The evolution of a UK regional tobacco control office in its early years: social contexts and policy dynamics

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SUMMARY

The Smoke Free North East Office (SFNEO) is the first dedicated tobacco control office in the UK coordinating a regional tobacco control network, Smoke Free North East (SFNE). Based on ethnographic research conducted between 2006 and 2008, this article examines the context for SFNEO's emergence at this time and in this region of England, and the main policy and practice challenges it has faced in its early years. SFNE formed in a favourable political and cultural climate, although regional champions were crucial in setting it up. It has worked well in branding itself and in taking advantage of the opportunity to lobby in support of comprehensive smoke free legislation, although the success of the legislation presents a risk that people will regard SFNE's work as finished. There is a need for independent sustainable funding, strong partnership working, and the 'bringing together' of existing organisations under its leadership if an organisation such as SFNE is to succeed. SFNE offers a model that is transferable to other places as well as to other public health concerns such as alcohol, and has been taken up by public health planners and policy makers with alacrity. This indicates a general perception that SFNE plays an effective role in public health delivery.

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INTRODUCTION

When it was launched on 31 May 2005, the Smoke Free North East Office (SFNEO) was the first tobacco control office of its kind in the UK (Fresh Smoke Free North East, 2006). It offers a public health delivery model that has generated considerable interest, not only for tobacco control but also as a way of tackling other issues such as alcohol. This article looks at the formation and early years development of the SFNEO and the regional tobacco control network that it coordinates, Fresh Smoke Free North East (SFNE). It answers Wanless (2002; 2004) and the call of other UK policy documents (such as the 2004 White Paper *Choosing Health*) for micro-level, real time studies of how decisions are made and the processes that underpin them. This is the subject matter of this paper. While the efficacy of complex interventions such as SFNE can be tested using evaluations based on health outcomes, the institutional and cultural contexts in which these interventions are carried out are less amenable to experimental manipulation but can be crucial for the effective translation of research into practice (Nutbeam, 1998; Campbell *et al*., 2007; Oldenburg *et al*., 1999; Eckersley *et al*., 2001:285; Glasgow *et al*., 2003). We look at how SFNEO has developed in its first few years, the international, national and regional contexts for this development, and suggest principles from its early years' experience that can be generalised to other areas.

METHODS

Data for this article was collected between April 2006 and March 2008. Ethnographic methods were used to build up a detailed and comprehensive picture of the organisational culture and policy contexts in which the director, two regional coordinators and other

commissioned and administrative staff of SFNEO operate. Participant-observation of events was supplemented by the analysis of relevant documents, and semi-structured interviews with key stakeholders – SFNEO staff, 15 of the 20 members of the SFNE Strategic Advisory Panel (SAP), eight of the nine other Regional Tobacco Programme managers (RTPMs), and four members of staff on the national tobacco team at the Department of Health. Examples of participant-observational research activities included 'deep hanging out' (Wogan 2004) in the SFNEO, shadowing the director and other members of staff to observe the roles and relationships of the SFNEO with other bodies, and attending meetings of the various SFNE committees and those of related organisations. Interviews were either face-to-face or by telephone, and the results recorded (with permission of the interviewee), transcribed and analysed by coding into key topics identified by the research team (Miles and Huberman, 1994). Research progress and outcomes were overseen and reflected upon by a multidisciplinary steering committee which met at six weekly intervals. Ethical approval for the research was obtained from the Sunderland NHS research ethics committee on behalf of the Central Research Ethics Committee of the NHS.

RESULTS

International, national and regional contexts

The initial inspiration for the development of a tobacco control office in the NE of England was the experience of California where smoking rates reduced to 14% from 1989 through the principle of changing social norms so that tobacco became less desirable, acceptable and accessible (California Department of Health Services, 1998; CDC, 1999). However, the situation in the NE of England is different to that of California, and SFNE does not slavishly follow the California model. Other countries (e.g. Ireland in March 2004 and Scotland in March 2006) subsequently introduced tobacco control measures in advance of England, where smoke free public places legislation came into force in July 2007. Models for tobacco control

also existed in Australia, where the director of the SFNEO had worked for several years, and New Zealand (Studlaw, 2005).

