Department of Health

Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control

An evidence-based resource for local Alliances

Prepared by the Tobacco Control National Support Team, May 2008

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FOREWORD

We have made great strides in reducing smoking rates across England. Tobacco control is delivering. Recently, with the effective introduction of comprehensive Smokefree legislation, raising the age of sale of tobacco from 16 to 18 years, with accessible NHS Stop Smoking Services and highly effective marketing campaigns, we should all be proud of what has been achieved. However, the problem is far from solved.

While great inroads continue to be made in tackling the smoking epidemic, it remains the single greatest cause of preventable illness and premature death in England, killing around 87,000 people each year. Sizeable proportions of our population remain exposed to the significant health risks from smoking, and are concentrated in our more deprived communities. Beyond the well-recognised effects on health, tobacco also plays a role in perpetuating poverty, deprivation and health inequality.

Tobacco control – not just Stop Smoking Services or media campaigns in isolation, but an integrated package of interventions – has enormous potential to tackle health inequalities and the ongoing burden of disease caused by smoking. The driving ethical principle of tobacco control is that of fairness. A fair chance for children and young people to grow up in an environment where smoking is not seen as the norm, for smokers to get help to quit (as the majority wish to do), and for people to live and work without being exposed to the hazards of secondhand smoke.

This document contains an evidence-based guide to how smoking prevalence can effectively be further driven down in our communities. The practical recommendations in this document set out a systematic approach to delivering an effective and comprehensive tobacco control programme at the local level.

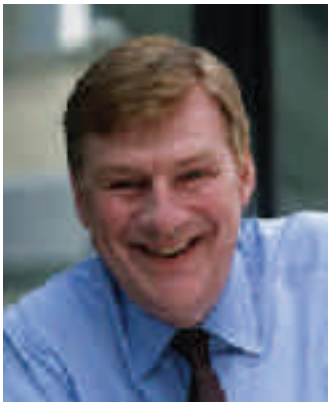
Tackling smoking needs to be everyone's business. It is not just the job of the people at the Department of Health involved in advancing national policy or our NHS colleagues involved in delivering NHS Stop Smoking Services. It is equally applicable to the respected youth group leader who can set a good example, to the local newsagent who does not sell tobacco to young people under 18, or to the local fire service for whom a cigarette-related fire could be just around the corner.

I wholeheartedly support this publication being made available to the widest audience including Local Authorities, the NHS, regulatory services and other public sector agencies. The harm caused by tobacco presents one of our country's most serious public health challenges and we all have a role to play in reducing the harm it causes in our communities.

Much good work is being done. At the time of writing, the UK is regarded as the European leader in comprehensive tobacco control. But it is essential we maintain our efforts to reduce smoking prevalence and the effects of tobacco on others.

There is a great deal of evidence showing that an integrated tobacco control programme is the key to driving down smoking prevalence. We need look no further than California where prevalence has been halved. We too can aspire to those levels if we remain focused and co-ordinated.

I support the High Impact Changes outlined in this document, and hope that this document can support you to bring about the greatest improvement possible in tackling smoking within your own communities.



Professor Sir Liam Donaldson
Chief Medical Officer
May 2008

INTRODUCTION

Smoking has been estimated to cost the NHS £1.5 billion a year and is the single greatest cause of preventable illness and premature death in the UK, each year killing around 87,000 people in England alone.

There is no doubt about the continued need to invest in tobacco control, and the table opposite is a stark illustration of this. Each year in England, deaths attributable to smoking total more than suicide, road traffic and other accidents, diabetes, drug and alcohol-related deaths put together. In addition, smoking is also a major cause of the health inequalities we suffer in this country, and because many young people start smoking each year, smoking-related ill health is perpetuated for future generations.

There are three key principles that underpin efforts to tackle the tobacco epidemic – a genuinely strategic approach to tobacco control, effective partnership working and a focus on denormalising smoking. To underachieve in any of these is to risk undoing the significant momentum built up over the past decade, and with it a strong possibility that the current trends will slow and prevalence rates will start to increase.

Cause of death	Number of deaths
Smoking-attributable deaths	87,000
Suicide	11,108
Alcohol-related deaths	8,758
Road traffic accidents	8,162
Other accidents/falls	6,846
Diabetes	5,128
Drug-related deaths	1,584

Produced by the Public Health Information Team, Birmingham's Public Health Network based at Heart of Birmingham Teaching Primary Care Trust (PCT)

What is tobacco control?

Research shows that no single approach to tackling smoking will be successful in isolation. This means that, as outlined in the *Smoking Kills* and *Choosing Health* White Papers, tackling smoking is everyone's business. Tobacco control is an internationally recognised, evidence-based approach to tackling the harm caused by tobacco. With 50 years of pioneering action behind them, it is quite legitimate to look to the US for a description of what works.

> "The mission of comprehensive tobacco control programmes is to reduce disease, disability and death related to tobacco use. A comprehensive approach – one that optimises synergy from applying a mix of educational, clinical, regulatory, economic and social strategies – has been established as the guiding principle for eliminating the health and economic burden of tobacco use."
>
> *Report of the Surgeon General 2000*

It may be helpful to view tobacco control as those strategies that:

- reduce demand for tobacco with:
  - price measures including high rates of tax;
  - non-price measures such as advertising restrictions, smokefree laws, health warnings, information and advocacy, and stop smoking programmes;
- reduce supply of tobacco by:
  - controlling illicit trade;
  - restricting access to minors.

The context in England

In England, tobacco control activity is guided by the Department of Health's six strand approach, based on international evidence that a co-ordinated and multi-faceted response to the tobacco epidemic is required to effectively tackle tobacco use. These six strands are:

- support smokers to quit;
- reduce exposure to secondhand smoke;
- run effective communications and education campaigns;
- reduce tobacco advertising, marketing and promotion;
- regulate tobacco products;
- reduce the availability and supply of tobacco products.

The application of this six strand approach to the local level can be viewed in Appendix One.

Reductions in smoking prevalence in the general population, particularly among smokers in routine and manual groups, are dependent on a range of effective tobacco control actions at national, regional and local levels. It is important to note that this will not be achieved by NHS Stop Smoking Services alone. These actions include:

- measures to combat the availability of smuggled and illicit tobacco products;
- effective enforcement of smokefree and age of sale legislation;
- strategic development of regional tobacco control communications and campaigns; there is expert support and guidance available from Regional Tobacco Policy Managers who can help ensure local activity complements regional programmes;
- strategic development of tobacco control partnerships and infrastructure between Local Authorities, the NHS and key stakeholders;
- an integrated stop smoking approach with comprehensive referral pathways to NHS support from health and social care settings.

Much has been achieved in tobacco control over the past decade at international, national, regional and local levels. Landmark comprehensive Smokefree legislation was successfully introduced in July 2007, a

comprehensive ban on tobacco advertising is in place, picture warnings will be introduced on cigarette packets from autumn 2008 and the age at which someone can legally be sold tobacco has been raised to 18. Internationally, the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC), the world's first public health treaty, has been ratified by over 150 countries committed to taking effective action against tobacco.

Moving forward, the Department of Health will be exploring the next steps in tobacco control, to set out what more can be done in this country to reduce smoking prevalence and uptake by young people. The Government has committed to:

- reducing health inequality, much of which is caused by tobacco use;
- using tax to maintain the high price of tobacco at levels that will impact on smoking prevalence;
- exploring how harm can be reduced for people addicted to nicotine who find they cannot quit;
- investing in social marketing initiatives at the national level to support smokers to quit;
- tackling the major problem of the availability of cheap illicit tobacco in our communities.

Routine and manual smokers

The Government has set a Public Service Agreement (PSA) target to reduce prevalence among routine and manual smokers from 31% in 2002 to 26% or less by 2010, recognising the high smoking prevalence among this group. Using tobacco control to meet this target means focusing on the significant numbers of smokers who attempt to quit each year without the benefit of evidence-based support. Many smokers, particularly those from routine and manual groups, opt for the 'cold turkey' approach, which is usually unsuccessful in the long term. NHS Stop Smoking Services will therefore be asked to concentrate on attracting more smokers from routine and manual groups to increase throughput and success rates. From April 2008, NHS Stop Smoking Services will be required to record the occupational status of their clients so data can be gathered on the success rates and throughput of routine and manual smokers over time.

The table below illustrates how only three of the English regions are currently below the national average of 30% prevalence among routine and manual smokers.

Prevalence of cigarette smokers among adults in routine and manual households. Average of 2004–06*

Region	Prevalence
North East	34%
North West	33%
Yorkshire and the Humber	32%
East Midlands	30%
West Midlands	29%
East of England	29%
London	27%
South East	30%
South West	30%
England	**30%**

** This regional routine and manual smoker prevalence estimate has been compiled using General Household Survey (GHS) data. Once data from the new Integrated Household Survey (IHS) becomes available around November 2009 it will be possible to more accurately measure regional and local smoking prevalence.*

Aims and rationale of this document

Even though we are seeing a decline in prevalence, smoking remains at epidemic proportions in England. There is robust evidence about the effectiveness of tobacco control, but at local level there are still questions about translating this into practice. This document is designed to help guide the development of evidence-based action that will have maximum impact on smoking within local communities, and to demonstrate how Tobacco Control Alliances can achieve success in their tobacco control efforts.

Who is it for?

This document is aimed at local Tobacco Control Alliances and their partner organisations, for example Local Authorities, NHS trusts, PCTs, the voluntary sector and other public health agencies. In short, it will be of use to all those in the public, private and voluntary sectors who have a direct or indirect role or responsibility for tobacco control.

A specific message has been included to convey to senior decision makers their essential role in providing strategic support, but the bulk of the document is aimed at local Tobacco Control leads. It is not prescriptive about who should do what, but recognises that individual Alliance co-ordinators are best placed to guide action by the range of local tobacco control partners. For example, Trading Standards may have a key leadership role in enforcing the age of sale of tobacco products, while the PCT will probably lead on the provision of NHS Stop Smoking Services.

Why High Impact Changes?

High Impact Changes have been extensively used across the NHS and local government to highlight practical measures that can be implemented at local level. The Department of Health's National Support Teams provide intensive tailored support to those local areas across England that face the greatest challenge with their public health priorities on sexual health, tobacco control, health inequalities, teenage pregnancy and childhood obesity. The Tobacco Control National Support Team (TCNST) has found that levels of tobacco control activity vary across England and that a consistent approach is required if the momentum generated from previous achievements is to be sustained. Alliances have asked for guidance and help to streamline their work and it is hoped that this practical guide for those working in tobacco control will answer this request. The guide has been put together over a number of months ***by*** frontline staff ***for*** frontline staff and has been subject to widespread and rigorous consultation with those working in tobacco control.

Central themes

The 10 High Impact Changes for tobacco control presented in this document are inextricably linked; the temptation to see them as separate from each other must be resisted. So, while a series of actions to adopt each High Impact Change is included, there are a number of common themes that run through each of the 10 Changes:

- the first High Impact Change, **working in partnership**, is the building block for success and it is unlikely that tobacco control at any level will be effective without good partnership working in place;
- **social marketing is key** and should be a core approach when implementing all 10 High Impact Changes;
- **denormalising smoking** as an accepted adult behaviour is key;
- the cross cutting nature of tobacco means **tobacco control is everyone's business** – individuals because their health and wellbeing is affected, the NHS because of the high cost of treating smoking-related illnesses, Local Authorities because quality of life and equality is at risk, and business because of productivity lost through illness and cigarette breaks. Agencies such as the fire service have a stake because of the number of fires caused by lit cigarettes. The impact of litter and environmental damage caused is also a factor;
- each approach is **founded upon the evidence base**, so is more likely to deliver desirable outcomes, demonstrate value for money and build confidence.

High Impact Changes explained

This is a 'how to' manual, designed to assist, guide, inspire and ultimately lead to public health gains across communities by strengthening the ability and capacity of local tobacco control advocates to make change happen.

Each of the 10 High Impact Changes is described in the following way:

- a description of what the change means;
- a summary of the evidence that shows it is worth doing;
- a checklist of the steps that people involved in local tobacco control could consider adopting in order to achieve the change;
- a case study* that demonstrates how the High Impact Change has already been successfully implemented by an Alliance, and what has been learned from the experience;
- a brief conclusion on why the High Impact Change is significant.

** Where possible, real life examples have been used to illustrate how a High Impact Change has been successfully achieved. However, Changes 3 and 7 – on health inequalities and smuggling, respectively – are still developing and examples of promising practice at a local level are at an early stage. We know that the evidence states it is important to concentrate on these areas and so, in these two instances, the example works through what good practice would look like and the types of action or intervention that could have an effect.*

Benefits

Smoking creates major health, economic and social burdens within our communities, which is why tobacco control needs to be elevated to a high level within organisations that can play a role in reducing smoking rates. This guide:

- provides everyone involved with local tobacco control with new ideas for making a difference in their areas – it shows what can be achieved, and how to do it;
- helps Alliances work towards their next priorities. Tobacco control does not end with the Smokefree legislation of July 2007 and while more than one in five adults are smokers in England, there is much more to be done;
- brings together in one place both the evidence and relevant practical experience on local comprehensive tobacco control, providing ideas and robust evidence to justify the case for focusing on comprehensive tobacco control action.

Having identified in this document what is important, it is now over to the local Alliances to do the hard part – implementation. It is a challenge, but these 10 High Impact Changes have the potential to reduce smoking prevalence.

Conclusion

Effective tobacco control needs to be driven by local priorities, local action and local leadership. Current action around the six strands promoted by the Department of Health varies considerably between local communities. The modest action of Alliances following the advice in this guide could do much to reduce smoking prevalence, ultimately saving thousands of lives, averting unnecessary disease and improving wellbeing and quality of life.

It is important not to see tobacco control as the domain of the health sector; it is a multi-sectoral concern and needs to be everyone's business. Local tobacco control leaders should try to involve as many sectors and stakeholders as possible in the development, implementation and dissemination of local tobacco control programmes. A key tool in this process will be the new Local Area Agreements (LAAs).

Work and effort at local level needs to reflect national priorities to achieve the ultimate aim of having local tobacco control strategies that are based on the best evidence of effectiveness and complement national and regional tobacco control priorities.

A MESSAGE TO SENIOR DECISION MAKERS

Why the need for High Impact Changes for tobacco control?

Tobacco use cannot be viewed as just a health issue – it is everyone's priority because of the toll of death and disease that smoking causes. For tobacco use to be effectively tackled, a range of people need to take action and work together. Tobacco control that is a focused, sustained and co-ordinated action on a number of fronts by a wide range of agencies, organisations and individuals is vital if the significant achievements of recent years in the fight against tobacco are to be built on.

The clear message of a comprehensive approach to tobacco control is aimed at influential local leaders such as Local Authority Chief Executives, Directors of Public Health, Commissioning leads and local politicians. They, and indeed anyone who has a leadership role within local communities, can play a crucial role in ensuring that a strategic approach to tobacco control is achieved.

Frontline workers in Tobacco Control Alliances, who we hope will want to follow the step-by-step actions set out in this document, cannot achieve success without high-level support and leadership. To achieve success the infrastructure and resources necessary to implement a comprehensive tobacco control programme must be made available. The strategic and operational aspects of tobacco control go hand in hand, but one working without the other is unlikely to see the results that a joint effort could produce.

The role of senior leaders

The actions recommended within this document have the potential to reduce the harmful effects of smoking and reduce prevalence within local communities, but only if they are implemented with the energy, vitality and backing of senior level personnel who have the ability to:

- put in place a sound local infrastructure and dedicated resources;
- drive capacity building where required;
- identify the overlap between national targets and local aspirations, translating tobacco control evidence into prioritised local action;
- promote inter-agency collaboration by sponsoring activity at organisational level;
- provide the political will, strategic thinking and high-level recognition that tackling smoking is a priority;
- show a willingness to help overcome issues that arise as part of local tobacco control work;
- demonstrate unquestionable commitment to a comprehensive tobacco control programme.

