcohol is served. In places where alcohol is served people who choose not to drink can be asked about this in a way that can be stigmatising and problematic.[61]	Public health teams. Partners in the community include Parent Teacher Associations, employers and community groups.	Policies on alcohol at council events. Number of schools with policies on alcohol as raffle prizes.
Lower consumption of units of alcohol. Run 'Reduce the Strength' initiatives. – Work with retailers to remove the sale of high ABV drinks in priority areas.	Some local authorities have run 'Reduce the Strength' initiatives to remove sale of high ABV drinks from priority areas.[62] These areas can be prioritised because there is a concentration of street drinkers, alcohol-related disorder, or other problems that have been raised by the police or community partners. Working with retailers to remove the availability of high strength drinks can help to reduce the strength of drinks available in targeted locations.	Public health and licensing teams. Partners include the police and community organisations working with homeless people. A strong partnership across multiple retailers is a key part of these initiatives.	Number of retailers participating. Number of alcohol-related incidents reported. Number of alcohol-related A&E visits.

Alcohol roadmap

Actions to take	Why they are important	Leaders and partners	How to evaluate
Influence price and affordability			
No applicable local levers – national policy required			
Communicate health messages			
Improve knowledge and awareness about alcohol harm. Run campaigns and communications reflecting evidence about behaviour change and how to communicate around alcohol.[63] – Digital, social and mass media campaigns – Local targeted and tested campaigns and communications for priority groups, including women or who are pregnant or planning conception – Proactive PR and earned media – Communications which capitalise on policy opportunities.	Mass media health campaigns about alcohol are often recalled by individuals, and have achieved changes in knowledge, attitudes and beliefs about alcohol,[64] including the link between alcohol and cancer.[65] Evaluation of the 'Alcohol is Toxic' campaign, run by Balance in the North East found that 22% of people who recalled the campaign had reduced the amount they drank.[66] The 'Drymester' campaign in Greater Manchester used communications as part of a comprehensive approach to reduce drinking alcohol during pregnancy. Four in five pregnant women had decreased their drinking after the campaign compared to one in 10 in the general population.[67]	Communications teams within local authorities. Regional coordination can drive economies at scale.	Reach and engagement with digital and social media campaigns. Pieces of media coverage and opportunity to see (OTS) and additional earned value (AEV). Awareness of the campaign and its messages, including with target groups. Behaviour changes in people who recalled the campaign. Include digital links to services so that traffic can be measured.

Actions to take	Why they are important	Leaders and partners	How to evaluate
Provide treatment			
Reduce hazardous and harmful alcohol consumption. Routine identification and brief advice (IBA). – Identification and brief advice in health care settings – Identification and brief advice in other settings including criminal justice and workplaces.	There are multiple opportunities across health and other settings to make brief interventions which support people to reduce the risks associated with drinking. Providing a supportive, non-judgemental intervention is effective and cost-effective.[68]	Public health teams can lead training and promote IBA in different settings. Partners can include primary and secondary care providers including those working in maternity or emergency settings. Wider partners in the community can including employers who can be supported to take a public health approach to alcohol harm.	Evaluate the scale and quality of the delivery of the programme. Proportion of a target group tested with AUDIT and the appropriateness of the intervention offered, based on the AUDIT score. Number of patients identified. Number of referrals. Number of related health conditions identified with appropriate referrals.
Reduce hazardous and harmful alcohol consumption. Provide a comprehensive, personalised approach to treatment and recovery. – Psychosocial and psychological support – Pharmacological support – Multidisciplinary approaches – Appropriately tailored support for priority groups including children and young people and pregnant women – Community treatment services – Residential treatment services.	Comprehensive services, in line with clinical guidelines[69] are essential for making sure the right support is there for people who need it. Alcohol dependence is often driven by a wide range of psychosocial factors and helping people to address these is a crucial part of a personalised approach to recovery.[70] Specialist services for priority groups, including children and young people, pregnant women and people experiencing or perpetrating domestic abuse help to make sure specific needs are met. Voluntary groups and those led by lived experience help facilitate a peer-led approach to recovery.	Public health teams and ICBs lead commissioning of alcohol treatment services. Partners in primary and secondary care include GPs, health visitors, maternity and emergency departments. Partners in wider local government include social care, housing and education providers. Partners in the community include lived experience community groups, services working with people affected by domestic violence, services for people who have experienced homelessness.	Clinical guidelines for alcohol treatment set out evaluation best practice for different components of treatment.