The national context was also important. In 1997, a new Labour government was swept to power which, through its 'Third Way' (Hale *et al*., 2004), sought to define itself as different from what had gone before, including launching a new public health agenda. For example, the 1999 White Paper *Saving Lives: Our Healthier Nation* rejected "the old arguments of the past" through altering the discourse from 'health variation' to 'health inequality', and shifting the emphasis towards social, economic and environmental factors as determinants of ill-health. This orientation was also reflected in the 1998 *Report of the Scientific Committee on Tobacco and Health* which highlighted the dangers of passive as well as active smoking. The White Paper *Smoking Kills*, published in the same year, highlighted the key role of smoking in shortening lives, and listed all the areas of concern which were subsequently to become the focus of SFNE's work. Following a policy introduced by the ten year *NHS Plan*, one of the first National Service Frameworks (NSFs), that for coronary heart disease (CHD), came out in 2000. It highlighted smoking cessation services and tobacco advertising as two important areas for the prevention of CHD. With the increasing focus on its dangers, the idea of 'controlling tobacco' was no longer regarded as maverick. The UK Tobacco Advertising and Promotion Act of 2003 banned most forms of tobacco advertising in print media, billboards, direct mailing and other promotions. Although sponsorship of Formula One motor racing was allowed until July 2005, it appeared that the power of the 'tobacco lobby', which had been a strong influence on policy in the 1980s, was waning.

The changing political and health policy climate in England was conducive to the formation of a tobacco control office but does not explain why the North East of England was home to the country's first such organisation. The role of regional champions was crucial in this regard. Data presented at an NHS health promotion conference in 2002 showed that, if efforts to reduce smoking prevalence in the North East were limited to smoking cessation, it

would take decades to achieve the set targets (Milne, 2005), and indicated the need for new, more comprehensive models of tobacco control. The concept of a tobacco control office was particularly attractive to those working in a region with a smoking prevalence rate of 28%, the highest in the country (Chappel *et al.,* 2006). A major bid to the European Union Public Health programme in 2003, supported by partners such as the Regional Development Agency, Government Office for the North East, the Association of North East Councils and the North East Regional Assembly, argued that smoking was more than just an NHS issue. Although it was unsuccessful, interviewees suggested that the collaborating on the bid had a galvanizing influence on the individuals and organisations involved.

SFNE thus reflects a move in both political and public health discourse away from an exclusive focus on smoking cessation towards more comprehensive, community-based and policy-oriented strategies. Examples from other parts of the world provided models and approaches that could be applied to the regional context of the North East of England, where individual champions were particularly energetic and the needs particularly great.

The SFNE model

The SFNE model has not been formally articulated but emerged from our analysis of the ethnographic and interview data. The SFNEO is distinctive for the following reasons:

1. It brings together a diverse range of tobacco control activities - including education and marketing, regulatory and policy measures, and cessation services - under one umbrella organisation with a common 'brand' and public face.

2. In addition to the money received from the Department of Health (DoH) as part of its normal Regional Tobacco Programme Management functions, it receives additional funding from the sixteen Primary Care Organisations (PCOs) in the region, based on a formula of £0.32p per head of population. This has boosted its income nearly fivefold between 2005 and 2008.

3. It maintains an identity that is separate from the NHS, despite its funding. This is underscored by its location in government offices in the centre of the region and by its governance arrangements.

