Briefing for the second meeting of the Health Devolution Commission, Friday 28th February 2020

Briefing for your Evidence Session

Introductory comments about Cancer Research UK

- Cancer Research UK is the world's leading cancer charity dedicated to saving lives through research.
- Cancer Research UK's pioneering work into the prevention, diagnosis and treatment of cancer has helped save millions of lives.
- Cancer Research UK has been at the heart of the progress that has already seen survival in the UK double in the last 40 years.
- Today, 2 in 4 people survive their cancer for at least 10 years. Cancer Research UK's ambition is to accelerate progress so that by 2034, 3 in 4 people will survive their cancer for at least 10 years.
- Cancer Research UK supports research into all aspects of cancer through the work of over 4,000 scientists, doctors and nurses.
- Together with its partners and supporters, Cancer Research UK's vision is to bring forward the day when all cancers are cured.

Our interest in the Commission is based on how devolution can improve the prevention, diagnosis and treatment of cancer across England. We are encouraged by what has happened across GM and want to see how learning can be shared, pushed and implemented across England.

In the time available in the meeting, it would be useful to focus on the two key questions the Commission hopes to answer through its Scope of Work (below). Further points for one subsidiary question have also been added, as it relates to our examples around smoking.

Key Question 1: What does good health devolution look like that builds community's health and improves a community's health and social care services

Key points - address through the lens of Greater Manchester:

Good health devolution - being responsive to the needs of local populations, being adequately resourced to secure a joined-up, coherent people-centred approach to health across local populations.

1. Our experience has mostly been in Greater Manchester – through the 'Making Smoking History' programme.
2. Other examples include through Yorkshire & Humber's 'Don't Be the 1' health harms smoking campaign.
3. The role and success of Cancer Vanguards.
4. But for these systems to work, we will need to address the issue of health and social care funding.

- Making Smoking History: Our knowledge and involvement in the Greater Manchester (GM) 'Making Smoking History' plan will be useful here. Please refer to the 'Background briefing' for further information on this and use this as an example. The key points are below:
  - We've been an instrumental partner in the development and implementation of this plan since 2015. The plan was published in July 2017, outlining an ambition to reduce adult smoking prevalence to 13% by 2021.
  - Smoking prevalence is higher in GM than the rest of England. Smoking continues to be the greatest cause of ill-health and death in Greater Manchester; 4,500 people die from smoking-related illness in Greater Manchester each year. Lung cancer remains the

largest cause of cancer death in Greater Manchester, of which the vast majority of cases are linked to smoking.

- The plan sets out an evidence-based framework, the GMPOWER model, to achieve this ambition. The model is based on the World Health Organisation's MPOWER model, which advocates a comprehensive, multi-component approach to tackling tobacco. The GMPOWER model incorporates an additional seventh component to capitalise on coproduction and citizen engagement in the Greater Manchester communities.
- The latest data shows that adult smoking prevalence across Greater Manchester has reduced from 17.5% in 2017 to 16.2% in 2018, with 27,000 fewer people smoking across the region. This means Greater Manchester is closing the smoking prevalence gap with the England average and is on track to achieving the 13% target by 2020/21.
- The right relationships and structures were already in place in GM for the Making Smoking History programme to succeed. The challenge will be to form new relationships and structures elsewhere across the country that have the will to deliver similar health programmes. Please refer to the Making Smoking History example in Greater Manchester in Appendix section 1.4 and 1.5 for further information.

- Don't Be the 1: Yorkshire & Humber's Breathe 2025 programme - a region-wide collaboration of local authorities and local health services aimed at stamping out smoking and removing it from view of the younger generation.
  - The Don't Be the 1 campaign is a Cancer Alliance-led scheme that sits underneath the Breathe 2025 programme. It covers Bradford, Calderdale, Craven, Harrogate, Kirklees, Leeds, and Wakefield. These areas have some of the highest smoking prevalence in the country and were in dire need of a more targeted health harms campaign to combat smoking and drive quits.
  - Designed around a health harms quit smoking campaign, pooled resources allowed for a comprehensive media and communications campaign over the course of four weeks.
  - This included TV adverts, Facebook and Twitter adverts, hospital TV screen adverts and posters (Further information on the campaign can be found in a separate attachment).
  - The campaign is currently capturing results on quits to show its success. Similar campaigns run in the North East of England, via Fresh NE, have been received very positively and have returned great results.