The benefits

We can reduce the massive burdens that tobacco use inflicts on our communities. Comprehensive tobacco control efforts can impact on health inequalities, reduce the economic burden on society and reduce the death, disease and disability that people throughout the country suffer because of smoking. Prioritising tobacco control will create many benefits. The 10 High Impact Changes in this guide:

- are based on evidence of effectiveness and represent the actions that will have the most impact on reducing smoking prevalence, improving health and wellbeing and reducing health inequalities;
- will support the achievement of other PSA, LAA and local targets;
- can help Local Authorities to promote the economic, social and environmental wellbeing of communities.

Conclusion

Smoking is the greatest cause of premature death in our country, making it a public health area of priority. If the principles of tobacco control are applied comprehensively then the potential is enormous. Smoking as a normal activity will be challenged and tobacco use denormalised.

The UK has been rated as the top country in Europe for tobacco control. This reflects significant progress made in the past decade but there is still more to be done. This document provides a range of evidence-based ideas about how to make tobacco control most effective in local communities. What is required is a strategic commitment.

THE 10 HIGH IMPACT CHANGES IN SUMMARY

1: Work in partnership

Effective partnerships are central to moving the tobacco control agenda forward. Partnerships need to be strategic and create a joined-up approach to tackling the public health issue of tobacco as a shared priority. This requires senior leadership, developed Tobacco Control Alliances and positioning of these within the framework of strategic local partnerships.

2: Gather and use the full range of data to inform tobacco control

Collecting robust data to determine the scale of the challenge in a given area will inform local tobacco control goals, helping to ensure that efforts are focused in the right places. The available knowledge can then be translated into informed planning and commissioning.

3: Use tobacco control to tackle health inequalities

A locality committed to addressing health inequalities will need to intelligently commission tobacco control if more significant reductions in smoking-related inequalities are to be achieved. Interventions targeted at the substantially untapped group of smokers within the routine and manual group must be a priority as this is the main means of tackling health inequalities.

4: Deliver consistent, coherent and co-ordinated communication

Bringing communications into the local strategic approach to tobacco control increases the effectiveness of national and local smokefree campaigns, is central to social marketing and is fundamental to tobacco control advocacy.

5: An integrated stop smoking approach

The local NHS Stop Smoking Service should be viewed as just one element of an overall strategic and comprehensive programme rather than the sole agency delivering tobacco control at a local level, albeit acknowledged as a function that underpins many other parts of a comprehensive programme.

6: Build and sustain capacity in tobacco control

Capacity building is a long-term process but in order to maintain progress and momentum in tobacco control it is essential that local capacity is strengthened and sustained. Successful tobacco control will require infrastructure, resources and political will.

7: Tackle cheap and illicit tobacco

Tobacco smuggling seriously undermines the impact of other tobacco control measures. There needs to be greater effort to reduce both the demand and supply of cheap illicit tobacco. This is a cross-cutting issue that requires engagement from all partners in a local Alliance.

8: Influence change through advocacy

Tobacco control advocacy is about changing the political, economic and social conditions that encourage tobacco use and gaining public, political and media support for tobacco-related issues.

9: Helping young people to be tobacco free

Smoking prevalence among 11–15 year olds has remained at 9% in recent years, but at age 15, 16% of boys and 24% of girls are regular smokers. Youth prevention should be part of a comprehensive tobacco control programme based on denormalising smoking across the wider population.

10: Maintain and promote smokefree environments

A concerted effort is required to sustain the profile of tobacco control and maintain the momentum provided by the Smokefree legislation of July 2007 if the significant benefits to be had from denormalising smoking are not to be lost.

HIGH IMPACT CHANGE 1:
Work in partnership

What does this mean?

> "The challenge is to move beyond simple co-operation and co-ordination to create a spirit of collaboration and partnership to address tobacco as a community issue. Several factors support successful collaborations, including mutual trust, shared decision making, open communication, and having a skilled convener."
>
> *Michael Winer and Karen Ray, Collaboration Handbook*

There is an often quoted phrase that no one can do everything but everyone can do something. Nowhere is this more relevant than in the world of tobacco control where the full benefits of a comprehensive programme are only realised through local partnership working supported by regional co-ordination.

Effective tobacco control is built on teamwork and a diverse range of skills. At a local level it requires a strategic approach with board-level support from PCTs, Local Authorities and others on Local Strategic Partnerships. Multisectoral working of this kind requires input from statutory, voluntary and business sector partners – in other words, a comprehensive tobacco control programme will involve multiple agencies and a clear commitment from senior officers at each partner organisation. The new Local Performance Framework can be a major influence on this kind of partnership working on tobacco.

The aim for a Tobacco Control Alliance is to have a range of partners across the local area that are committed and active in making their own contribution to reducing the impact of smoking on health and health inequalities. However, there is a cyclical nature to partnership working that needs renewing, revitalising and refocusing from time to time. To help Alliances assess their functionality as partnerships, a toolkit has been produced by Fresh Smoke Free North East, and this resource is an excellent tool for those wishing to plan for the challenges and priorities ahead, and to reflect and take stock following activity around the Smokefree legislation in July 2007.

In addition, evidence from the North East [1, page 60] shows that there are three key factors underlying an effective partnership:

- a clear but detailed purpose that enables each of the partners to identify the importance of their and their organisation's contribution;

- co-ordination by a 'neutral' officer not seen as entirely within the structure and procedures of any one member organisation (e.g. NHS trust or Local Authority). In reality, it is highly unlikely that the co-ordinator will come from outside these two structures but the way he or she approaches the work and partnership relations can be based on this requirement for neutrality;
- dedication of managerial time and attention to developing effective working relationships and a shared sense of mission.

We also know that by its very nature, a partnership must:

- be equitable;
- be diverse and multi-agency;
- allow for informal networking between meetings;
- have accountability;
- have a shared goal.

There are different types and levels of Tobacco Control Alliance – regional, sub-regional, local, for example – but whatever the type, the principles within this High Impact Change are equally relevant.

What is the evidence that it works?

While PCTs are primarily responsible for the way tobacco control is managed by the health services in their respective areas, they cannot serve their populations in isolation. Partnership working in the local community is essential. The importance of partnerships was highlighted by the Healthcare Commission in its 2007 report *No ifs, no buts: Improving services for tobacco control* which revealed that a characteristic of high performing PCTs was their engagement in partnerships with local agencies such as councils, hospitals and prisons. Those PCTs with the highest proportion of quitters compared with smokers achieved a score of 'excellent' in the key review area of partnership working.

The US view is that fully engaged partnership working is essential for successful local tobacco control action [2, page 60] and areas intending to develop truly effective partnership working around tobacco control recognise the importance of developing productive relationships, as well as an adequate infrastructure. [3, page 60]

Action checklist

To follow are suggested mechanisms for creating an effective partnership. The action could potentially be led by the Alliance co-ordinator but will be of use to all those individuals and organisations involved with driving forward a clearly targeted, evidence-based and prioritised strategic approach to tobacco control.

- ☑ Seek advice, guidance and support from the Regional Tobacco Policy Manager as required.
- ☑ Work through the functionality review developed by Fresh to facilitate a frank self-assessment of existing partnership arrangements and thus clarify a way forward. It should take no more than one meeting to assess existing partnership arrangements followed by some time to record and report the review and enhancements planned.
- ☑ Keep the Alliance distinct from the local Stop Smoking Service but ensure that the two work in synergy; widen activities to encompass the entire tobacco control agenda.

- ☑ A successful partnership requires a strong co-ordinator who has a dedicated tobacco control role and who has a clear vision, high-level support and high-level recognition. This co-ordinator's role will be to act as the catalyst for unleashing broad community participation and support for tobacco control. As such they will need to be able to think and plan strategically and creatively, have the ability to inspire confidence and to successfully manage up, down and across to build partnerships and Alliances to expand the tobacco control network in the locality, all the while keeping partners in the loop and aware of what is expected of them.
- ☑ Similarly, effective partnerships need high-profile leadership via a champion with management buy-in and the ability to influence at high level as to the strategy and ethos of the group. An assistant Director of Public Health or Local Authority Public Health lead would perhaps best satisfy this need, albeit chairs from any relevant partner should not automatically be ruled out.
- ☑ Both co-ordinator and champion need negotiation skills and diplomacy; the champion will chair the partnership group while the co-ordinator guides the champion so they influence when they have the opportunity.
- ☑ If wider backing from public health, the Local Authority and the third sector is to be achieved, the partnership will need to demonstrate why it is important for people to engage, emphasising to potential new members how both the Alliance and their organisation will benefit from involvement. Links with Local Strategic Partnerships are important.
- ☑ Look beyond the public health world for potential partners. While links with those looking at heart disease and cancer prevention programmes can be fruitful, relationships outside the health community can build diversity and help reach a larger audience. Target those who have the potential to help advance the programme, be that the media, council leaders, NGOs, health professionals, lawyers, economists, schools, unions or business leaders. (A full list of potential partners is included in Appendix Two.)
- ☑ Partners operate at different levels: some – the core members – are active all the time, others – influential supporters – active only for short periods. Regardless of the level of input, consistent and ongoing consultation and communication with key stakeholders is needed to ensure their ongoing commitment to help implement all 10 High Impact Changes.
- ☑ Be realistic that while different partners can bring diversity and different things to the table, partners will have different agendas. As such it will take time, effort and persistence to develop an Alliance but once it is up and running, the Alliance will start to feed into itself and parties will take more responsibility and come up with their own ideas. Consider using effective sub-groups for specific topic areas with quarterly meetings being held to develop and implement the tobacco control strategy.

How does this High Impact Change work in practice?

The Smokefree Swindon Partnership: using effective partnership working to promote the smokefree agenda

The challenge

Successful implementation of Smokefree legislation in the Swindon area, ensuring maximum compliance by local organisations, whether private, public or third sector, and maximum opportunity to encourage quit attempts.

Action

The Smokefree Swindon Partnership was established to achieve effective implementation of the legislation. The Partnership involved a range of partner organisations including Swindon Borough Council, New College, Swindon and Marlborough NHS Trust, Swindon PCT, Wiltshire Fire Service, Wiltshire Police Force and other community representatives.

The objective was to ensure that all member organisations delivered a consistent and co-ordinated approach to implementing legislation and the smokefree agenda, with every partner providing an avenue of access to the services of the others. This joint approach by the Local Authority, PCT and other public and private sector organisations maximised the opportunity to improve the health of Swindon, contributed to reducing health inequalities and minimised the potential issues arising from non-compliance.

A programme of advice and visits pre legislation and a programme of compliance visits to over 500 'high risk' premises post 1 July was set in place. During this process the enforcement team provided information to local employers about the NHS Stop Smoking Services, and the latter also provided information to local businesses, offered on-site stop smoking groups and signposted employers to further information sources.

One of the main challenges was to ensure positive engagement with local businesses, the licensed trade and other organisations to minimise non-compliance and promote the NHS Stop Smoking Services. This involved a series of activities including mail outs, use of local media and a series of seminars to answer questions such as 'what is classed as a smokefree shelter?' and 'what NHS Stop Smoking Services are available?'. Free materials were provided to businesses including guidance notes, signage and other literature. The literature made reference to the Smokefree Swindon Partnership and promoted the NHS Stop Smoking Services, including the fact that the local service was able to provide on-site stop smoking groups for businesses and their employees.

Results

By working in partnership on this issue, some of the positive outcomes were:

- smooth introduction of the legislation;
- minimal non-compliance, thus good provision of smokefree public places for the Swindon population;
- increased awareness of local NHS Stop Smoking Services and signposting by partner organisations to the services;
- minimal negative publicity;
- council seen to be proactive and supportive to local organisations;
- six industry on-site stop smoking groups three months prior to legislation and seven groups in the three months after 1 July increased accessibility to NHS Stop Smoking Service provision;
- extended pharmacy scheme from seven to 15 pharmacies providing the service three months prior to legislation;
- the introduction of a Saturday morning session and extended evening stop smoking provision.

The Swindon 'Supersurvey' lifestyle survey of 2006 showed an estimated smoking prevalence of 19% in Swindon. The survey was repeated in 2007 and showed that smoking prevalence in Swindon appeared to have fallen to an estimated 17%. This reflected the positive partnership working to promote a smokefree Swindon.

What we can learn from this

The partnership worked together to ensure that the overall objective of a smokefree Swindon was achieved with the minimum disruption for local businesses and the maximum benefit of improving the health of the local population.

Important success factors were:

- identifying key stakeholders and partners who had a contribution to make and engaging with them;
- keeping partners engaged;
- demonstrating both the contribution and benefits for stakeholders and partners;
- sharing of information, contacts and local knowledge;
- recognising that the 'whole is greater than the sum of the parts';
- commitment of senior management such as Directors and Chief Executives;
- appreciating that membership attendance may not necessarily be consistent/continuous but maintaining the links for future developments.

In the light of the 2007 Smokefree legislation, Swindon's Tobacco Control Strategy is being reviewed with a Tobacco Control Visioning Day a key part of the process. This event involves all current Alliance members, with a wide range of people from all sectors that may have an interest in the tobacco control agenda, from health promotion and local government through to HM Revenue and Customs. The aim is also to look to engage with potential new partners.

Why is this High Impact Change significant?

Partnerships need to be truly strategic with members able to work together to create a joined-up approach to tackling the public health issue of tobacco as a shared priority. Good partnerships bring together everything that follows in this document – a piecemeal approach will fail to have any effect on smoking prevalence and hence health inequalities. By working in partnership with other organisations the harmful effects of tobacco and the benefits of quitting can be better communicated while the wider health needs of local people will be met more effectively. In short, partnerships are an asset in moving the tobacco control agenda forward.

Further reading

- Local Alliance Toolkit 2007
  Fresh Smoke Free North East
  http://www.freshne.com/content/editor/File/Toolkit/Fresh%20Toolkit%20pdf%20format.pdf
- No ifs, no buts: Improving services for tobacco control
  Healthcare Commission, January 2007
  http://www.healthcarecommission.org.uk/_db/_documents/Tobacco_control_report.pdf
- Tackling smoking through partnerships; Lessons learned from the National Alliance Scheme
  Health Development Agency, 2001
  http://www.nice.org.uk/nicemedia/documents/smokingpartnerships.pdf
- Evolution of a comprehensive tobacco control programme: building system capacity and strategic partnerships – lessons from Massachusetts
  Robbins H and Krakow M, Tobacco Control, 2000; 9: 423–430
  http://tobaccocontrol.bmj.com/cgi/content/abstract/9/4/423
- Collaboration Handbook. Creating, Sustaining and Enjoying the Journey
  Winer M and Ray K, Amherst H Wilder Foundation, Minnesota, 1994
- Delivering Health and Wellbeing in Partnership: The Crucial Role of the New Local Performance Framework
  http://www.communities.gov.uk/publications/localgovernment/health

HIGH IMPACT CHANGE 2:
Gather and use the full range of data to inform tobacco control

What does this mean?

The value of organised, accurate and up-to-date information cannot be overstated. By collecting and making active use of reliable local data, the local needs, gaps, strengths and weaknesses of current and future tobacco control programmes can be assessed. Without such information it will be very hard to make good decisions about how to tackle smoking locally or know where best to direct energy and resources. Nor will it be possible to demonstrate effectiveness, and without reliable information to back up arguments it will be hard to even get over the threshold of the high-level decision makers who need to be influenced.