4. It promotes social norm change (the 'denormalization' of tobacco) rather than smoking cessation as its core strategy.

5. Its quasi-independence gives it scope to act as a lobbying organisation.

The SFNE model in practice

The SFNEO's work is overseen by the SAP, 18 people representing a range of statutory and voluntary sector agencies and organisations, only a minority of which are NHS. The SAP is chaired by the regional director of public health, a joint civil service/DoH appointment. The management committee (which scrutinises the budget) is chaired by a member of the Local Authority Chief Executives' Group, while regional universities as well as NHS and DoH-funded research and evaluation bodies are represented on the Intelligence sub-committee. Such a broad and diverse grouping of leaders is unusual for public health delivery and reflects the wider constituency from which its identity strongly derives.

SFNE works to a Regional Tobacco Strategy that broadly derives from a DoH template and provides eight key areas for action (Table 1). Its average total income of £810,483 (+/- 5%) over the three years has made a big difference to the scope of SFNE's work and what it has been able to achieve, particularly with regard to items '1', '2' and '4' of the strategy. One eighth of the Office's first year budget was allocated to establishing a public face and key messages for SFNE. An external integrated media agency with extensive experience in social marketing was commissioned to undertake brand development. The rationale for using a media agency in this way, articulated by a member of the SAP, was that enthusiasm and interest in tobacco control alone does not necessarily generate or translate into the specific marketing skills required for an organisation such as SFNE to flourish. Key

communication principles the media agency established were for SFNE to be seen as 'anti-smoking, not anti-smoker', and for its logo to allow both regional and local identities to be represented. Thus 'FRESH' was chosen as the umbrella title, with 'Smoke Free North East' or 'Smoke Free (place name/agency/activity)' underneath it (Figure 1).

Media expertise of this sort is traditionally held at arms length by the NHS. Its use was particularly significant when the Health Improvement and Protection Bill was announced by the Government in May 2005, offering the chance for a comprehensive ban on smoking in enclosed public places and workplaces. However, such an outcome was not a foregone conclusion. The government initially proposed exempting private members' clubs and licensed premises that did not prepare or serve food ('wet pubs') from the legislation, while an even weaker option contained in the Bill was that of devolving the decision about whether or not to go 'smoke free' to local authority level. The SFNEO was heavily involved in lobbying for the comprehensive option during the consultation on the smoke free elements of the Bill, which ran from June to September 2005. In interviews, other RTPMs said that, since their appointments were as civil servants, they were denied the chance for such overt political engagement. SFNE, in receiving the bulk of its funding from local PCOs rather than central government, was in a different position with regards to what it could or could not do.

SFNE commissioned a region-wide survey in May 2005 which found that 52% of pubs in the North East were 'wet' and hence would be exempt if the Government's favoured option were accepted; in Easington, the sixth most deprived local authority in England, the figure was 81%. SFNE encouraged North East PCOs, local authorities and key regional agencies to write declaring their support for a comprehensive ban. Sources in the DoH report that responses to the Health Bill triggered by SFNE were second only to those from supporters of Cancer Research UK. The majority of the region's 30 MPs originally favoured the Bill's weaker options but, after SFNE's lobbying, two-thirds (20) voted for the comprehensive ban. SFNE also found increasing public support for this measure – 70% of

North East adults supported smoke-free legislation by the time the Bill was passed in its comprehensive form, compared to 63% in 2003. Documentary sources monitoring subsequent compliance with the smoke-free legislation indicate a 98.7% compliance rate, the highest in the country (DoH, 2008).

The successful lobbying by partners for a comprehensive ban was the first such experience for many, and media training was provided. Interviews with the SAP members suggested this task-focussed activity helped establish a 'campaigning mentality' and strong sense of dynamism, energy and positive affect unique in their experience of partnership working (Heckler and Russell, 2008). However, the unexpected emergence and success of the Health Bill presented both an opportunity and a threat for SFNE in the longer term. It was helpful insofar as it provided an instant, emotionally charged 'issue', which drew partners together in powerful ways that many found unexpected and exciting. However, success of this sort also proved challenging since, following the introduction of a comprehensive ban on smoking in enclosed public places on July 1st 2007, there was a risk that SFNE's task would be regarded as finished. However interviews with SFNEO staff and SAP members reflected their view that their job had only just begun. With a national Public Service Agreement aimed at reducing overall smoking prevalence to 21% by 2010, and other targets to reduce major inequalities in smoking prevalence far from being achieved, there was still much to do. SFNEO staff have made progress in identifying new issues, such as the challenge of cheap and illicit tobacco. Participant-observation at a North of England summit on tobacco smuggling hosted by the SFNEO in December 2007, which drew over 250 people, indicated a galvanizing effect. However, others who lack the vantage point of the SFNEO's staff need to be drawn into tackling issues such as this with similar zeal.

