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

Authors: Andrew Russell, Serena Heckler, Martin White, Soumen Sengupta, David Chappel, David J Hunter, James Mason, Eugene Milne, Susan Lewis

Corresponding author:

Dr Andrew Russell

Medical Anthropology Research Group

Durham University

Department of Anthropology

43 Old Elvet

Durham DH1 3HN

a.j.russell@durham.ac.uk

Tel: +44-191-334-6196

Fax: +44-191-334-6101

Co-authors:

Serena Heckler, Durham University, Durham, UK

Martin White, Institute of Health & Society, Newcastle University, Newcastle-upon-Tyne, UK

Soumen Sengupta, West Dunbartonshire Community Health Partnership, Dumbarton, UK

David Chappel, North East Public Health Observatory, Stockton-on-Tees, UK

David J Hunter, Durham University, Durham, UK

James Mason, Durham University, Durham, UK

Eugene Milne, North East Strategic Health Authority, Newcastle-upon-Tyne, UK

Susan Lewis, Durham University, Durham, UK

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.

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

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 SFNE, 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 and obesity. This article looks at the formation and early years development of the SFNEO and Fresh - Smoke Free North East (SFNE - the regional tobacco control network that it coordinates). Wanless (2002; 2004) and other key UK policy documents such as the government's *Choosing Health* (DoH, 2004; DoH, 2005) call 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 SFNEO, its director, two regional coordinators and other commissioned and administrative staff, operates. 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. 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). 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. 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, since 1989, smoking rates had reduced to 14% 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 has

not slavishly followed the California model. Other countries (e.g. Ireland in March 2004 and

Scotland in March 2006) had introduced tobacco control measures in advance of England,

where smoke free public places legislation came into force in July 2007. Active tobacco

control lobbies 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 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 (DoH, 1999). This orientation was also reflected in the Report of the Scientific

Committee on Tobacco and Health which highlighted the dangers of passive as well as active

smoking (DoH, 1998a). Meanwhile the White Paper 'Smoking Kills' 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 (DoH, 1998b). The NHS Ten Year Plan (NHS, 2000)

introduced the notion of National Service Frameworks (NSFs). The NSF for coronary heart

disease (CHD) came out in the same year and highlighted smoking cessation services and

tobacco advertising as two important areas for the prevention of CHD (DoH, 2000). 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 each year (2005-8).

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, made up of 18 people who represent a range of statutory and voluntary sector agencies and organisations, only a minority of which are NHS. It 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 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' 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, as 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. Such an outcome was not a foregone conclusion, however; the government initially proposed exempting private members' clubs and licensed premises that did not prepare or serve food ('wet pubs') from the legislation. 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 consultation on the smoke free elements of the Bill ran from June to September 2005, during which period the SFNEO was heavily involved in lobbying. Interviews with the other RTPMs highlighted that their appointments were as civil servants which denied them 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 (Heywood *et al.,* 2003). Documentary sources monitoring 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 similarly 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 showed the galvanising effect of a North of England summit on tobacco smuggling held in Newcastle on December 7th 2007

on this work, with over 250 people in attendance. 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. During discussions in the planning phase of the SFNEO it had been 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 sustainability and effectiveness. SFNE suffered from the NHS reorganisation and the consequent interregnum that occurred in 2005/6 when it was announced that the two Strategic Health Authorities in the North East were to be merged into one, and a new regional director of public health was awaited. 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. In such circumstances, strong leadership and negotiating skills were needed from the new regional director of public health (the person ultimately responsible for 'signing off' the public health activities of PCOs in the region) who took up his post in July 2006. 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. The regional director of public health 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 turmoils of reorganisation all too familiar in the NHS. The alternative (and the norm in many other areas of public health work, as several interviewees described it) 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 suggests 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 (Rhodes and Marsh, 1992; Ryan et al., 2001). 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 softened this antipathy somewhat. 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 an achievement that is unusual in the field of public health where delivery tends to be haphazard and piecemeal. As such, the SFNEO may offer a model of organisation and leadership in public health that has considerable potential for application elsewhere. Examples include use of the SFNEO model in establishing a NE office for Alcohol Control arising out of a Regional Alcohol Advisory Group (NEPHO, 2006). This new office has both similar funding arrangements and an 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.

FUNDING

ACKNOWLEDGEMENTS

REFERENCES

California Department of Health Services, Tobacco Control Section (1998) *A model for change: the California experience in tobacco control*. California Department of Health Services, Tobacco Control Section, Sacramento, CA.

Campbell N.C., Murray E., Darbyshire J., Emery J., Farmer A., Griffiths F., Guthrie B., Lester H., Wilson p., and Kinmonth A.L. (2007) Designing and evaluating complex interventions to improve health care. *British Medical Journal*, **334**, 455-9.