This requires the development of a systematic approach to identify exactly what data is needed to allow an Alliance to carry out the priority activities it has identified. Sources might include Health Equity Audits (HEAs) or Joint Strategic Needs Assessments (JSNAs) of the health and wellbeing of a local community. Relations with PCT health informatics teams, public health analysts and Public Health Observatories should also prove fruitful, while from late 2009 local prevalence data at PCT level will be available through the new Integrated Household Survey. Local NHS Stop Smoking Services should by now be following the data requirements of new Department of Health guidance published in October 2007 with a subsequent yield of consistent and quality data.

But this High Impact Change is about more than just data – it's about gathering intelligence and using innovative approaches to translate the available knowledge into informed planning and commissioning and tailored messages for the local population.

This activity is intimately linked to the need for effective partnership working as stressed in the previous section. Making the fullest use of local partnerships to get the best data and information from all concerned is key. This will make it clear what has to be done, and why – in short helping to map and tailor services to a specific area and support evaluation of the impact of an Alliance's work on the ultimate goal of reducing smoking prevalence. Once local partnerships are working well, systems should be established so that relevant data flows smoothly from Alliance organisations as opposed to being difficult to locate and acquire. Partners may not always realise they have information that could be helpful, but the more cohesive the group becomes the better the data should be.

A shift towards social marketing principles is also important. Investing time and effort in understanding a smoker's behaviours, attitudes, beliefs and motivations, and the environment in which they live and work can also be instrumental in developing a comprehensive tobacco control programme. *(A brief summary of social marketing is included at Appendix Three for those not familiar with this approach.)*

What is the evidence that it works?

Some 20 years ago, the first *Directional Paper of the National Program to Reduce Tobacco Use in Canada* [1, page 60] identified research and knowledge development as a strategic direction, including ongoing surveys of tobacco use to aid planning at the regional level. Data gaps, including a critical absence of baseline information needed for many national goals, were again recognised when the Strategy was updated in 1993. [2, page 60]

This emphasis on gathering the full range of data available was echoed in a 2007 review [3, page 60] of what has worked well in the US. The paper stressed that activities to collect and disseminate solid health data, such as the number of deaths and hospitalisations due to tobacco-related illnesses, were an important part of a tobacco control strategy.

Action checklist

Work on this High Impact Change should be led by the appropriate members of the Tobacco Control Alliance. Important points to consider when striving for a rich picture of local data are:

- ☑ Make sure any complicated data is translated into simple language that is easily understood and communicated.
- ☑ Use the full breadth of data – international down to national, regional and local – and then share this with different partners and co-ordinate responses. No piece of information is too small and getting the views of 50 people on the high street can be very powerful with the only resource implication being time. Be mindful, however, that data collection is not all about quit rates and consider introducing data from national smoking-related behaviours and attitudes surveys to influence how services are delivered locally. (http://www.statistics.gov.uk/downloads/theme_health/smoking2006.pdf)
- ☑ Don't rely merely on the usual health sources but be aware that there is a wealth of data in different organisations. For example, seeking out information on fire statistics will reveal that 125 people die in smoking-related fires each year. Sharing of data like this across organisations can be extremely helpful.
- ☑ This High Impact Change is not just about statistics – contact data is important too. Think outside the box about what information is out there and who can deliver it to the Alliance. For example, collecting local business contact information will be important if campaigns targeted at employers are being considered.
- ☑ Local data obtained through social marketing techniques will carry greater weight when preparing specific messages to communicate to target audiences. Strategic needs assessments will provide very localised information as will Quality and Outcomes Framework data. The latter is an excellent source of local smoking prevalence by GP area and postcode, providing robust data about which areas to target.

- ☑ Work with Local Authorities to include questions on smoking prevalence in any household surveys they are conducting. For consistency ask the same questions as those asked in national surveys.
- ☑ Use the best evidence available on effective interventions by looking at what works in other places, but also systematically evaluate new interventions piloted locally. This will not only demonstrate effectiveness but also highlight if an intervention doesn't work. This can save others working in tobacco control from wasting further resources and time on that activity.
- ☑ Involving voluntary and community sectors in the data gathering exercise can be more motivating than just asking them to support the NHS or an LAA target.
- ☑ Economic research is an important, yet often neglected, component. Policy makers and the general public are often unaware of the massive financial costs to society of tobacco use and this can be quantified by rigorous data collection in the local area. The West Midlands Public Health Steering Group website (http://www.smokingcosts.org.uk/) is a valuable tool for working out how much smoking costs locally broken down by either PCT or Local Authority area.
- ☑ Grow and build on the data and evidence that already exists by mapping the local data already available and springboarding activities off other surveys or annual events like No Smoking Day or World No Tobacco Day. These can offer a useful peg to collect information on issues such as how many vending machines are in the area.

How does this High Impact Change work in practice?

Using the data to inform tobacco control action

The challenge

The consultation on the smokefree elements of the Health Bill in 2005 created a considerable challenge to tobacco control advocates. Option Four proposed to have certain premises exempted and meant that a large number of employees would remain exposed to secondhand smoke in the workplace. The most obvious example of this was in licensed premises where only those that served food would need to enforce the legislation. There was a feeling that, on this basis, many areas would not benefit from the legislation as the majority of premises were 'wet' led, that is relied entirely on the drinks trade for their revenue, rather than 'dry' led where food is an important element of the trade. In the North East of England, which historically has many working men's clubs and wet led pubs, the Regional Tobacco Control Office, Fresh, felt this would potentially increase health inequalities and that there was a need to demonstrate this during the consultation.

Action

The decision was made to calculate the total number of premises that would remain exempt in each Local Authority area in the North East region. Each Environmental Health Department was contacted; in some cases they were able to supply the relevant information or contact details for premises in their area but unfortunately differences in databases and record keeping meant that this was not always the case. Therefore, using the initial data as a baseline, time was spent searching via the internet and telephone directories to establish contact details for the remaining premises. These were then contacted to determine their status as 'wet' or 'dry'.

Results

A table was created that showed, for each Local Authority area in the region, the total number of pubs and working men's clubs, the number exempt and the percentage of premises exempt, and linked this to the area's Index of Multiple Deprivation and Lung Cancer Standardised Mortality Ratios. This showed that on average 50% of North East premises would be exempt from Smokefree legislation if accepted in the proposed format. In Easington, not just one of the poorest areas of the region, but of England overall, the figure would be 81%. This information was quickly picked up by national, regional and local media, leading to debate about the proposed legislation and the consultation process, and proved instrumental in lending weight to the advocacy efforts which eventually secured comprehensive Smokefree legislation. Part of the table is reproduced below.

What we can learn from this

This simple case study provides a useful example of the influence that can be exerted in overcoming potential obstacles in tobacco control when innovative and collaborative methods are used to uncover data that is then translated into meaningful facts and communicated effectively to key audiences.

PARTIAL NORTH EAST RESULTS OF EXEMPTIONS/INEQUALITIES MAPPING

Local Authority	Total Number Pubs/WMC	Total number exempt	% of premises exempt under proposed Option 4	IMD* 1) average 2) ranking	Lung Cancer SMR** (persons)
Gateshead	248	178	72%	32.60 30	165
Newcastle	359	169	47%	33.55 23	165
Sunderland	230	100	43%	33.84 22	159
Easington	137	111	81%	41.44 6	141
Middlesbrough	141	77	55%	40.68 9	146
NORTH EAST			**50% licensed premises will be exempt**		

* Ranks of all districts in England (1 = most deprived (Knowsley 48.18); 354 = least deprived (Hart 4.70))
** Mortality from lung cancer (ICD10 C33–C34); indirectly standardised ratios (SMR), 2001–02 pooled, all ages (standard rates are England and Wales annual age-specific mortality rates 2001–02). England and Wales = 100

Why is this High Impact Change significant?

Gathering data and translating it into policy, and drawing in a wide range of agencies and local representatives will inform the setting of local tobacco control goals as well as the actual scale of the challenge in your area. This subsequently informs active commissioning and developed monitoring processes. It will also help with social marketing exercises and help deliver consumer-centred messages and service planning that is really tailored to local community needs.

National policy has revealed the immediate need to focus on routine and manual smokers. Following this High Impact Change to the full will result in data becoming available that will, in time, show whether local areas are effectively targeting tobacco control interventions at this important group and help ensure Alliances are focusing their efforts in the right places by using robust data. Only by identifying who knows what about local people and how this information can be accessed will a 'rich picture' of local data be achieved.

Further reading

- Improving the measurement and use of tobacco control "inputs" [editorial] Wakefield MA and Chaloupka FJ, Tobacco Control, 1998; 78: 333S5 **http://tobaccocontrol.bmj.com/cgi/content/extract/7/4/333**
- Globalink **http://www.globalink.org/**

HIGH IMPACT CHANGE 3:
Use tobacco control to tackle health inequalities

What does this mean?

Smoking is the key cause of health inequality in our communities. Among the most deprived groups, three out of four families smoke and spend a seventh of their disposable income on cigarettes (Marsh A and McKay S, *Poor Smokers*, Policy Studies Institute, 1994). 'Smoking poverty' of this nature can see children in smoking households more likely to be lacking basic amenities such as food and clothing. In addition to the financial impact, smoking is the greatest single factor in the different life expectancy between social classes. Indeed, premature death is the most extreme form of social exclusion and without shared enthusiasm for explicit action, inequalities are likely to get even worse over the next few decades.

Addressing the inequalities in health brought about by the use of tobacco remains a huge challenge. Routine and manual, who make up the largest group of smokers and number 4.25 million in England, are the social group with the highest volume of smoking – 29% prevalence compared with 15% in the managerial and professional group. Therefore, tailoring tobacco control work according to the needs of this group is, and will continue to be for some years to come, the most effective way of tackling this issue and helping to reduce the gap in life expectancy between rich and poor people.

Government has already played a central role in tackling health inequalities with the introduction of policy measures such as a comprehensive ban on tobacco advertising and promotion, increasing taxes, preventing smoking in the workplace, and provision of nicotine replacement products and other stop smoking aids. But there is much that can be done at a local level and social targeting of tobacco control interventions and tailored communication approaches will be a significant contribution to these national efforts to reduce health disparities.

What is the evidence that it works?

Most, but not all, of the substantial social inequalities in adult male mortality during the 1990s in England, Wales, Poland and North America were due to the effects of smoking. [1, page 61] To reduce health inequalities every effort must be made to enable the less well off to stop smoking or never start. This is highlighted by the fact that non-smoking men in social class I and II have a 50% better chance of surviving an extra 20 years compared with smokers from the same social class. This figure goes up to 63% for men in social class IV and V. [2, page 61]

Opinion from the US is that tobacco control programmes should consider populations disproportionately affected by tobacco addiction and tobacco-related morbidity and

mortality when designing and implementing prevention and treatment programmes. [3, page 61] Department of Health planning guidance for the NHS recognises that stop smoking support is a significant contributing factor in reducing health inequalities, and this has been identified as a key intervention and priority since 2002/03. Its importance is once again stressed in the 2008/09 Operating Framework. [4, page 61] There is also some evidence that telephone helplines have a role to play in reaching disadvantaged groups. [5, page 61]

Indeed, a number of papers have concluded that Stop Smoking Services are effectively targeting smokers from poorer areas, with those in lower socio-economic groups using services – and successfully quitting – more often than those from more affluent communities. [6, page 61]

Action checklist

The following points will be worth considering when addressing the challenge of making sure tobacco control policies at a local level are supporting national efforts to reduce health disparities.

- ☑ There is a wealth of research now available providing invaluable insight into the behaviours, attitudes, demographics and lives of routine and manual smokers. This should be used locally as it provides a clearer picture of the target group. In addition to using this data, Alliances could also use social marketing techniques to develop a rich picture of local needs, including what smokers see as their needs. This market research will then inform commissioning and delivery of appropriate interventions.
- ☑ Develop and implement effective population-specific tobacco control programmes directed at specific groups. While it is desirable to devote some effort to tackling very deprived smokers, the greatest gains around health inequalities are to be found in tackling high volumes of routine and manual smokers and allocating resource accordingly.
- ☑ Using local data to make the case that smoking is a major cause of death and impacts on someone's ability to work and on their income, for example, can help commissioners to prioritise work around routine and manual smokers.
- ☑ A health equity audit is an important tool in attempts to reduce health inequalities. Equity audits provide a strong foundation upon which resource allocation decisions can be made and identify how fairly services or other resources are distributed relative to the health needs of different groups and areas. An example of an HEA from Derwentside in County Durham can be viewed at **http://www.health-promotion.cdd.nhs.uk/media/pdf/6/a/Derwentside_Stop_Smoking_Services_Health_Equity_Audit.pdf**
- ☑ Be aware that targets, for example Local Area Agreement performance indicators, PSA targets and targets around cardiovascular disease (CVD)/coronary heart disease (CHD) are important to highlight as these are a prime motivation for many organisations to act at a local level. Alliances may wish to take steps to try to influence how targets are agreed to make sure they are realistic; a good Alliance Chair is crucial in this respect as they are often involved in the original discussion of target setting.

- ☑ Smokers should not be presented or viewed as an insignificant minority only a danger to themselves. While not wanting to victimise smokers it is important to stress the scale of the impact of the smoking minority on the non-smoking majority in terms of economic costs, hospital waiting lists and access to GP appointments.
- ☑ There is merit to be had in learning from the experiences of colleagues working in other agencies that also need to concentrate on these target groups on issues such as food and alcohol, albeit continuing to make the point that smoking is the biggest cause of health inequalities.
- ☑ Smokers take more sick days than non-smokers and absenteeism levels affect employers. There may be opportunities, therefore, to work with local employers to try to reduce prevalence.
- ☑ Contractual arrangements need to ensure that health inequalities are prioritised and addressed – reducing health inequalities needs to be a guiding principle of contracts.

How does this High Impact Change work in practice?

How conducting market research into smokers' needs can help tackle health inequalities

The challenge

Tobacco control is one of the most powerful levers available to tackle health inequalities – the challenge for local Alliances is translating this knowledge into effective action. Finding ways to fully utilise tobacco control's strong evidence base to tackle health inequalities will require Alliances to develop a systematic approach that takes account of client need and uses this as the basis for effective intervention.

Action (*)

One key area where Alliances can adopt this approach to effectively tackle health inequalities is in focusing on routine and manual occupational groups. But what would this look like in practice? In this example market research will be important. While health equity audits have a place in deciding resource deployment, what local areas really require is a rich picture of local needs.

Market research can of course be carried out by an external agency but local sources such as Local Authority Community Engagement Projects could also be used to identify the lifestyle segments of the intended audience as opposed to basic demographic categories.

Commissioners will then be in a position to work with both this detailed picture of local population needs and the evidence base to identify appropriate models of intervention that actively target smokers, especially the routine and manual group.

Delivering interventions, whether stop smoking support, work to denormalise smoking or action on illicit supply, then becomes part of a planned approach to health inequalities.

Results
The benefit for Alliances working in this way is that intervention models backed by both the evidence base and local market research are not only likely to be effective but will also have a stronger appeal to partners. A local area that sets out to explore the needs of its population can expect to get active buy-in from across the local public sector from the start. This then provides a basis for commissioners to deliver truly world class commissioning.

Because the interventions are tailored to real need they are naturally relevant to demand and will deliver better results for the target audience as well as putting the local area in a position to act on health inequalities in a clearly evident way.

What we can learn from this
Delivering on health inequalities aspirations requires a systematic and market-led approach. A clear flow from market research, to informed commissioning, to delivery of appropriate interventions will deliver on tobacco control. A key target group that may be used to demonstrate this approach is routine and manual smokers.

(*) As stated in the introduction, work in this area is developmental and as such this example highlights what good practice would look like rather than detailing a real life example

Why is this High Impact Change significant?