Unhealthy food and drink roadmap

Actions to take	Why they are important	Leaders and partners	How to evaluate
Regulate advertising			
Reduce exposure to positive messages and images of products high in fat, salt and sugar. Restrict advertising, sponsorship and marketing of products high in fat, salt or sugar. – Restrict advertising on council owned spaces and public transport – Restrict marketing at council events – Restrict marketing for schools and events – Encourage other statutory bodies and community groups to restrict sponsorship and marketing.	Local and regional areas across England are leading the way in restricting advertising, marketing and sponsorship of food and drink high in fat, salt and sugar (HFSS) to protect their population. Transport for London (TfL) restricted advertising across its network, it was associated with a reduction in purchasing of HFSS products and estimated that it could reduce the number of people with obesity by 4.8% and overweight by 1.8%, without negatively affecting advertising income.[71] A comprehensive policy could also restrict alcohol marketing in the same way and be extended to other harmful products.	Public health leadership. Key partners to get onboard are transport and teams responsible for advertising procurement. Partners in the community include schools and community organisations, particularly those working with children and young people. The London advertising restrictions faced significant industry opposition.[72]	Regular review of policy implementation to ensure compliance and address issues. Spot checks in local areas. Where resource is available, academic evaluations can be commissioned to review exposure to advertising, including target groups and purchasing of HFSS food and drink. Qualitative evaluation with children and young people.

Actions to take	Why they are important	Leaders and partners	How to evaluate
Shape use and environment			
Strengthen the sustainability of the local food environment. Local Food Partnerships which improve the health, sustainability and fairness of the local food environment. – Community meal programmes and redistributing surplus food – Community nutrition programmes in schools, workplaces and other community settings – Support for local and sustainable food production.	Food partnerships can help communities access nutritious, low-cost food. This overcomes one of the most challenging barriers for diet-related health inequalities. They do this by putting community partnerships at the heart of local food environment. There are over 100 food partnerships across the UK [73] and the Association of Directors of Public Health (ADPH) have highlighted their role in building community resilience to public health challenges.[74]	There could be one lead coordinator and a Board responsible for delivery. Successful food partnerships will include multiple partners across civil society, local government and local businesses.	Local Authorities can use Sustain's Good Food Local [75] to track action in their area. If feasible, baseline measurements and future reviews could look at the percentage of households reporting food insecurity and self-reported healthy eating. Number of organisations involved in a food partnership and the different communities they represent. Number of service users and the demographics of service users. Volumes of surplus food redistributed.
Make unhealthy food less available. Refuse planning applications for hot food takeaways and fast-food outlets which are: – Within walking distance of schools and other places where children and young people congregate, unless the location is within a designated town centre or – In locations where there is evidence that a concentration of such uses is having an adverse impact on local health, pollution or anti-social-behaviour.	Having more takeaways in a neighbourhood is associated with people eating more takeaway food. To address this, local authorities have tried to manage how exposed children are to takeaways near schools. These takeaway management zones have helped to reduce obesity. [76] This evidence has been recognised in the National Planning Policy Framework which now contains a direction to councils to 'prioritise preventing ill-health'. [77]	Leadership from planning teams in local authorities with support from public health. Wider partners include local businesses and community groups who are often supportive of retail diversity.	Whether the concentration of takeaways of fast-food outlets is changing. The number of planning applications submitted and the number refused.
Improve children's health and attention to education. Improve the food environment in schools. – Use auto-enrolment to increase uptake of free school meals – Expand eligibility of free school meals – Make sure that food provided in schools (breakfast and lunch) meets the school food standards.	Free school meals have benefits for children and their families. Trials for universal free school meals saw children eating more fruit and vegetables, helped to reduce obesity, helped to reduce health inequalities and help to improve health and wellbeing for children and their parents. [78] When all children have free school meals it helps to level the playing field and reduce stigma. It's estimated that 250,000 children who are eligible are not registered. [79] All food in schools should meet good nutritional standards.[80]	Leadership from education and public health. Partners include schools and families to understand the reasons for roll out and build support.	The percentage of eligible children enrolled in free school meals. Consider baseline and follow up assessments on healthy food consumption, weight and wellbeing.
Demonstrate what a healthier food environment looks like. Improve the food environment in local authority and healthcare settings. – Implement food procurement policies – Change product availability of placement in vending machines – Introduce rules for food provided at local authority events.	Local authorities and healthcare environments should lead by example and model the environment they want to create. They can do this by looking at ways to shape their own food environments. Public sector procurement agreements can help to focus on sustainable food. [81] Changes to product placement in hospital vending machines led to people changing what food they purchased. [82]	Leadership across the local authority and ICB. Partner with vending machine providers and events companies.	Overall policy change with parameters written into policy documents. Collect data on purchasing from vending machines. Collect data on what food is consumed at events. Work with procurement partners to look at cost effectiveness.