CDC [Centers for Disease Control and Prevention] (1999) *Best practices for comprehensive tobacco control programs—August 1999*. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Atlanta, GA.

Chappel D.C., Walrond S. and Bailey K. (2006) *The prevalence of smoking in the North East of England*. North East Public Health Observatory Occasional Paper No. 23, Stockton-on-Tees.

DoH [Department of Health] (1998a) *The report of the scientific committee on tobacco and health*. The Stationery Office, London.

DoH [Department of Health] (1998b) *Smoking kills, a white paper on tobacco*. The Stationery Office, London.

DoH [Department of Health] (1999) *Saving lives: our healthier nation white paper*. The Stationery Office, London.

DoH [Department of Health] (2000) *National service framework for coronary heart disease*. The Stationery Office, London.

DoH [Department of Health] (2004) *Choosing health: making health choices easier*. The Stationery Office, London.

DoH [Department of Health] (2005) *Delivering choosing health: making healthier choices easier*. The Stationery Office, London.

DoH [Department of Health] (2008) *Smoke Free England - one year on*. The Stationery Office, London.

Eckersley, R., Dixon, J.M., and Douglas, B. (2001) *The social origins of health and wellbeing*. Cambridge: Cambridge University Press.

Fresh Smoke Free North East (2005) *A Smoke free North East regional tobacco strategy 2005-2008*. Fresh Smoke Free North East, Chester-le-Street.

Fresh Smoke Free North East (2006) *Annual report 2005-6*. Chester-le-Street: Fresh Smoke Free North East 2006.

Glasgow, R.E., Lichtenstein, E., and Marcus, A.C. (2003) Why don't we see more translation of health promotion research to practice? Rethinking the efficacy-to-effectiveness transition. *American Journal of Public Health*, **93**, 1261-7.

Hale, S., Leggett, W., and Martell, L. (2004) (eds) *The third way and beyond: criticisms, futures, alternatives*, Manchester: Manchester University Press.

Heckler, S. and Russell, A. (2008) Analysing successful partnerships: the role of affect in a tobacco control advisory panel in the North East of England. *Evidence and Policy,* **14***, (4).*

Heywood, P., White, M., and Adams, J. (2003) *A survey of public opinion on smoking bans in public places in the North east*. Newcastle University, Newcastle-upon-Tyne.

HM Treasury (2006) *New Responses to New Challenges: Reinforcing the Tackling Tobacco Smuggling Strategy*. London: HM Treasury.

Hunter, D., Marks L. (2005) *Managing for health: what incentives exist for NHS managers to focus on wider health issues?* King's Fund, London.

Krauss, M., Mueller, N., and Luke, D. (2004) Interorganizational relationships within state tobacco control networks: a social network analysis. *Preventing Chronic Disease: Public Health Research, Practice and Policy*, **1**(4), 1-25.

Miles, M.B., and Huberman, A.M. (1994) *Qualitative data analysis*. Sage, Newbury Park, CA.

Milne, E. (2005) NHS smoking cessation services and smoking prevalence: observational study. *British Medical Journal*, **330**, 760.

NHS [National Health Service] (2000). *The NHS plan: a plan for investment, a plan for reform*. The Stationery Office, London.

NEPHO [North East Public Health Observatory] (2006). *Alcohol and Health in North East England*. Stockton: NEPHO.

Nutbeam, D. (1998) Evaluating health promotion – progress, problems and solutions. *Health Promotion International,* **13**, 27-44.

Oldenburg, B.F., Sallis, J.F., Ffrench, M.L. and Owen, N. (1999) Health promotion research and the diffusion and institutionalization of interventions. *Health Education Research*, **14**(1), 121-30.

Read, M.D. (1992) Policy networks and issue networks: the politics of smoking. In Rhodes, R.A.W., and Marsh, D. (eds) *Policy networks in British government*. Clarendon Press, Oxford.

Rhodes, R.A.W., and Marsh, D. (1992) (eds) *Policy networks in British government*. Clarendon Press, Oxford.

Ryan, M., Savage, S.P., and Wall, D.S. (2001) (eds) *Policy networks in criminal justice*. Palgrave, London.

Studlaw, D. (2005) The political dynamics of tobacco control in Australia and New Zealand: explaining policy problems, instruments, and patterns of adoption. *Australian Journal of Political Science*, **40,** 255-74.

Wogan, P. (2004) Deep hanging out: reflections on fieldwork and multisited Andean ethnography. *Identities: Global Studies in Culture and Power,* **11:** 129-39.

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)