Smoking and health inequalities are inextricably linked. Fully informed commissioning of tobacco control is the way to address health inequalities. A locality committed to resolving the gap between rich and poor will therefore need to intelligently commission tobacco control if more significant reductions in smoking-related inequalities are to be achieved.

Social marketing offers a means of developing initiatives to reach out to high smoking prevalence groups that previous stop smoking approaches may have underserved, and as such is a key element of an approach to tackle health inequalities

It is clear from the evidence that there are gains to be had in terms of using tobacco control to impact on the morbidity and mortality caused by smoking. But efforts must be focused on the areas of greatest need and as such interventions targeted at the substantially untapped group of routine and manual smokers should be a priority.

Further reading

- Smoking Prevalence and Deprivation. ASH interactive map showing smoking prevalence and deprivation by ward across England **http://www.mapsinternational.co.uk/jc/ash/ash.html**
- Avoiding the danger that Stop Smoking Services may exacerbate health inequalities: building equity into performance assessment **www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1964765**
- Smoking and Health Inequalities: ASH factsheet **http://www.ash.org.uk/files/documents/ASH_98/ASH_98.html**
- Socio-economic inequalities in smoking in the European Union. Applying an equity lens to tobacco control policies **http://www.ensp.org/files/socio.pdf**
- Poor Smokers Marsh A and McKay S, Policy Studies Institute, 1994 **http://www.psi.org.uk/publications/publication.asp?publication_id=150**

HIGH IMPACT CHANGE 4: Deliver consistent, coherent and co-ordinated communication

What does this mean?

Establishing a communications strand as part of a strategic approach to tobacco control is vital and needs to take account of internal and external communications: internal to ensure that all partners are on message, external to ensure that clear and consistent messages around tobacco control are being relayed to the general public. Clearly, communications about tobacco control are happening about England, but the problem is that they do not always present a clear joined-up set of messages. What one Alliance says publicly may be completely different from a neighbouring partnership. So it's very important not only that communication reflects central messages and uses the NHS Smokefree national branding and imagery (where the focus is on activity encouraging smokers to stop), but also that, at a local level, all Alliance members and champions are on message. This can be encapsulated in the phrase 'One message, many voices'.

A three-year marketing strategy has been developed by the Department of Health and Regional Tobacco Policy Managers are in a position to provide detailed information on the strategy to Alliances. The strategy focuses on routine and manual smokers and its overarching objectives are to trigger quit attempts, increase the effectiveness of quit attempts and reinforce motivation to quit. This important strategy represents a new way of working and will also include a move towards a model of community activation. Running alongside it will be funding for increased communications capacity at regional level in the future. This should facilitate three-way communication between local areas, the regions and national policy and thus ensure a co-ordinated and comprehensive approach to marketing.

With this new infrastructure in place, achieving a truly comprehensive approach to communications should be within reach, with all key partners giving key messages consistent with national campaigns and themes. And with a new focus on consumer insight, Alliances will be better able to understand audience differences – for example, why routine and manual smokers find it harder to quit, how audiences differ in their smoking rates and why, and whether policy interventions are having an impact.

What is the evidence that it works?

The high-profile US document *Best Practices for Comprehensive Tobacco Control Programs* [1, page 62] highlights health communication as one of five key interventions for a comprehensive tobacco control policy, stating that an effective regional communication plan should deliver strategic, culturally appropriate and high impact messages in sustained and adequately funded campaigns integrated into the overall tobacco control effort.

International evidence has demonstrated the effectiveness of mass media campaigns as a key strand of tobacco control strategy. Pioneering states like California, Massachusetts, Oregon and Florida have shown a clear link between mass media campaigns and significant reductions in tobacco use, [2, page 62] a result mirrored in Australia where the National Tobacco Campaign saw prevalence drop from 23.5% in 1997 to 20.4% in 2000. [3, page 62] In England, smokers have reported that TV advertising is a major prompt to quitting [4, page 62] while there is also data to suggest that multimedia campaigns can prevent young people from starting to smoke and increase quitting among young people and adults when combined with other interventions. [5, page 62]

Public anti-smoking campaigns have been shown to be cost effective [6, page 62] and most likely to succeed if designed according to social marketing theory, with sufficiently large, sustained campaigns and appropriately targeted messages based on empirical evidence for the intended population. [7, page 62]

Action checklist

All Alliance partners and champions have a role to play if the aim of 'One message, many voices' is to be achieved. The following are strategies to reach that objective.

- ☑ Co-ordination with the Regional Tobacco Policy Manager on all marketing and communications activity is essential to ensure consistency within regions and across the country. In addition to the support and guidance that Regional Tobacco Policy Managers and the new regional communications resource can offer, ensure that there is input from the communications professionals of the PCT and Local Authority within the Alliance.
- ☑ Use the NHS Smokefree branding on all materials produced, while using existing DH marketing materials whenever possible for consistent messaging, to save money and to capitalise on the messages local people will be receiving from nationally funded marketing campaigns. **(NB: Any communication supporting DH tobacco control objectives and programmes, and principally communications encouraging smokers to stop, should use NHS Smokefree branding but non-DH programmes of work, for example direct lobbying, should not.)**
- ☑ All local communications work should support the national marketing strategy where possible and should be built upon social marketing principles. This will help identify the messages that are likely to gain most local support. It is very important to identify the different target segments within the larger population that will respond to different types of messages and channels. *(See Appendix Three.)*
- ☑ Brief training or education to ensure that planners, commissioners and service providers have a working understanding of the national strategy may be necessary. This could have benefits for other public health issues if such an approach is embedded into local practice.
- ☑ A media/communications sub-group could be created by the Alliance to co-ordinate local-level marketing messages to supplement and complement the marketing campaigns produced at a national and regional level. At the very least, communications leads from Alliance partners and key stakeholders should be in contact and willing to co-operate. Regional Tobacco Policy Managers should be kept abreast of such work to ensure regional co-ordination of campaigns.

- ☑ Where media buying activity is required, it could be more effective to pool resources with neighbouring Alliances, to achieve better buying power and greater reach of the media. Again, involve Regional Tobacco Policy Managers and the new communications resource to ensure linkage with national strategy.
- ☑ Focus on the 'Many voices' aspect of communications. For example, teachers, council departments and business leaders could issue health messages. This could add credibility to a local campaign because it would not just be a public health body communicating about tobacco control.
- ☑ Work closely with Regional Tobacco Policy Managers and, where there is one, the regional office, to ensure regional co-ordination of press release activity. Agree common messages to ensure consistency among key spokespeople. For example, intelligence gathering and sharing will be required across Alliances to generate responses to negative press coverage. All such campaigns should be the subject of thorough monitoring and evaluation.
- ☑ If necessary, media training should be provided for those in the Alliance best placed to make the case for tobacco control. This could include tips on how to counter opposition from various sources.
- ☑ All media opportunities should publicise local NHS Stop Smoking Services and the package of national support available for smokers wishing to quit (including the NHS Smoking Helpline www.nhs.uk/gosmokefree and the Together Programme). Local messaging should be kept simple and consistent with national messaging, focusing on the unique selling points of the Services – they are free, smokers are up to four times more likely to quit if they use the Services, they have experienced staff, and have helped thousands of local people give up for good. The Department of Health has a crib sheet for Alliances giving tips on the kind of language to use, although Alliances should be mindful of using language appropriate to the local target audience.
- ☑ Producing relevant resources for supporters to use – websites, policy papers, draft letters or press releases – can be instrumental in successful local advocacy.

How does this High Impact Change work in practice?

How SmokeFree Liverpool tackled the communications challenge in the run-up to Smokefree legislation

The challenge

The challenge was to reinforce to the people of Liverpool, local businesses, stakeholders and partners that smoking in the workplace was a significant public health issue. As the date of legislation neared, to get businesses and the public as prepared as possible to optimise successful legislation and to create a powerful vision of a 'Successfully SmokeFree Liverpool'.

Action

An integrated impact assessment was commissioned to identify potential challenges and insight was gleaned from local businesses to help shape targeted messaging.

A core aim was to get businesses to buy into the fact that going smokefree ahead of legislation would serve them well. During the last months before the implementation of the legislation, there was great emphasis on maximising the numbers of businesses going smokefree before 1 July. The key message was that workers deserved a smokefree environment.

This was done through the 'Why Wait?' campaign which involved business leaders and suggested that although comprehensive Smokefree legislation would be introduced on 1 July, businesses should trial it beforehand to iron out any issues/problems ahead of schedule.

The campaign consisted of ads in the business press, a roadshow and press activity. A 'Why Wait?' committee was established to include local businesses. The aim was to allow businesses themselves to feed advice, support and messages provided by SmokeFree Liverpool back into other businesses in the city. It was a clear example of business-to-business communications and engagement working at its best.

Specific activities pre-legislation to achieve 100% public and business awareness of Smokefree legislation by 1 July included:

- ads in the business pages of the local newspapers using case studies of businesses that had successfully gone smokefree ahead of the legislation;
- a roadshow where a branded SmokeFree Liverpool 'Why Wait' car visited thousands of businesses across the city over a 10-month period, distributing information packs and signposting support, including stop smoking support;
- a campaign on the local radio station, Radio City, emphasising the benefit to businesses of going smokefree prior to 1 July and offering the incentive of being entered into a competition to visit SmokeFree New York;
- huge banners displaying the date of legislation in key locations, including the front of Liverpool John Lennon Airport, to raise awareness not only among the local community but for visitors to the city too;
- regular in-depth briefings to journalists and quick reactions to journalists' queries such as solutions to businesses' concerns, how successful uptake was in the run-up to 1 July and plans for after 1 July;
- a range of widely distributed tailored promotional materials for a variety of business types;
- workshops and seminars for business communities across the city, such as pubs, restaurants, care homes, taxi drivers, the Chinese Business Community, Chamber of Commerce members and others;
- the '100 Day Countdown' clock launched by an Advan (moving billboard), displaying days, hours, minutes and seconds until 1 July, which reached every corner of the city over 100 days.

All these actions continually reinforced the key message of worker health and used all possible advocates to carry the message.

Results

- decision makers and the community of Liverpool got on board in the early stages, with widespread acceptance of the message;
- many businesses, including restaurants and even some pubs, went smokefree early and in turn the smoking prevalence in the local population declined;
- on the launch day, 8,000 businesses were visited by a diverse range of trained Liverpool PCT, City Council and voluntary sector staff, who left behind information and promotional materials. Not one staff member involved received a negative reaction from business;
- in addition, 8,000 young people signed a petition calling on the local football clubs to go completely smokefree ahead of legislation.

What we can learn from this

A successful communications campaign of this magnitude required SmokeFree Liverpool to:

- use every voice to reach every audience – the 'swarm of bees' approach;
- identify a core message and stick to it to build a successful smokefree brand;
- gain commitment and engagement from **all** partners.

Why is this High Impact Change significant?

Communication campaigns serve to tie together a variety of tobacco control programme components, to raise public awareness of tobacco issues, and to build public support for tobacco control as an appropriate response to the tobacco epidemic. It is important that clear and efficient processes and lines of communication are developed to augment national campaigns at a local level.

Further reading

- Department of Health Tobacco Control Marketing Communications Strategy
- Department of Health 'Go Smokefree' website
  www.nhs.uk/gosmokefree
- It's our health: realising the potential of effective social marketing
  Joint report, Department of Health and National Consumer Council, 2006
  http://www.nsms.org.uk/images/CoreFiles/NCCSUMMARYItsOurHealthJune2006.pdf
- Mass Media Interventions to Stimulate and Promote Smoking Cessation
  http://www.nice.org.uk/nicemedia/pdf/SmokingCessationExpertOpinionMassMediaSummary.pdf

- Mass media and smoking cessation: a critical review
  Flay BR, American Journal of Public Health 1987; 77: 153–60
- Strategy Planning for Tobacco Control Advocacy
  American Cancer Society/UICC
  http://strategyguides.globalink.org/pdfs/guide1_AdvocacyGuide.pdf
- Campaign Development Toolkit: An International Guide for Planning and Implementing Stop Smoking Campaigns
  Feltracco A and Gutierrez K, Brantford, ON: Global Dialogue for Effective Stop Smoking Campaigns, 2007
  http://www.stopsmokingcampaigns.org/index.php?page=english_toolkit
- Social marketing: Why should the devil have all the best tunes?
  Hastings G, Elsevier/Butterworth-Heinemann, 2007
  http://www.elsevier.com/wps/find/bookdescription.cws_home/711135/description#description
- National Social Marketing Centre website
  http://www.nsms.org.uk/public/default.aspx

HIGH IMPACT CHANGE 5:
An integrated stop smoking approach

What does this mean?

When talking about an integrated stop smoking approach we are highlighting the importance of embedding the idea that quitting smoking is not only achievable and desirable, but an outcome that should be encouraged and supported by all organisations. If we are to achieve the tobacco control aim of denormalising smoking as a desirable, everyday activity, then it is also important to ensure that supporting smokers to stop is the business of every organisation. As the most evidence-based support system available, local NHS Stop Smoking Services are one vital part of this equation, as are the other support options available from the NHS. Indeed, no other country in the world has an integrated Stop Smoking Service available to all and free at the point of delivery.

However, all too often the Stop Smoking Services are seen as the sole agency that can deliver tobacco control at a local level. It is a mistake to believe that Stop Smoking Services equate to tobacco control or that they can in isolation provide prevalence reduction on the scale that is required. Instead, they should be viewed as one vital element of an overall strategic and comprehensive tobacco control programme. They should be fully involved in tobacco control and seen as a resource for information on quitting support, providing expert advice to organisations that want to integrate a stop smoking approach for their workforce. This is also vitally important for the focus on routine and manual smokers. To ensure continuing improvement of Stop Smoking Services, the Department of Health has issued updated *Service and Monitoring Guidance* to ensure adherence to the quality principles and consistency in data quality and data recording.

What is the evidence that it works?

All the major international guidance on tobacco control strategies consider helping smokers to stop as a key part of a multi-pronged attack, together with fiscal measures, health promotion and legislative reform. One US report describes a comprehensive state-wide tobacco control programme as a co-ordinated effort to establish smokefree policies and social norms, to promote and assist tobacco users to quit and to prevent initiation of tobacco use. [1, page 62]

Stop Smoking Services are the most cost effective of all health interventions provided by the NHS in England. There is no doubt they are an effective intervention [2, page 62] and most effective when combined with a comprehensive approach that provides support for stopping smoking and wider tobacco control. [3, page 62]

Action checklist

This High Impact Change is not about setting out how to structure a local Stop Smoking Service. It is about the steps that can be taken to integrate the work done by the treatment arm into the wider tobacco control programme at a local level. The following pointers should be of use.

- ☑ Helping people to quit should be everyone's business, requiring involvement not just from health partners in the Alliance but from those outside the health sector too. Large-scale collaboration of this sort will help promote brief interventions and referral as widely as possible. Partners can glean the necessary knowledge to make referrals via training and close working with the local Stop Smoking Service.
- ☑ Specialist stop smoking advisors could become more involved in the wider tobacco control agenda. They can play an active part within the Alliance in order to maximise opportunities provided through partnership working.
- ☑ Evidence-based stop smoking options should be promoted by partner organisations of the Alliance. For example, fire crews doing home safety visits could use this opportunity to direct smokers to the local NHS Stop Smoking Service. Schools, hospitals, Local Authorities, PCTs, GPs, employers, community groups and charities are other agencies that have opportunities to promote the Stop Smoking Service.
- ☑ Maximising and auditing referrals from health and social care settings are important as is the need for a systems approach in primary care.
- ☑ Stop Smoking Services data and analysis can be fed back into the Alliance and used to inform future commissioning, interventions and delivery of the wider tobacco control programme. This further illustrates the two-way process that can be achieved between the Stop Smoking Services and the wider Tobacco Control Alliance.
- ☑ Attention should be given to the development of stop smoking support in pharmacy and acute services, for example 'Stop Before the Op' programmes.
- ☑ Local campaigns specifically targeted at triggering quit attempts and promoting the NHS Stop Smoking Services are of real value but any publicity needs to be in line with the new DH marketing strategy detailed in High Impact Change 4. The whole NHS Stop Smoking support provision should be promoted to help to increase access to effective support and to reach smokers who may not wish to use their local service for various reasons. The routine use of the NHS smoking helpline number and www.nhs.uk/gosmokefree should be in place.
- ☑ The website www.smokinginengland.info [4, page 63] contains a wealth of useful information on quitting activity in England.