Unhealthy food and drink roadmap

Actions to take	Why they are important	Leaders and partners	How to evaluate
Influence price and affordability			
Address income-related inequalities. Increase uptake of Healthy Start scheme. – Targeted communications to lower income areas. Use translated communications for key communities – Train community organisations who meet pregnant women and young children with families – Work with GP surgeries to send text messages to families who might be eligible for the scheme.	The value of Healthy Start vouchers was increased under Fit for the Future: 10 Year Health Plan for England [83] in a sign of how the scheme helps to address health inequalities. However, many families who are eligible are not taking part in the scheme. By providing targeted communications, training and partnership working with health visitors and GP surgeries, local authorities have been able to increase the uptake of the Healthy Start scheme [84] with one local authority increasing uptake from 49% of eligible families to 71%. [85]	Public health leadership with partners across the community. Training partners who meet pregnant women and families with young children, for example, early years providers, food banks, advice organisations and staff in children's centres. GP Primary Care Networks and health visitors can help spread targeted communication about the scheme.	The percentage of eligible families taking part in the scheme. How many partner organisations are aware of the scheme and talking to clients about it.
Make healthier food more easily affordable for people on low incomes. Provide healthy food subsidy schemes to low-income households.	People who have taken part in healthy food voucher schemes have reported that they and their children have eaten more fruit and vegetables, have eaten fewer unhealthy snacks and have better connections with their local community. Depending on the design of the scheme, there can be additional economic benefits to the local community with each £1 in vouchers worth a further £2.11 to the local economy. [85] International rebate schemes have seen a greater proportion of the food shop being spent on fruit and vegetables. [87]	This could be led by public health, or by civil society organisations which run the scheme. Partners can include local independent retailers and local markets. Local community groups, health, education and social care providers can help with communication about the scheme.	The percentage of people in targeted areas using the food voucher scheme. The percentage of people self-reporting eating more fruit and vegetables. Qualitative evaluations which look at how accessible the scheme is. The financial benefits for the retailers taking part in the scheme.
Help to give children the best start in life. Provide breastfeeding support services. – Provide support groups – Become accredited with UNICEF's Baby Friendly Initiative – Work with local businesses to increase breast-feeding friendly environments – Provide breast-feeding friendly environments across the local authority.	There is strong evidence on the benefits of breastfeeding. [88] However, the UK has one of the lowest breastfeeding rates in the world. [89] Addressing this needs a comprehensive, supportive and non-judgemental approach. Providing supportive breastfeeding groups and working to make the wider local environment friendlier for breastfeeding can help to tackle these low rates.	Leadership should come from public health and ICB maternity teams. Partners include local businesses, health visitors and health and social care providers who can communicate information about support groups.	Number of local businesses providing breastfeeding friendly premises. Percentage of women breastfeeding. Percentage of eligible women attending support groups. Achieving accreditation to UNICEF's Baby Friendly Initiative.

Actions to take	Why they are important	Leaders and partners	How to evaluate
Communicate health messages			
Provide positive messages about the benefits of healthy eating. Campaigns and communications about healthy eating, reflecting evidence about behaviour change and how to communicate around food and health.[90] – Digital, social and mass media campaigns – Local targeted and tested campaigns for high prevalence groups – Proactive PR and earned media – Communications which capitalise on policy opportunities.	Campaigns and communications can't change health outcomes in isolation. But they do help people think about making changes to their behaviour.[91] Campaigns have also helped people temporarily eat more fruit and vegetables[92] and change what they buy.[93]	Communications teams within local authorities. Regional coordination can drive economies at scale.	Reach and engagement with digital and social media campaigns. Pieces of media coverage and opportunities to see (OTS) and additional earned value (AEV). Awareness of the campaign and its messages, including with target groups. Include digital links to services so that traffic can be measured.
Provide treatment			
Help people living with overweight and obesity to lose weight. Provide comprehensive overweight and obesity management services. – Commission a 4 tier service – Digital support – Face-to-face, telephone and online behavioural support on diet and exercise – Pharmacological support – Intensive multi-disciplinary support for complex cases.	Weight management services help people to lose weight and improve or reverse health problems associated with obesity.[94] Overweight and obesity is complex and for treatment to be most effective, a comprehensive approach should be offered. It should include psychological behavioural support to help address individual causes. Despite strong evidence for these services, pre-pandemic data showed that only 52% of local authorities commissioned tier 1 services, while 82% commissioned tier 2.[95] A survey of ICBs found that just over half commission both tier and 3 and 4 services.[96]	Public health teams in local authorities lead commissioning of tiers 1 and 2. The ICB leads commissioning of tiers 3 and 4. Partners can include the health and social care workforce for brief interventions. Communications teams for targeted communication on the services.	Outcomes related to behaviour change around food, physical activity and wellbeing along with baseline and follow on weight measurements. General health surveys for obesity related conditions. The percentage of the eligible population accessing services and participant experience. The demographics of the population accessing services. The demographics of the population accessing services.