Bringing all tobacco control activities under one umbrella organisation has sometimes been problematic. One issue that the SFNEO faced initially was its somewhat difficult situation vis-à-vis the Regional Tobacco Control Alliance, a collection of individuals with an

interest in tobacco control established voluntarily in 1996 with intermittent DoH funding. The SFNEO took over much of the coordination and strategic planning work of this alliance, which seriously limited the latter's role and caused some early years friction which needed careful 'change management'.

Another problem for SFNE in its early years has been ensuring its financial sustainability during a period of major NHS reorganisation (Hunter and Marks, 2005). Public health work like tobacco control needs long-term funding to ensure results, and SFNE was fortunate in being independent of the NHS during the considerable stress and uncertainty that accompanied this reorganisation. Discussions in the planning phase of the SFNEO had proposed that the organisation should be part of an NHS PCO. In retrospect, given the subsequent reorganisation of primary care, such a move would have been disastrous for SFNE's identity, sustainability and effectiveness. SFNE suffered from the NHS reorganisation in 2005/6 when it was announced that the two North East Strategic Health Authorities were to be merged into one, and a new Regional Director of Public Health (RDPH) was to be appointed. During this interregnum, some PCOs challenged the continuation of annual per capita funding beyond 2005/6, even though the amount sought was less than a third of their annual smoking cessation budgets. A dip of seven percent in the total amount given by PCOs in 2006-7, for example, (£657,275 down to £608,668) was due to one choosing to make its contribution 'in kind'. There were discussions at some meetings about the more radical possibility (in health terms) of local authorities taking over or contributing to the funding stream currently provided by the PCOs, but achieving agreements on 'equal buy-in' from local authorities proved even more difficult than it was from PCOs. Strong leadership and negotiating skills were needed when the new RDPH (the person ultimately responsible for 'signing off' the public health activities of PCOs in the region) took up his post in July 2006. The RDPH subsequently gave a commitment that all PCOs were to continue their per capita support of SFNE for three years from April 2008.

SFNE, then, demonstrates unique features in terms of its funding streams, unusual partnerships for public health delivery, its focus on broader issues than purely smoking cessation services, and how it delivers on these concerns. It provides leadership and the potential for long-term, steady progress on the twin tasks of denormalizing tobacco and significantly reducing smoking prevalence without being derailed by the all too familiar turmoils of reorganisation in the NHS. The alternative (and the norm in many other areas of public health work, according to several interviewees) is a preoccupation with regularly changing, immediate problems, targets and workforce planning (i.e. 'who does what and in what way?' rather than 'what are we trying to achieve and for whom?'), often to the detriment of longer term issues.

DISCUSSION

We have identified the significant political and policy contexts that led to the formation of SFNE in the North East of England, and the key successes and challenges of its early years. A number of high profile national organisations have explicit interests in tobacco control, for example the National Institute for Health and Clinical Excellence (NICE), and Action on Smoking and Health (ASH). There have also been a number of alliances of agencies that have been pro-active in co-ordinating tobacco control activities, particularly at regional levels (for example, Smoke Free London). However, our research demonstrates that the SFNEO is unique in terms of its multiple sources of statutory funding and its ability to act as a quasi-independent, campaigning organisation able to bring unusual partners together to lobby where other organisations and individuals might otherwise have been prevented or discouraged from doing so. Its focus on social norm change, manifested through its extensive use of media agencies and social marketing, has been another unique and pioneering feature of SFNEO in its early years. As the delivery mechanism for a large-scale tobacco control programme that brings all aspects of tobacco control under one umbrella, SFNEO provides