How does this High Impact Change work in practice?

Engaging the third sector to support local Stop Smoking Services

The challenge

To raise awareness of the harmful effects of smoking, not just in relation to health but also the financial burden, with clients seeking help and advice at five Citizens Advice Bureaux (CAB) in Birmingham.

Action

CAB staff have a good opportunity to provide information with regard to the health and financial benefits of stopping smoking. A £12,000 project was therefore set up in 2005/06 to integrate the CAB into the wider tobacco control programme being run in the city. Through working in partnership with Birmingham's Public Health Network and Smoke Free Birmingham, trained CAB staff were able to offer brief interventions to clients during the interview process, providing information leaflets about the health and financial impacts of smoking along with contact details for the local NHS Stop Smoking Service. Smokers were referred to the Stop Smoking Service nearest their home or work and given the option of different providers like pharmacists and GPs. A bespoke proforma on a laptop provided by Smoke Free Birmingham was used to capture client details for referrals, while local stop smoking material was also sent out with post-interview summary letters using an agreed form of words to ensure consistency.

All five CAB in Birmingham displayed project posters and local Stop Smoking Service materials. Posters and leaflets produced by HM Revenue and Customs about cheap and illicit tobacco were also made available.

Results

More than 50 CAB staff and volunteers were trained in brief interventions and there is the potential in the future to train more staff as stop smoking advisors, who in turn could train other CAB staff and volunteers.

Data from the first year of the project is still being analysed but data about who visited CAB, on what days, and from where in the city will support mapping of the deprivation across Birmingham and help identify where there is need.

What we can learn from this

Birmingham was able to show how an agency not usually connected with tobacco control was successfully integrated into local activity to drive down smoking prevalence. While the early months of the project were difficult due to both the CAB going through a national reorganisation process and some staff being very protective of their vulnerable clients, the initiative has clearly demonstrated that it is a useful mechanism for engaging with a different client group. The pilot could easily be replicated in other regions and can be seen as a useful way of not only helping to refer smokers to local services but also of generating useful local data.

Why is this High Impact Change significant?

An integrated stop smoking approach is an important component of tobacco control policy, but it is not tobacco control in its own right. Stop smoking approaches need to remain a central and integral part of a comprehensive tobacco control programme if activities in other parts of the programme are not to be jeopardised, but it is better to view tobacco control as the intervention that drives people to its treatment arm, with specialists available at that point to support and motivate smokers to give up.

It would be beneficial if all the key strands of tobacco control could be brought up to the funding level that NHS Stop Smoking Services receive, in line with their respective impacts on prevalence.

Further reading

- NHS Stop Smoking Services: service and monitoring guidance, October 2007/08
  Department of Health, October 2007
  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079644?IdcService=GET_FILE&dID=160449&Rendition=Web
- High Impact Changes. Achieving four week quit targets: Making it easier for smokers to quit
  Hodgson P and Furber A, 2007
  http://www.yhpho.org.uk/Download/Public/1176/1/Tobacco%20control%2014.09.07.pdf
- Smoking Cessation in Practice: Facilitators guide to creating sustainable delivery systems
  ABC Pathway: Clinicians 30 Second Stop Smoking Advice
  For more information contact Pat Hodgson, RTPM for Yorkshire and The Humber
  Patricia.Hodgson@dh.gsi.gov.uk
- Smoking Cessation Services
  NICE public health guidance,
  February 2008
  http://www.nice.nhs.uk/guidance/index.jsp?action=download&o=39596

HIGH IMPACT CHANGE 6:
Build and sustain capacity in tobacco control

What does this mean?

When asking the question 'What is the current ability to respond to tobacco control comprehensively at a local level?', the answer will undoubtedly reveal the need for infrastructure, resources and the political will to sustain the programme.

Successful tobacco control depends largely on having the human resources to develop and implement a range of activities at different levels; in an ideal world the resources available would be relative to the scale of the problem. Admittedly, securing much of that resource may be outside the immediate control of the Alliance co-ordinator, but concentrating on how to expand the infrastructure of a local Alliance can only help efficient delivery of tobacco control in the area.

Capacity building is about developing people's skills and tools, building networks and training leaders, collaboration, and collecting local data and knowledge to provide an understanding of the local community. If the necessary consensus and political commitment for tobacco control in the area can be successfully developed, then delivering the recommendations in this document will be that much easier.

The key aim is to keep as many relevant people as possible interested in the tobacco control agenda, providing them with new angles as to why they should engage with the programme at every opportunity. There is a risk that if this momentum diminishes, previous achievements will be diluted and smoking prevalence will stabilise and then rise rather than fall.

What is the evidence that it works?

The importance of capacity building is ably summarised by the WHO which states that "creating a national plan of action for tobacco control and establishing the infrastructure and capacity to implement the plan of action are key to the successful mitigation of the tobacco epidemic." [1, page 63]

Internal capacity at Alliance level is essential for the sustainability, efficacy and efficiency of the tobacco control action plan. Sufficient capacity enable programmes to run their strategic efforts, provide strong leadership and foster collaboration between the centre and local tobacco control communities. [2, page 63]

Action checklist

In order to sustain progress it is essential that local capacity is strengthened and sustained. The following recommendations, covering both capacity building for Tobacco Control Alliances and for the local NHS Stop Smoking Service, will go some way to helping local Alliances to maintain momentum, recognising that capacity building is a long-term process requiring time and commitment.

- ☑ Target key decision makers in PCTs and Local Authorities to fulfil the role of trained and educated ambassadors and champions who can sell the whole tobacco control message from executive level to grassroots level. These designated leads should have some element of tobacco control built into their role, with protected time for local Alliance activity, and be supported by an overall lead with senior-level buy-in.
- ☑ Key stakeholders are unlikely to present themselves to the Alliance, so the Alliance should take steps to be included on the agendas of other organisations, using information and data from other High Impact Changes in this document to show the impact tobacco control is making at a local level. For example, this could be achieved by hosting network meetings, regular update sessions, themed conferences and attending group meetings.
- ☑ When encouraging partners to join Alliance activities, messages should be made relevant to each organisation. For example, to Trading Standards make the case around illicit sales, to the Local Authority and PCT speak about health inequalities and treatment, and to environmental health services stress protection issues. Once they become members, help new partners build a pool of resources to spread the tobacco control message among their own professional colleagues.
- ☑ Encourage all partner organisations to develop organisational objectives around tobacco control with support from the Alliance co-ordinator. Try to have a working knowledge of individual charity objectives and develop training and education programmes that promote tobacco control with proposals for joint action.
- ☑ The Alliance's high-level leads should be in a position to ensure that those local staff whom it would be useful to train – perhaps in social marketing or brief interventions – are in a position to access training and have protected time for such personal development.
- ☑ Consider conducting a needs assessment of the local NHS Stop Smoking Service, exploring if it has the correct infrastructure and what resources, if any, are needed to support its future expansion.

- ☑ In addition to all Alliance members, staff who could be trained to increase tobacco control capacity in brief interventions for stopping smoking might include community workers, community pharmacists, school nurses, occupational health nurses in the workplace, teachers, youth workers, frontline health and social care professionals, and voluntary and community organisation workers.
- ☑ These other organisations and individuals can then explain and signpost interventions which are not just around Stop Smoking Services but also include tobacco control in the widest sense.
- ☑ Level 2 training could also be provided to support those who are able to give more intense stop smoking support over a period of time in primary care, pharmacy and dental settings.
- ☑ Encourage GP surgeries in the local area to have a trained Level 2 advisor within the practice.

How does this High Impact Change work in practice?

Creating sustainable systems for the delivery of brief interventions

The challenge

In 2003, the three-year target for four-week quits was increased to 2,840 in South East Sheffield PCT. During the first year only 16% of the target was achieved (452). Though the Sheffield NHS Stop Smoking Service had trained over 600 healthcare providers to provide stop smoking groups within the four PCT areas, the advisors were not sustaining their activity.

Action

The PCT employed a development worker to help achieve its target. The worker identified 32 GP practices and 26 pharmacies in the area interested in improving their systems for delivering stop smoking interventions. A number of issues were identified after assessment of their current systems, for example confusion about how to refer to the specialist service, where to send the referrals, how to access services and lack of sustained motivation to continue providing interventions.

The worker undertook a number of tasks to support GP practices and pharmacies to develop a sustainable system, providing referral pads, posters, leaflets, brief intervention training and providing guidance on developing protocols for running one-to-one sessions. New advisors were given intensive support and current advisors offered update sessions. Follow-up visits were carried out every six months to ensure that systems in GP surgeries and pharmacies were sustained.

Results

As the table below shows, there was a significant increase in four-week quits, with a 90% increase from 2003/04 to 2004/05 and a further 12% in the following year. By the end of 2005/06, the number of four-week quits was double that from before the employment of the development worker.

Year	Four-week quits		Quits per 100,000
2003/04	452		312
2004/05	859	*(92% increase)*	658
2005/06	962	*(112% increase in two years)*	719

What we can learn from this

According to the Cochrane Database of Systematic Reviews, [3, page 63] "Simply training healthcare providers without addressing the constraints imposed by the conditions in which they practice is unlikely to be a wide use of resources." It is important that attention is paid to developing sustainable systems in healthcare organisations so that provider training is put to good use and stop smoking interventions reach smokers.

Why is this High Impact Change significant?

Capacity building activities can be an essential tool for building local networks and ensuring that local partners have the necessary skills to successfully engage in the types of advocacy work that are likely to reduce tobacco use.

Continued investment is crucial to tobacco control success because it brings reduced prevalence, cost effectiveness, economies of scale and denormalises smoking. Disinvestment now runs the risk of undoing all the good that has come about in the 10 years since the *Smoking Kills* White Paper was published.

Further reading

- Evolution of a comprehensive tobacco control programme: building system capacity and strategic partnerships – lessons from Massachusetts
  Robbins H and Krakow M, Massachusetts Department of Public Health, Massachusetts Tobacco Control Program, Boston
  http://tobaccocontrol.bmj.com/cgi/content/abstract/9/4/423
- Case study of capacity building for smoke-free indoor air in two rural Wisconsin communities
  Mahon S and Taylor-Powell E, Preventing Chronic Disease, 2007; 4(4)
  http://www.cdc.gov/pcd/issues/2007/oct/06_0159.htm
- Achieving the Framework Convention on Tobacco Control's potential by investing in national capacity
  Wipfli H, Stillman F et al, Tobacco Control, 2004; 13: 433–437
  http://tobaccocontrol.bmj.com/cgi/content/full/13/4/433

HIGH IMPACT CHANGE 7:
Tackle cheap and illicit tobacco

What does this mean?

Price is the single most effective lever in helping people to stop smoking. The current situation with the smuggling of cheap illicit tobacco is an international problem that requires a range of action to be taken. Unless smuggling is counteracted at all levels – international, national, regional and local – the impact of other tobacco control measures will be seriously undermined. Illicit trade impacts on high tax policies that are designed to reduce tobacco consumption, erodes attempts to stop people smoking in the first place, and encourages relapse. Criminal activity in this illicit trade also tends to target smokers in deprived areas, increasing health inequalities further. Action on illicit tobacco is therefore a vital piece of comprehensive tobacco control. The Government recognises illicit tobacco as a serious problem and in the 2008 Budget announced that a new National Tobacco Smuggling Strategy will be developed in 2008 by the newly created UK Border Agency. There is also a role for local Alliances to engage in this issue and tackle both the demand for and supply of cheap illicit tobacco.

There are two key points to note when undertaking work on this High Impact Change – supply and demand. This is a very complicated issue and measures to tackle illegal supply are complex; demand reduction is therefore key in local action. It is also very important to steer clear of the idea that genuine tobacco is 'safer' or 'better quality' than 'fake' versions. Cigarettes kill half of all smokers whether they are legal or illegal and any promotion of messages that illicit tobacco is more harmful could have serious repercussions for overall health messages about the impact of smoking.

This is a real cross-cutting issue that requires engagement from all partners in the local Alliance in partnership with HM Revenue and Customs. A North of England smuggling summit was held in late 2007 and an action plan is being developed following this event. This will be freely available for use across England, following a three-month consultation period in summer 2008. Regional Tobacco Policy Managers will be able to provide updates on these developments. On receipt of that action plan it would be advisable to review what is being done locally.

What is the evidence that it works?

There is little research evidence of what works to tackle illicit tobacco locally because work to date has centred on global, international and national issues. It is acknowledged therefore that more research in this area is required and we are in the infancy of this particular High Impact Change. That said, Alliances are well placed to scope the evidence gaps and explore how best to address the issues.

Those doing productive work should share their best practice so Alliances continuously contribute to the body of evidence.

The facts that are known, however, are that illicit tobacco accounts for 16% of the UK market [1, page 63] and costs the exchequer almost £2 billion annually in lost revenue [2, page 63] and that cheap tobacco undermines health and social inequality goals by making cheap cigarettes widely available to the poorest people. [3, page 63] Availability of cheap hand rolling tobacco is especially common on the illicit market.

Focus groups conducted in the North East [4, page 63] do provide some evidence and techniques about the best messages to give out locally and centre on reminding peripheral buyers of illicit tobacco that it is helping them stay addicted to smoking for potentially much longer than if they were buying legitimate cigarettes. This research also reveals that there is little point in driving home messages about breaking the law or cigarettes being harmful as they have little resonance with this group.

Action checklist

This section covers what can be done locally. Agencies such as HM Revenue and Customs are well placed to influence supply by targeting criminal activity, but for local Alliances the priority is to tackle demand by getting the message across to smokers that they are being deceived. They can also facilitate the sharing of intelligence and encourage a full range of agencies such as Trading Standards and the Local Authority to join forces on this essential activity.

- ☑ Successful implementation of this High Impact Change will require the engagement of a full range of tobacco control stakeholders working together effectively to improve the intelligence base. Not only do Local Strategic Partnerships and local health strategies need to factor in smuggling as a priority issue but also look to Trading Standards, HM Revenue and Customs and Crime and Disorder Reduction Partnerships to support local efforts. There is also a potential role here for youth advocacy.
- ☑ It is crucial that all stakeholders in the Alliance understand that illicit tobacco sales risk undermining all other local tobacco control efforts. All partners should give this message when making public statements.
- ☑ Look to colleagues in other agencies who have successfully tackled drug use/abuse and selling for lessons in how best to deal with this issue.
- ☑ Work with the Local Authority to map informal markets and hotspots for illicit trade.
- ☑ Social marketing, rather than mass media, is likely to be a better communications approach given the scepticism of this group of smokers to any message seen to be coming from the Government, represented as the 'taxman'. However, usual publicity routes can be used to increase awareness of enforcement action and thus reduce demand. Marketing on illicit tobacco needs to be complemented by information on the support available for people who want to quit.
- ☑ Focus groups will provide useful information and help Alliances better understand the motivations of the purchasers and their knowledge and attitudes towards cheap tobacco. However, public messages developed on the back of research like this should avoid any implication that genuine cigarettes are less harmful as there is no evidence base for this. The fact is that all tobacco is harmful to health.