Cross-cutting actions

These actions are common across tobacco, alcohol and unhealthy food and drinks.

Actions to take	Why they are important	Leaders and partners	How to evaluate
Ensure the most effective, evidence-based policies and programmes in place. Protect policies and programmes from the vested interests of harmful industries and ensure policies are developed without conflicts of interest. – Establish governance protocols which set out the principles of engagement with industry – Make sure that protocols align with national and international guidelines – Sign up to local declarations on tobacco – Ensure transparency by committing to publish meetings and minutes on local authority websites.	There is well established evidence that harmful industries use a comprehensive approach to corporate political engagement.[97] To respond to this, local and regional governments should take a comprehensive approach to effective governance. ADPH has produced a toolkit to help local authorities develop policies and protocols on good governance.[98] There are also national and international guidelines which set out principles of engagement.[99,100] These can be used to support protocols and policies for local governments to follow. Protecting policies and programmes from conflicts of interest is the most impactful overarching action that a council to take to tackle harms to their population. It needs a strong, coherent approach across all departments. Having a champion senior official or political leader will help bring other parts of the local authority on board.	Public health teams in local authorities. Key partners include senior leadership across local authorities. There needs to be strong leadership across the local authority to ensure coherence and consistency.	Protocols in place and in use across the local authority. Number of meetings with industry. Publication of minutes and meetings with industry.
Strengthen national legislation, regulation and guidance. Advocate for stronger restrictions at a national level. – Encourage local authority sign up of calls to action – Build relationships with MPs so that they can call for change in parliament – Build relationships with regional political leaders, Mayors and other representatives where appropriate – Become a member of the Smokefree Action Coalition, Alcohol Health Alliance and Obesity Health Alliance – Share examples of success and best practice to support others as they advocate for change.	There are many actions which local authorities and regional organisations can take to protect the health of their populations. However, some of the most effective interventions, like tax increases, Minimum Unit Pricing, or wider advertising and marketing restrictions can only be made at a national level. Local authorities have always had a role in leading by example, introducing new and innovative policies and they can also help call for national change.	Public health leadership. Partners can include trading standards, licensing, the police and community organisations.	Membership of national advocacy coalitions.

Key resources and supporting information

Below are key resources that can support in taking forward policies on the three biggest killers at a regional and local level.

ASH, AHA and OHA report advocating for a coherent approach on a national policy level
Holding us Back: tobacco, alcohol and unhealthy food and drink:
https://ash.org.uk/resources/view/holding-us-back-tobacco-alcohol-and-unhealthy-food-and-drink

Alcohol Health Alliance
https://ahauk.org/

AHA Manifesto
https://ahauk.org/what-we-do/our-priorities/our-manifesto/

Obesity Health Alliance
https://obesityhealthalliance.org.uk

OHA Report
https://obesityhealthalliance.org.uk/turning-the-tide-strategy/

Action on Smoking and Health
https://ash.org.uk/

ASH – Article 5.3 Toolkit
https://ash.org.uk/for-professionals/local-toolkit/article-5-3-toolkit?

Sustain
Healthier Food Advertising Policy toolkit
www.sustainweb.org/reports/feb22-advertising-policy-toolkit/

The Health Foundation
Addressing the leading factors for ill health – a framework for local government action:
www.health.org.uk/reports-and-analysis/briefings/addressing-the-leading-risk-factors-for-ill-health-a-framework-for

Association of Directors of Public Health North East
Position Statement on Commercial Determinants of Health
www.adph.org.uk/networks/northeast/resources/position-statement-on-commercial-determinants-of-health

Association of Directors of Public Health
Good Governance toolkit:
www.adph.org.uk/resources/good-governance-toolkit

Nesta
A blueprint to halve obesity in the UK:
https://blueprint.nesta.org.uk/

Department of Health and Social Care
Alcohol licensing: a guide for public health teams
www.gov.uk/guidance/alcohol-licensing-a-guide-for-public-health-teams

The Lancet Series
Commercial determinants of health:
www.thelancet.com/series-do/commercial-determinants-health

Endnotes

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All information is correct at the time of printing (June 2026). Please check our website for the most up-to-date details.