leadership, accountability, and an organisational structure for the evidence-based achievement of a range of measurable outcomes (Nutbeam, 1998) that commissioners/funders can 'buy into' with relative confidence. The partnerships that have developed around SFNE extend well beyond the normal boundaries of NHS working, are dynamic in how they operate, and are charged with positive affect (Heckler and Russell, 2008). The office has been able to achieve some durability and direction during a time of upheaval and reorganisation within the NHS, and has developed strong and dynamic partnerships amongst an unusually broad range of groups and individuals. It now has to channel the energies generated during its highly successful lobbying for the smoke free legislation of July 1st 2007 into new challenges that continue to demonstrate the appropriateness of its unique modus operandi for these tasks. The established partnerships will need to grow and develop further as the focus and action priorities of SFNE alter to sustain this momentum. There is evidence that this is happening already, with the increasing involvement of revenue and border control agencies in the strategies on cheap and illicit tobacco (HM Treasury, 2006), one of the issues that SFNE is drawing into the tobacco control agenda.

There has been much research interest in policy networks in different social arenas. According to an earlier study of the UK tobacco policy network, SFNE should be part of a peripheral 'issue network' surrounding a 'producer network' that is an amalgam of government and tobacco industry interests surrounded by a public environment ambivalent about the smoke-free debate (Read, 1992). This contrasts with the findings of our study where, as in the USA (Krauss, 2004), the policy dynamic has shifted from tobacco networks to tobacco *control* networks. SFNE is at the centre of a complex partnership of organisations that contribute positively to debate and action on tobacco control in a public environment that is, in general, increasingly favourably disposed towards the tobacco control agenda. The arrival of the SFNEO has caused some existing organisations that were already working at local or regional levels to feel disenfranchized or disempowered, although the increased

resources it has been able to put at their disposal and the centralised lobbying SFNE has been able to coordinate has helped soften this antipathy. SFNE has also established itself as a key umbrella organisation at the national level, although it remains dependent on sustained funding from its regional base.

It is too early, and not the purpose of this article, to measure many of the outcomes on which SFNE must ultimately be judged, although some (such as changes in public opinion and compliance rates with the new legislation) have been alluded to above. Some measures, such as smoking prevalence data, will only assume significance over a period beyond the lifetime of our project and will not necessarily be directly attributable to SFNE anyway. A monitoring framework is in place which will start to yield results by 2010. The ability to be judged against the delivery of such tangible outcomes is unusual in the public health field where delivery often tends to be haphazard and piecemeal. As such, the SFNEO may offer a model of public health organisation and leadership that has considerable potential for application elsewhere. Examples include use of a model deriving from that of the SFNEO in establishing a NE Alcohol Office. This new office has similar funding arrangements to the SFNEO and a similar emphasis on social marketing, lobbying and collective action by different public sector agencies working in partnership. Meanwhile two other English regions (North West and South West) have copied the SFNE funding, marketing and partnership model for their own tobacco control activities. The interest in extending this organisational form into other areas and types of public health delivery is a tangible demonstration of the perception, across the region and beyond, that the SFNE model is effective.

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Figure 1: Brand identity of FRESH North East

Table 1: The eight key action areas of the Regional Tobacco Strategy

1. Developing infrastructure, skills and capacity to deliver tobacco control
2. Reducing people's exposure to second hand smoke
3. Helping smokers to stop smoking through the NHS Stop Smoking Services
4. Using media and education to raise awareness of tobacco issues
5. Reducing the supply and availability of illegal tobacco products such as smuggled and counterfeit tobacco
6. Reducing the illegal supply of tobacco products to children
7. Reducing the level of tobacco promotion
8. Research, monitoring and evaluation

Source: (Fresh Smoke Free North East, 2005)