- ☑ Establishing a safe, anonymous intelligence-sharing forum for the local community is required. Alliances should therefore promote smuggling information hotlines like the Customs Confidential Hotline or Crimestoppers, and encourage stop smoking advisors to send a message back to clients that if they use smuggled cigarettes there is a way to pass on information. HM Revenue and Customs can explain how someone can supply information, in confidence if necessary.
- ☑ The supply of illicit tobacco locally is linked to the health inequalities faced by routine and manual smokers. Efforts should be made to work with business as a lot of smuggled tobacco passes through workplaces; the biggest local employers could be approached to ensure this trade is not condoned on their premises.

How does this High Impact Change work in practice?

Tobacco smuggling in the North of England

The challenge

Tobacco taxation policy is being undermined by the availability of cheap and illicit sources of tobacco products. This is particularly common in communities with higher smoking rates, which also suffer most from health inequalities. Evidence in northern communities, such as Easington, has shown that the average retail price of a packet of cigarettes is around £2.50–£3.00 – as opposed to the legitimately retailed price of around £5.50. Qualitative research in the North East has found that the cheap tobacco trade is a commonplace local industry with high social acceptance and minimal concern within local communities of the likely impact this will have.

Action

In December 2007, the three Northern English regions (North East, North West and Yorkshire and the Humber) joined forces and organised a high-level one-day Summit on Smuggled and Counterfeit Tobacco. Over 200 individuals from across the North, and representing Trading Standards, police, health and HM Revenue and Customs, came together for the first time to examine the scale of the issue, and discuss ways of addressing this. The delegates learned about the international picture of the trade, the role of the Framework Convention on Tobacco Control Illicit Trade Protocol, the criminology behind tobacco smuggling, a picture of the scale of the issue within the North, qualitative research into smokers' and recent quitters' perceptions of the issue, and some local case study sharing. Detailed table discussions elicited a wealth of knowledge about the issue and identified some concrete measures for addressing both supply and demand issues.

Results
The event attracted significant media interest across the North, raising the issue of the health impact of cheap and illicit tobacco. Much stronger partnerships have been forged across the disciplines with a greater understanding of the particular roles and responsibilities across the lead agencies. A surge in interest in effective partnership working has been achieved, with the result that the forthcoming North of England Action Plan on Cheap and Illicit Tobacco is helping to influence the development of the new National Tobacco Smuggling Strategy. The North of England Plan will look specifically at local action around six key areas: developing partnerships, developing the role of health professionals, intelligence sharing, mapping informal markets, marketing and communications, and working with business.

What we can learn from this
A focused meeting/event around a specific issue can help to unite otherwise disparate groups to a common issue. If this is underpinned by effective media liaison, useful publicity can also be generated. There is a real appetite now to work in partnership on this issue, and the North of England Action Plan could be used as a discussion focus for a local Alliance.

Why is this High Impact Change significant?

Price is one of the most significant factors in triggering attempts to quit smoking. Smuggled and illicit tobacco, sold at prices significantly below those of legal tobacco sales, threatens to undermine the progress made in the other key strands of tobacco control.

Cheap smuggled tobacco finds its way to the most vulnerable people – children, teenagers and the poor. It is highly likely that without tackling this issue the PSA target for reducing prevalence among routine and manual smokers will not be achieved.

Further reading

- PowerPoint presentations from the December 2007 North of England Summit on Tobacco Smuggling
  http://www.freshne.com (archived events section)
- ASH Budget Submission 2008 – pages 6–11
  http://www.ash.org.uk/files/documents/ASH_681.pdf
- New responses to new challenges: Reinforcing the National Tobacco Smuggling Strategy
  HM Treasury and HM Revenue and Customs, 2006
  http://www.hm-treasury.gov.uk/media/7/7/bud06_tobacco_273.pdf
- Tobacco smuggling – a briefing paper
  http://www.ashscotland.org.uk/ash/files/Tobacco%20smuggling%20%20a%20briefing%20paper%20March%202008.pdf
- They're doing people a service: a qualitative study of smoking, smuggling and social deprivation
  Wiltshire S et al, British Medical Journal, 2001; 323: 203–7
  http://www.bmj.com/cgi/content/abstract/323/7306/203

HIGH IMPACT CHANGE 8:
Influence change through advocacy

What does this mean?

"Advocacy is when the Director-General of WHO speaks at global events about health problems. Advocacy is when technical staff provide valuable information and evidence to institutions and organisations about a health challenge. Advocacy is when information is distributed through a variety of channels to target the general public. Advocacy is when lobbyists in the political arena raise awareness about a specific problem. Advocacy is when all members of Rotary International at all levels and on any occasion speak about polio eradication. Advocacy is the beginning and the end of any successful health initiative."

Extract from Advocacy: A Practical Guide with Polio Eradication as a Case Study. WHO The Global Polio Eradication Initiative

An advocate is someone who acts on behalf of a person, group, or interest; advocacy is about winning support of key constituencies in order to influence policies and spending, and bring about social change.

Advocacy can be used to inspire and generate growth in public support to bring about change. At its simplest level advocacy means making effort to persuade others to take some type of action. But tobacco control advocacy is about more than getting stories in the media, albeit the media is probably the most influential advocacy vehicle that exists.

It's about changing the political, economic and social conditions that encourage tobacco use and gaining public and media support for tobacco-related issues with the ultimate aim of denormalising tobacco use – changing social norms. Although there have been many successes in recent years, the focus on ending the tobacco epidemic for the benefit of future generations needs to be maintained.

This High Impact Change needs to be linked to the overall Alliance communications strategy to ensure consistency and integration. Advocacy efforts ought to be evaluated as carefully as any other communication campaign.

The 2008 consultation on a National Tobacco Strategy for England presents an excellent opportunity for local Alliances to galvanise their partners and submit evidence in support of a wide spectrum of tobacco control measures. The consultation should also be publicised using the media as it will raise the awareness of the continued impact of tobacco on local health and wellbeing and reinforce the message that the job is not over, post Smokefree legislation. Regional Tobacco Policy Managers will be able to keep local Alliances informed on this important development.

What is the evidence that it works?

Public advocacy for a tobacco-free society has been part of the national tobacco control strategy in the United States for the past 15 years. [1, page 63] To be successful it needs to involve a variety of stakeholders from different levels, including key opinion-formers [2, page 63] while some recent evidence suggests that survivors and victims of tobacco-related diseases can and should play significant roles in tobacco control advocacy efforts. [3, page 63] Messages need to be tailored to different target audiences at different stages in an advocacy campaign. [4, page 63]

To assess how strong an English Alliance is on advocacy, the Fresh Smoke Free North East functionality review tool is a useful resource. [5, page 64]

Action checklist

- ☑ Ensure that all local partners and Alliance members have the knowledge and skills to become tobacco control advocates, understanding that tobacco control is core to their own organisation's concerns. For example, fire services and reducing fires, police and reducing crime through less illegal sales and activity on the streets, workplaces and reduced sick time/ smoking breaks and the benefits of stop smoking approaches to this, NHS and 'Stop before the Op' programmes and reduced bed days and post-operative complications.
- ☑ Presentations can be made to key groups like the Local Strategic Partnership to extend awareness and highlight their role in health inequalities, and to get tobacco control at the core of their strategic and delivery plans.
- ☑ Identify, develop and support local champions for tobacco control – elected members, for example – and encourage their Alliance membership if possible. These advocates should be supported to gain maximum publicity through the media, but steps should be taken to ensure that they are fully briefed to stay on message, thus achieving the 'One message, many voices' target from High Impact Change 4.
- ☑ Don't lose anyone who can benefit delivery of the local tobacco control strategy. It is important to maintain contact with past Alliance members and key decision makers through email, news and information. This needs to be in 'digestible' form; get advice from communication specialists on the most effective forms of delivery if required. Regional Tobacco Policy Managers can also provide advocacy training.
- ☑ Undertake monitoring to gauge local awareness of the Alliance.
- ☑ Ensure that communication routes and usage both support and enhance the advocacy role of tobacco control co-ordinators and Alliances.
- ☑ Advocates should utilise national and regional campaigns to their best advantage. It is essential, therefore, to maintain awareness of campaigns and contribute to them with local intelligence. For example, build on the wealth of advocacy experience generated through attaining Smokefree legislation.
- ☑ Initiate or join debates on tobacco control to promote evidence-based arguments and build positive public opinion.
- ☑ Stop Smoking Services, as successful advocates, can channel potential quitters through the service.

How does this High Impact Change work in practice?

How successful advocacy helped to shape the law

The challenge

During the consultation on the smokefree elements of the Health Bill in 2005, many tobacco control advocates recognised that there was a serious challenge to ensure that as many people as possible were protected from secondhand smoke. If the option which proposed exemptions for certain premises became law, it could serve to widen health inequalities.

Action

This prompted a groundswell of enthusiasm and support which led to tobacco control activity that was replicated, to a greater or lesser extent, across the country. This widespread collaboration across regions and organisational boundaries ensured agreement on key messages that led to consistent information about secondhand smoke being relayed to key decision makers and the general public in a variety of innovative ways. Consequently, this prompted greater public debate around the issue of comprehensive legislation, raised this as a very real and appropriate possibility in the minds of the general public, and led to consistency in responses to the consultation.

Results

Ultimately the efforts of countless individuals and their organisations ensured a large response to the consultation. When the Government facilitated a free vote on the issue in Parliament, further advocacy efforts could take place to ensure that MPs had information to enable them to make an informed choice. On 1 July 2007 England introduced the comprehensive Smokefree legislation, joining Scotland, Wales and Northern Ireland in making the UK a smokefree nation.

What we can learn from this

Several key lessons are apparent from the advocacy efforts:

- strategy, leadership and co-ordination – agree and define aims, develop strategy and provide strong co-ordination to deliver this;
- know your evidence base – draw on the full range of available reputable data, use credible scientific arguments, and gauge public opinion;
- know your friends – and use the full range of partners to engage in Tobacco Control Alliances, and keep them engaged and motivated;
- identify your challenges – be aware of the range of arguments that counter your aims and develop appropriate responses;
- key messages – have simple messages, ensure consistency, and have a variety of messengers;
- media is key – vital to interest the media, both print and broadcast, in order to generate debate on key issues and to inform the general public;
- consolidate – recognise how advocacy efforts fit within the long-term comprehensive tobacco control agenda, keep the Tobacco Control Alliance engaged and motivated in this wider agenda, ensure efforts are evidence based, and remember that tobacco remains the number one public health priority.

Key lessons based on work undertaken by Fresh Smoke Free North East

Why is this High Impact Change significant?

The use of advocacy to inspire and generate growth in public support is key in any efforts to influence social norms and bring about behaviour change. Alliance stakeholders should use all available avenues to push tobacco control to the centre of agendas.

Further reading

- The Tobacco Control Advocacy Pack
  Hooper P and Farren C
- Strategy Planning for Tobacco Control Advocacy
  American Cancer Society/UICC
  http://strategyguides.globalink.org/pdfs/guide1_AdvocacyGuide.pdf
- Tobacco Control Advocacy in Australia: Reflections on 30 Years of Progress
  Chapman S, Health Education and Behavior, 2001; Vol. 28, No. 3: 274–289
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  WHO, The Global Polio Eradication Initiative
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- Public Health Advocacy and Tobacco Control: Making Smoking History
  Chapman S, Blackwell Publishing, 2007
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HIGH IMPACT CHANGE 9: Helping young people to be tobacco free

What does this mean?

This High Impact Change is about doing all that we can to protect the young people in our communities from tobacco. There is a need to realise that traditional educational approaches have had limited impact and that success is likely to be achieved by implementing comprehensive tobacco control measures, and fully including young people in the process.

Some 80% of people start smoking as teenagers and while smoking prevalence has declined in the last few decades, with around 9% of 11–15 year olds regularly smoking, those young people who do experiment run the real risk of addiction and of becoming long-term smokers. Also, prevalence appears to have stalled in recent years and there is a dramatic increase in prevalence over the age range – 16% of boys and 24% of girls being regular smokers at age 15. The traditional approach to the adolescent smoking problem has been to try to prevent uptake. However, despite sustained education about the health effects of smoking, adolescents continue to smoke, suggesting that traditional approaches may educate, but they do not influence.

Tackling youth smoking as a standalone intervention will probably have little impact. This High Impact Change is linked to the nine other work areas recommended in this report, as youth prevention has to be part of a comprehensive tobacco control programme based on denormalising smoking as a habit. Thus, efforts to enforce smokefree regulations have a bearing, as do action on the illicit trade and enforcing the age of sale of tobacco.

What is the evidence that it works?

The evidence base about what works in supporting young people to be tobacco free is still developing, and it is therefore helpful to consider what steps can be taken to add to the evidence base when doing work around this High Impact Change. Unpublished focus group data from young people living in the North East gives revealing background information about the need to practise what we preach. Teenagers aged 12–16 from a disadvantaged community spoke about their frustration at the apparently hypocritical stance taken by adults and those in authority when it came to smoking in front of them. [1, page 64] A joint ASH/No Smoking Day report from 2003 reported that where there had been success in tackling youth smoking it was in programmes supported by comprehensive community-wide strategies that facilitated population-wide shifts in behaviour and attitudes. [2, page 64] In other words, denormalising smoking in the adult population and addressing any tendency to see smoking as a normal activity makes it less appealing to the young. [3, page 64]

The need for youth prevention to be seen as part of a wider strategy is echoed by a whole series of major research papers in the US which conclude that the effectiveness of programmes targeted at youth is enhanced by comprehensive school health education and by community-wide programmes that involve parents, mass media, community organisations, or other elements of an adolescent's social environment. Programmes conducted in this way can postpone or prevent smoking onset in 20–40% of adolescents. [4, page 64] In the UK, a school-based prevention initiative, the Assist Trial carried out in Cardiff and Bristol, appears to show some promise in reducing uptake.

The key here is the word comprehensive – youth are an integral and vital part of the community and should therefore be directly involved in any community agenda, such as tobacco control, in a meaningful fashion, and be provided with a supportive environment and appropriate training and guidance.

The National Institute for Health and Clinical Excellence (NICE) will be publishing guidance in 2008 around youth smoking prevention – *Preventing the Uptake of Smoking in Children* – and the local Alliance should review this guidance when it is published and facilitate any necessary actions to ensure adherence to its recommendations.

Finally, young people tend to respond to social trends. Evidence from youth advocacy forums show they want 'just the facts' to allow them to make up their own mind about tobacco, rather than being told the 'rights and wrongs' of tobacco use. Social influence is probably therefore the best intervention. [5, page 64]

Action checklist

Although denormalising smoking across the wider population is the key to youth prevention, there are still some specific steps an Alliance can take to engage with youth in the local area.

- ☑ An Alliance should consider producing a defining statement that recommends engaging and working with children and young people in order to achieve a tobacco-free society.
- ☑ A multi-agency approach is recommended; aim to work in partnership with schools, colleges, Trading Standards, young people's services, borough or ward forums, and the local community and voluntary sector. Working directly with schools, for example, gives rise to a consistent level of information about smoking in education programmes alongside drugs and alcohol.
- ☑ Encourage the role of youth advocacy and try to get youth leaders and young people to join the Alliance. Young people can make good advocates because smoking generally begins at school age. In addition to seeking out youth representation, Alliances could work with youth forums and parliaments to gain an understanding of how children and young people feel about tobacco. Exploring ethical arguments such as tobacco farmers and the tobacco industry plus wider debates on the environmental impact of smoking could be a start point. The aim is to empower young people with a wider knowledge base about all tobacco control issues and capitalise on their energy and enthusiasm.
- ☑ Map the work currently under way in the area to protect young people and gain inspiration from work being done elsewhere. For example, innovative work

in Northamptonshire is using an Age Progression Camera pilot to show sixth form pupils at a local school how they will look at the age of 40 if they continue or start to smoke (http://www.northantset.co.uk/corby/Pupils-watch-as-good-looks.3728490.jp). Other examples like D-MYST's Toxic Movies campaign in Liverpool or the Florida 'Truth' campaign raise awareness of non-health-related responses to the tobacco industry. Innovative piloting of an educational workshop around the role of the tobacco industry with Year 10 students in Newcastle-upon-Tyne is also under way, with some encouraging feedback around changed attitudes of the students to smoking.

- ☑ Work with Trading Standards to educate retailers, reduce underage sales and increase test purchasing in all retail environments where young people can access tobacco, including those with tobacco vending machines.
- ☑ Support local actions to stem the flow of illegal tobacco imports and educate the general public on illicit sales to further reduce access 'on streets'.
- ☑ Work with the Healthy Schools co-ordinator to ensure that there is an evidence-based approach in place to undertake tobacco education across each of the four key stages of the curriculum.
- ☑ Work closely with Alliance partners to reinforce the message that adults at work or in a position of authority should practise what they preach and not smoke in front of children. Findings from focus groups [1, page 64] undertaken by the University of Durham have revealed interesting views from the teenagers in the group including: "They stand on the street, chatting to the cops. They're 13 or 14. The cops never tackle them on the smoking or 'where did you get them from'... If it's so bad, why do the cops ignore it?" Teenagers in the group reported that the schools they attend are smokefree, as are the grounds. Children aren't allowed out of the grounds at breaktimes but school staff step just outside the grounds and smoke in full view of the pupils. Youth workers questioned the professional conduct of some of their colleagues who had been known to use cigarettes to 'connect' with kids. This highlights the importance of having effective smokefree policies in educational settings, and ensuring that staff adhere to them.
- ☑ Treatment facilities should be promoted to young people and quality should be on a par with that for adult Stop Smoking Services. Ensure information about where they can get stop smoking support is signposted at every opportunity and consider whether the Stop Smoking Service could set up specific programmes for young people. Train professionals working with young people to Level 2 support to enable provision of advice and support when appropriate.
- ☑ Brief interventions should be part of school nurse targets; at the very least they should be delivering messages about where and how to access support. And professionals working with parents could be trained to pass on the message about the dangers of secondhand smoke and therefore reduce the risk of children's exposure in the home.

How does this High Impact Change work in practice?

Giving young people a voice on tobacco control

The challenge

SmokeFree Liverpool, a partnership involving Liverpool City Council and PCT among other partners, understood that the majority of adult smokers had started as young people and wished to enable young people to actively resist marketing directed at them.

Action

D-MYST (Direct Movement by the Youth Smokefree Team) was set up as a group run by, and for, young people as part of the wider SmokeFree Liverpool Tobacco Control Programme. The aims were to provide young people with an opportunity to air their views and concerns on tobacco and to take action to denormalise and deglamorise smoking by:

- raising the awareness of the dangers of tobacco and exposure to secondhand smoke among other young people;
- campaigning for and promoting smokefree environments for all;
- campaigning to remove images of smoking and the placement of tobacco products in media primarily targeted at young people.

Training from New York's Reality Check project provided a core group of young people with the skills and knowledge to lead local and national advocacy campaigns and develop capacity among their peers through a structured programme with co-ordinator support from within the Public Health Team.

Results

D-MYST has developed a considerable media presence. Campaigns have included the successful call for smokefree sports stadia, including a petition of over 8,000 local signatures that resulted in a decision by Liverpool and Everton football clubs to make their stadia entirely smokefree. The more recent Toxic Movies campaign, which aims to raise awareness about smoking in films, has also attracted significant coverage and is enabling the young people involved to get actively involved in researching this form of tobacco marketing.

What we can learn from this

Where there are concerns about youth uptake of smoking, directly empowering young people to actively denormalise smoking and defuse its aspirational image can be effective in generating media coverage, improving awareness and leading to real change at a local level.

Why is this High Impact Change significant?

People who begin to smoke at an early age are more likely to develop severe levels of nicotine addiction than those who start at a later age. This obviously has implications for their long-term smoking status and ability to quit, and highlights the vicious cycle of tobacco use whereby a new generation of children becomes addicted each year, going on to replace the thousands of people who have died prematurely because of their addiction, perpetuating health inequality in our communities.

Young people start to smoke despite the best efforts of parents and health educators. By working to reduce adult and parental smoking the risk for children and young people can be reduced. By working to decrease the number of sources available to children it will be easier to focus more readily on the areas where they are still able to buy tobacco.

Further reading

- Investing in youth tobacco control: a review of smoking prevention and control strategies
  Lantz P et al, Tobacco Control, 2000; 9: 47–63.
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HIGH IMPACT CHANGE 10: Maintain and promote smokefree environments

What does this mean?

Last but by no means the least of the High Impact Changes is this recommendation to maintain the momentum built up during Smokefree legislation. This is crucial to the other High Impact Changes that rely on smoking to be denormalised – health inequalities and youth prevention, for example.

It's highly likely that Alliances will encounter a significant groundswell of both public and business opinion that smokefree is a done deal since the legislation of July 2007. But it's still very important to focus on this policy area and begin to explore ways to extend smokefree into those places that are currently exempt from the law. This is in line with Clause 4 of the Health Act, which gives the Secretary of State for Health the remit to extend smokefree provision further.

The exception provided for a one-year period for mental health facilities is an example of how areas can work collaboratively to utilise the momentum of Smokefree legislation to prepare to extend provisions in particularly sensitive areas. In addition, many Alliances will have a prison in their area and there is not only good guidance available for working within this setting (Acquitted: Best Practice Guidance for developing smoking cessation services in prisons. **http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005383**) but precedents have been set; in North America a total prison tobacco ban took effect in April 2008 in federal prisons in Canada. Closer to home, the same happened when the Isle of Man went smokefree in March 2008. In short, there are examples being set that Alliances can aspire to.

This High Impact Change is about offering pointers so a concerted effort is made locally to maintain the momentum Smokefree legislation has had on preventing ill health in non-smokers, reducing health inequalities, prompting quits and preventing relapse.

What is the evidence that it works?

Comprehensive smokefree policy, as implemented across the UK and in many countries across the world, is the only approach that has been shown to be practical and effective in protecting people from harm from secondhand smoke exposure. [1, page 65] Tobacco control advocates have an important role in ensuring these policies are effectively implemented to assist tobacco users to quit and to prevent initiation of tobacco use. [2, page 65]

There is good evidence from Scotland about the impact of its February 2006 Smokefree legislation on prevalence and quit rates. [3, page 65] A small-scale review carried out just three months after similar legislation was introduced in England calculated that hospitality workers' exposure to harmful secondhand smoke fell by 95%; workers who had previously been exposed to the equivalent of smoking 190 cigarettes a year before the legislation had seen exposure drop afterwards to the equivalent of around 44 cigarettes. [4, page 65]

Action checklist

Sustaining the profile of tobacco control following Smokefree legislation can be a tricky process. The following points go some way to answering the question of how to maintain the drive to denormalise smoking.

- ☑ Encourage key local stakeholders to continue to lead by example. Publicise the success of smokefree locally using examples of better businesses and health.
- ☑ Take opportunities to reiterate that smokefree is a long process and there is still a longer-term goal of complete smokefree in all settings. In that context, start preparing now for the three-year review of Smokefree legislation in 2009/10 by gathering evidence and intelligence for proposals to extend smokefree environments.
- ☑ Within the framework of national policy developments expected in 2008, identify which areas to subsequently concentrate on in terms of extending the benefits of smokefree.
- ☑ Work effectively with relevant partners to ensure currently exempted premises such as mental health units, prisons and sports stadia can also successfully go smokefree.
- ☑ Ensure compliance monitoring is not allowed to lag. Maintain partnerships with Environmental Health so regular inspections are carried out and reported breaches followed up. Alliances may wish to check if enforcement is incorporated into Local Authority performance indicators – if not, a target could be suggested. For example, they could aim to visit 10% of local businesses a year, not just pubs and clubs but others too. These visits could be done in conjunction with visits councils need to do around alcohol. Help the council tackle any problems it is facing in terms of a lack of clarity over whose job it should be to take enforcement action, promoting the fact that tobacco control has been going for 50 years and there is much transferable learning to be had from it for other health areas that Local Authorities need to tackle.
- ☑ Make visits to bars and cafés to gauge progress and attitude. Share good practice on problematic areas and reinforce what is working to overcome the negative aspects of the legislation like litter and noise.
- ☑ Work with Regional Tobacco Policy Managers to maintain media coverage of smokefree initiatives and enhance national programmes. A consistent approach across England is required and to that end national smokefree branding should continue to be used at every opportunity in line with the new Department of Health marketing communications strategy. Anniversaries of Smokefree legislation are a useful peg for media work so it is important to collate local data to make the most of these opportunities. For example, there might be local data about smoking in designated rooms in care homes, local businesses could be surveyed to see if cleaning costs have gone down and the hospitality industry could be surveyed to see if they have become more attractive to the family market in the light of smokefree premises.

- ☑ Continue to promote greater awareness of the effects of secondhand smoke on non-smokers' health. This argument still needs to be made, especially in some more deprived communities. Similarly, there is still a lot of work to be done to lobby the health profession. Many hospitals are not enforcing smokefree regulations and opportunities to educate relatives and friends to create a smokefree environment when patients come home from hospital post operatively are being missed.
- ☑ Provide training for frontline staff – health, education, public health and voluntary – on smokefree issues to ensure all key staff are fully aware of the dangers of secondhand smoke. There are packages available from organisations such as the Roy Castle Lung Cancer Foundation, for example.
- ☑ Continue to highlight the harms to health from exposure to secondhand smoke, especially to the health of children from exposure in the home.

How does this High Impact Change work in practice?

How Fresh is supporting mental health trusts in the North East to become smokefree

The challenge

Smokefree mental health is traditionally an area that has been viewed as more sensitive or difficult to challenge due to the high levels of smoking prevalence and engrained smoking culture. The challenge was to support two NHS mental health trusts to be smokefree by 1 July 2008, after the temporary 12-month exemption for residential mental health units, provided by the Smokefree legislation of 1 July 2007.

Action

Fresh has encouraged collaborative working across the trusts and with external partners, for example NHS Stop Smoking Services, and the Local Authority Smokefree Compliance Officer. A working group engaged a variety of staff and partners from all levels in the smokefree implementation process, and a board-level champion has been invaluable in moving the agenda forward and giving it high priority status. It is anticipated this will also help form a structure for the future monitoring and review of the policy and levels of compliance.

An open and transparent consultation process was used and fully utilised established links with staff and service user and carer focus groups. The working group recognised that the smokefree policy/regulations could evoke strong negative and positive reactions which are both equally important to deal with, and good communication at an early stage was crucial in helping to identify potential problem areas which required intensive support and guidance from managers and directorate heads. Local action plans have been developed for individual units with specific timeframes to help achieve full compliance by the deadline.

Results

Due to the level of preparation by the two mental health trusts involved in the project only a few remaining residential units have required the temporary smokefree exemption – a great achievement. Those exempted units will continue to work through their action plans to successfully become smokefree with careful monitoring by the smokefree working group and with support from external partners.

Improved communication has resulted in the sharing of good practice across the region via in-patient staff events and road shows organised by one of the trusts, and regional site visits co-ordinated with partners. This has helped to highlight real success stories where units are completely smokefree and have been for some time and have used the policy as a positive change. Examples are the refurbishment of old smoking rooms into a mini-gym, educational resource centre or activity room for all service users to utilise and engage with one another.

Introducing an effective smokefree policy has helped to facilitate wider stop smoking support tailored to this important client group through offering more staff training, increased access to NICE-approved products and specialist advice from NHS Stop Smoking Services.

What we can learn from this

Embedding a strong, consistent approach to policy and enforcement of smokefree regulations as early as possible will help achieve good levels of compliance; it needs to be viewed as everyone's responsibility. Do not assume that a particular client group is too difficult or challenging to deal with. Utilising the support available and encouraging open communication can help facilitate positive change over time.

To avoid confusion, getting the facts right and distinguishing between what is the law and what is organisational policy is helpful. Careful consideration needs to be given when developing policies around prohibiting smoking in external areas; evidence from pilots across Tees, Esk and Wear Valleys NHS Trust demonstrated that it is too soon to implement restrictions in grounds for patients in a residential mental health setting and this has therefore not been adopted anywhere across the North East region at this stage.

Why is this High Impact Change significant?

It's all very well developing and implementing Smokefree legislation but maintaining it is another challenge altogether. Although tobacco continues to be the biggest cause of premature death in this country, other emerging public health risks like obesity and alcohol also require consideration and people working in these areas can learn from the achievements made in tobacco control. Nevertheless, focus must be maintained on reducing smoking prevelance. The very significant benefits to be had from denormalising smoking will be lost if momentum slows down.

Further reading

- PowerPoint presentation on the evaluation of Scotland's Smokefree legislation **http://www.smokefreeconference07.com/documents/0915HawPentlandmon.ppt**
- Comprehensive Smokefree Legislation in England: How advocacy won the day ASH report, December 2007 **http://www.ash.org.uk/files/documents/ASH_675/ASH_675.html**

HIGH IMPACT CHANGES – THE EVIDENCE

This section provides more detailed references to the evidence quoted for each High Impact Change.

One: Work in partnership

[1] The North East has a well developed tobacco control programme and the following research papers from academics at the University of Durham underline the importance of partnership working.

- Heckler S and Russell A, The anatomy of partnership: an ethnographic dissection of a tobacco control advisory panel in the North East of England. Article under consideration by Evidence and Policy
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Three: Use tobacco control to tackle health inequalities

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Gruer, Hart, Gordon and Watt, NHS Health Scotland
http://www.ashscotland.org.uk/ash/files/Laurence%20Gruer_Smoking%20and%20health%20inequalities.pdf

[3] Ending the Tobacco Problem: A Blueprint for the Nation
Institute of Medicine, National Academies Press, 2007
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[4] The NHS in England: the operating framework for 2008/09
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North East Public Health Observatory Occasional Paper No. 20, November 2005
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[5] Telephone counselling for smoking cessation
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Institute of Medicine, 2007
States that the most fully developed programmes for preventing tobacco use by youth have been implemented in school settings, and school-based programmes should remain the mainstay and be funded on an ongoing basis as a permanent component of tobacco control strategy.
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Best Practices for Comprehensive Tobacco Control Programs
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State-of-the-Science Conference Statement on Tobacco
National Institutes of Health
Comprehensive state-wide programmes have reduced overall tobacco use in young adults.
http://consensus.nih.gov/2006/TobaccoStatementFinal090506.pdf

[5] A meta-analysis of adolescent smoking prevention programmes
Bruvold W, American Journal of Public Health, 1993; 83(6): 872–880
http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1694752

Ten: Maintain and promote smokefree environments

[1] World Health Organization Framework Convention on Tobacco Control
http://www.who.int/entity/tobacco/framework/WHO_FCTC_english.pdf

[2] Best Practices for Comprehensive Tobacco Control Programs
Centres for Disease Control and Prevention, 2007
http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/00_pdfs/2007/BestPractices_Complete.pdf

[3] Evaluation of Scotland's Smokefree Legislation
NHS Health Scotland
http://www.smokefreeconference07.com/documents/0915HawPentlandmon.ppt

[4] Tobacco Control Collaborating Centre
Research funded by Cancer Research UK
http://info.cancerresearchuk.org/news/archive/pressreleases/2007/october/367622

MONITORING AND EVALUATION

What does this mean?

The work Alliances do needs to demonstrate effectiveness. As part of the monitoring process the Tobacco Control National Support Team would like to encourage local Alliances to review the work they are doing and feed back up-to-date information about what is working well at a local level so this High Impact Change document can be revised to incorporate new evidence.

To help that process outcomes will need to be monitored. Splitting them into activities that prevent youth starting to smoke, those that promote quitting, those that eliminate exposure to secondhand smoke and those that tackle health inequalities would be an effective way of evaluating local approaches.

Being able to respond to changing circumstances facilitates and improves the effectiveness of delivery in all the 10 High Impact Changes. Evaluation can also help partnerships to identify and set intelligent targets for the future.

Action checklist

In order to maximise the benefits and support that monitoring and evaluation can bring the following steps are recommended:

- ☑ Clearly specify and commission monitoring and evaluation activities in service-level agreements and contracts with providers.
- ☑ Invest senior leadership energies in resolving data gathering and processing problems quickly.
- ☑ Procure IT systems that are flexible and not over-reliant on one contractor.
- ☑ Where possible seek to gather and share data on the basis of geographical areas that represent natural communities; this is helpful both for informing social marketing and ensuring that tobacco control's potential contribution to Local/Multi-Area Agreement aspirations is well illustrated.
- ☑ Specify and support systematic outcome monitoring throughout the year, not just at year-end.
- ☑ Establish evaluation mechanisms up front. This is important for demonstrating the effectiveness of the initiative.
- ☑ Support organised evaluation of effectiveness of interventions – and learn from them.
- ☑ Task Tobacco Control Alliances and commissioners to carry out periodic reviews of effectiveness of interventions.
- ☑ Regular systematic reviewing of collection and processing of Stop Smoking Services data will add to the overall evaluation effort.

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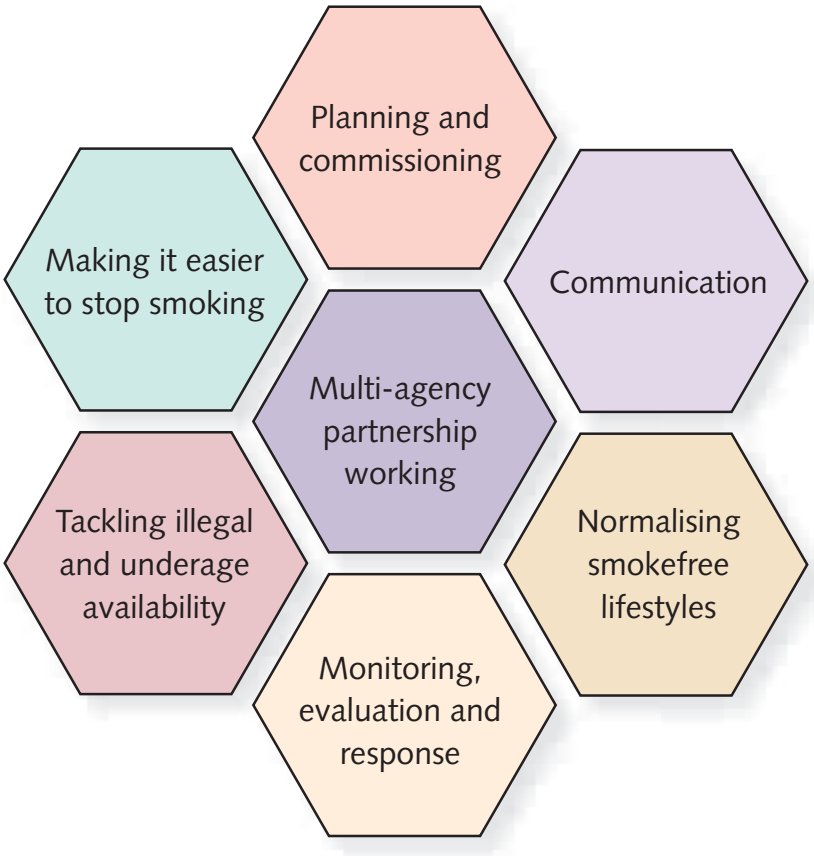
APPENDIX ONE: An integrated local model of tobacco control

Nationally, tobacco control activity is guided by the Department of Health's six strand approach, based upon the international evidence that a coordinated, multi-faceted response to the tobacco epidemic is required to effectively tackle health inequalities.

The six strands are:

- build Stop Smoking Services and strengthen local action;
- reduce exposure to secondhand smoke;
- support national education and media campaigns;
- reduce tobacco promotion;
- tobacco regulation;
- reduce the availability and supply of tobacco products.

This six strand approach has been developed into a localised model by the Tobacco Control National Support Team. The Team's work with local areas in England employs the integrated 'hexagons' model of local tobacco control essential elements depicted below.



The Hexagon Model

The hexagon represents a holistic model of tobacco control with seven broad themes employed by the National Support Team to analyse strengths and opportunities for enhancement in identified areas. The aim of the model is to focus specifically on local delivery so there is naturally a greater emphasis on multi-agency formulation of local strategy than on policy development at international and national levels.

At the heart of the hexagon is multi-agency partnership working – vital for Tobacco Control Alliances at a local level to plan strategically and deliver evidence-based interventions. Closely aligned to this is the need for effective planning and commissioning, based on needs assessment and identification of those populations and areas with the greatest burden from tobacco. These, together with monitoring, evaluation and response, form the central spine of this model.

The four remaining elements form the basis of the interventions needed for effective local tobacco control. Normalising Smokefree lifestyles is central to reducing the perceived attractiveness of smoking. Making it easier to stop smoking looks to the provision and accessibility of evidence-based ways to help smokers stop. Tackling illegal and underage availability remains crucial since price sensitivity is still one of the most effective levers available. And communication is vital to publicise the benefits of stopping smoking, the means of doing so, to advocate for further progress in denormalising smoking and to fully capitalise on social marketing.

APPENDIX TWO: Potential partners for local tobacco control activity

High Impact Change One speaks about the need for effective partnerships. These are some of the agencies, groups and individuals that could provide support:

- Health promotion units
- Health and Safety representatives from the Local Authority
- Health professionals
- Respiratory specialists
- Cancer specialists
- Midwives – both hospital and community based
- Health visitors
- Pharmacists
- School nurses
- Dentists
- Primary Care Trust patient panels
- Local Authority Public Health Department
- Trading Standards
- Environmental Health Officers
- HM Revenue and Customs
- Council members
- Leisure and Children's Services
- Council housing and planning departments
- Council community health and social care departments
- Education Department at County Council
- Individual city councillors
- Business leaders
- Chamber of Commerce
- Small business associations
- Hospitality sector representatives
- Lawyers
- Economists
- Business Link
- TUC/individual unions
- Schools and further education colleges
- Healthy School schemes
- Sure Start
- Teachers
- Students
- Parents' organisations
- Youth clubs
- The media
- Non-governmental organisations
- Women's and children's groups
- Environmental groups
- Consumer organisations
- Regional Tobacco Policy Managers
- Department of Health
- Children's Centres

APPENDIX THREE: What is social marketing?

Social marketing is the systematic application of marketing concepts and techniques to achieve specific behavioural goals relevant to a social good.

Health-related Social marketing is the systematic application of marketing concepts and techniques to achieve specific behavioural goals relevant to improving health and reducing health inequalities.

Department of Health definition

Social marketing is designed to reach more smokers and to bring about positive change in behaviour more effectively.

Its four cornerstones – the four Ps – are borrowed from commercial marketing and should guide all social marketing interventions.

The four Ps are:

Product:	in terms of tobacco control the product is a non-smoking lifestyle.
Place:	the communication vehicles used to reach the target audience and the specific locations where they can be reached, e.g. supermarkets, schools and shopping centres.
Price:	what smokers must give up in order to receive the product – perceived costs might be increased effort and time, anxiety resulting from quitting.
Promotion:	how Alliances communicate their offer to exchange the product for an acceptable price.

(Based on information in the Social Marketing Manual: A Guide for State Nutrition Networks. US Department of Agriculture. April 1997 **http://www.fns.usda.gov/OANE/MENU/Published/NutritionEducation/Files/socmktman.pdf***)*

READING LIST

The following is a selection of useful publications and websites that have relevance to all the High Impact Changes in this document.

English reports

Smoking Cessation Services
NICE public health guidance, February 2008
http://www.nice.nhs.uk/guidance/index.jsp?action=download&o=39596

NHS Stop Smoking Services: service and monitoring guidance, October 2007/08
Department of Health, October 2007
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079644

Local Alliance Toolkit 2007
Fresh Smoke Free North East, September 2007
http://www.freshne.com/content/editor/File/Toolkit/Fresh%20Toolkit%20pdf%20format.pdf

The Cancer Reform Strategy
Department of Health, December 2007
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

No ifs, no buts: Improving services for tobacco control
Healthcare Commission, January 2007
http://www.healthcarecommission.org.uk/_db/_documents/Tobacco_control_report.pdf

Tackling Health Inequalities Summit
Department of Health conference report, 2005
http://www.dh.gov.uk/en/Healthcare/International/EuropeanUnion/EUpresidency2005/DH_4119613?IdcService=GET_FILE&dID=7416&Rendition=Web

Up-to-date information on key aspects of smoking and smoking cessation in England derived from the Smoking Toolkit Study
http://www.smokinginengland.info/

A Zone of Ambiguity: The Political Economy of Cigarette Bootlegging
Hornsby R and Hobbs D, British Journal of Criminology, 2007; 47(4): 551–71
http://bjc.oxfordjournals.org/cgi/content/abstract/47/4/551

Turning off the tap: An update on cigarette smuggling in the UK and Sweden, with recommendations to control smuggling
Joossens L and Raw M, London: Cancer Research UK, 2002
http://info.cancerresearchuk.org/images/pdfs/pp_turning_off_the_tap
See also http://www.bmj.com/cgi/reprint/321/7266/947.pdf

Public Health Advocacy and Tobacco Control: Making Smoking History
Chapman S, Blackwell Publishing, 2007
http://www.blackwellpublishing.com/book.asp?ref=9781405161633&site=1

Social marketing: Why should the devil have all the best tunes?
Hastings G, Butterworth-Heinemann, 2007
http://www.elsevier.com/wps/find/bookdescription.cws_home/711135/description#description

Campaign Development Toolkit: An International Guide for Planning and Implementing Stop Smoking Campaigns
Feltracco A and Gutierrez K, Brantford, ON: Global Dialogue for Effective Stop Smoking Campaigns, 2007
http://www.stopsmokingcampaigns.org/index.php?page=english_toolkit

US reports

A Model for Change: The California Experience in Tobacco Control
California Department of Health Services, 1998
http://www.dhs.ca.gov/tobacco/documents/pubs/modelforchange.pdf

Ending the Tobacco Problem: A Blueprint for the Nation
Institute of Medicine, National Academies Press, 2007
http://books.nap.edu/openbook.php?record_id=11795&page=1

Reducing Tobacco Use: A Report of the Surgeon General
US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health, 2000
http://www.cdc.gov/tobacco/data_statistics/sgr/sgr_2000/index.htm

Greater Than the Sum: Systems Thinking in Tobacco Control
Tobacco Control Monograph No. 18, National Institutes of Health, 2007
http://cancercontrol.cancer.gov/tcrb/monographs/18/index.html.

Evolution of a comprehensive tobacco control programme: building system capacity and strategic partnerships – lessons from Massachusetts
Robbins H and Krakow M, Tobacco Control, 2000; 9: 423–430
http://tobaccocontrol.bmj.com/cgi/content/full/9/4/423

Evaluating ASSIST: A Blueprint for Understanding State-level Tobacco Control
National Cancer Institute Tobacco Control Monograph No. 17, October 2006
http://cancercontrol.cancer.gov/tcrb/monographs/17/m17_complete.pdf

Best Practices for Comprehensive Tobacco Control Programmes
Centers for Disease Control and Prevention, 2007
http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/00_pdfs/2007/BestPractices_Complete.pdf

NIH State-of-the-Science Conference Statement on Tobacco Use: Prevention, Cessation, and Control
National Institutes of Health, 2006
http://consensus.nih.gov/2006/TobaccoStatementFinal090506.pdf

Tobacco-Free Coalition of Oregon
www.tobaccofreeoregon.org

Taking On Goliath – Civil Society's Leadership Role in Tobacco Control
Open Society Institute, June 2007
http://repositories.cdlib.org/tc/surveys/Goliath

Preventing Tobacco Use Among Young People
Surgeon General's Report, 1994
http://profiles.nlm.nih.gov/NN/B/C/F/T/_/nnbcft.pdf

Training World Leaders in the Fight Against Tobacco
Free Online Tobacco Control Training from the Johns Hopkins Bloomberg School of Public Health
http://www.globaltobaccocontrol.org/

Guide to Community Preventive Services (Community Guide) of the effectiveness of interventions to reduce or prevent tobacco
http://www.thecommunityguide.org/tobacco/default.htm

Media advocacy, tobacco control policy change and teen smoking in Florida
Niederdeppe J, Farrelly M and Wenter D, Tobacco Control, 2007; 16: 47–52
http://tobaccocontrol.bmj.com/cgi/content/abstract/16/1/47

A Frame for Advocacy
Johns Hopkins University Center for Communications Programs
http://www.infoforhealth.org/pr/advocacy/index.shtml

Reports from around the world

Tobacco Control: A Blueprint to Protect the Health of Canadians
Health Canada, 1995
http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/1995/1995_85bk1_e.html

WHO report on the global tobacco epidemic – the MPOWER package
World Health Organization, February 2008
The report outlines six policy initiatives to counter the growing tobacco epidemic. Together these policies are known as MPOWER, an acronym for Monitor tobacco use and prevention policies; Protect people from tobacco smoke; Offer help to quit tobacco use; Warn about the danger of tobacco; Enforce bans on tobacco advertising, promotion and sponsorship; and Raise taxes on tobacco
www.who.int/tobacco/mpower/en/

Tobacco Free Japan: Recommendations for Tobacco Control Policy
A unique project whereby experts from Japan and the US and opinion leaders from healthcare fields have joined together to develop scientific, evidence-based tobacco policy to be developed and implemented after the Framework Convention on Tobacco Control is in effect
http://www.tobaccofree.jp/E/Full.html

Global Tobacco Research Network (GTRN)
The GTRN website is designed to provide researchers with access to various data sources related to tobacco control
http://www.tobaccoresearch.net/PPTs.htm

Which are the most effective and cost-effective interventions for tobacco control?
World Health Organization Europe, 2003
http://www.euro.who.int/document/e82993.pdf

Tobacco control: a blue chip investment in public health
VicHealth Centre for Tobacco Control, Melbourne: Cancer Council Victoria, 2001
http://www.vctc.org.au/downloads/BlueChipOverview.pdf

What potential has tobacco control for reducing health inequalities? The New Zealand situation
Wilson N, Blakely T and Tobias M
http://www.equityhealthj.com/content/5/1/14

European Strategy for Tobacco Control 2002
http://www.euro.who.int/Document/E77976.pdf

Tobacco control at a glance
World Bank, 2003
http://www1.worldbank.org/tobacco/pdf/AAG%20Tobacco%206-03.pdf

Building blocks for tobacco control: a handbook
World Health Organization, 2004
http://www.who.int/tobacco/resources/publications/general/HANDBOOK%20Lowres%20with%20cover.pdf

Organising cigarette smuggling and policy making, ending up in smoke
Van Duyne P C, Crime, Law and Social Change, 2003; Volume 39, Number 3 285–317
http://www.springerlink.com/content/qr77315754h4x070/

Tobacco Smuggling: Factsheet 8
Framework Convention Alliance for Tobacco Control, 2005
http://www.fctc.org/docs/factsheets/fca_factsheet_008_en.pdf

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www.dh.gov.uk/publications