- Cancer Vanguard: Cancer Vanguards are a useful example. In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguard' sites for the NHS England New Care Models programme.
  - This was one of the first steps towards delivering the Five Year Forward View and support improvement and integration of services. Each of the three vanguards (one in GM, one in NW/SW London and one in NE/Central London), leads a local delivery system, ensuring that outcomes that matter to patients and their families are at the centre of it all.
  - They encompass the whole cancer pathway with an emphasis on early diagnosis and detection and they ensure the work programme is in the best interests of the cancer population in their respective areas.
  - Collaboration is key to the success of the Cancer Vanguards – by working radically yet inclusively across a defined population, incorporating all partners from public health and screening, primary and community care, secondary and hospice care – they provide high quality care across the whole patient pathway.

- Funding: We welcome the ambition in NHS Long Term Plan to simplify payment mechanisms and encourage integration through shared budgets and responsibility for achieving financial balance.
  - However, funding flows in the NHS at present are complicated and do not support partnership working, integration and the better management of demand.
  - Barriers to partnership working across NHS and local government, with misaligned incentives and a lack of statutory underpinning increase the likelihood that organisations default to legal duties rather than system working.
  - Cancer Research UK believes that all organisations across an integrated care system should be given the resource, regulatory frameworks and support to have the capacity to develop an effective model of integrated care for their local health economy.
  - Equally, we are concerned that cuts to the public health grant, which funds vital public health functions, are having a detrimental effect on Local Government's ability to prevent cancer. As a result, we are inviting councils to support calls for sustainable public health funding.
  - We continue to call on the Government to provide increased and sustainable funding for public health - to prevent ill health, reduce health inequalities and support a sustainable health and social care system.
  - If councils are to plan and deliver key public health functions and services, a long-term, sustainable funding solution is needed. This needs to go beyond the 1% increase to public health funding announced at the last Spending Round.
  - Cancer Research UK has joined around 90 other organisations in publishing a Consensus Statement calling for a sustainable solution to public health funding to improve health outcomes, reduce health inequalities and ensure the sustainability of the health and social care system.

Key Question 1.1: In what ways does health devolution enable the building of healthier communities and the prevention of ill-health?

Key points – address through the lens of smoking:

Health devolution allows localities to focus and tailor services on the areas of greatest need.

1. Local areas look to deliver the best health services for their residents, yet there is still great variation in prevalence and availability of services. Smoking prevalence has been reducing across the UK, but there is still a large gap in rates across local authorities. In London alone, there are huge differences borough by borough; in Richmond the smoking prevalence is just 5.9%, yet in Barking & Dagenham it is 22.4%.
2. 4 in 10 cancers are preventable – Every year, more than 135,000 people die from cancer in England. By 2035, the number of new cancer cases is projected to rise to over half a million a year in the UK. Smoking related illnesses cost society £11 billion in England every year.
3. Much can be done locally to prevent smoking and obesity through health devolution. Prevention is critical within this system. Local health services, such as Stop Smoking Services, Sexual Health Services and Weight Management Services are provided by local authorities that are experiencing year-on-year funding reductions.
4. Tobacco use remains the UK's single greatest cause of preventable cancer and avoidable death. Evidence shows that specialist stop smoking services are the most effective way to help smokers quit for good: a smoker using a service like this is around three times more likely to quit successfully, versus going 'cold turkey'.
5. However, we know that stop smoking services and local tobacco control have been badly affected by reductions to public health funding. Our recent research showed that among the local authorities that still had a budget for stop smoking services, 35% had cut this budget

between 2018/19 and 2019/20. This was the fifth successive year in which more than a third of councils had cut their stop smoking service budgets.

6. Tobacco control has been among the worst hit of all the areas of public health spending. Between 2014/15 and 2017/18, total local authority spending in England on stop smoking services and wider tobacco control fell by £41.3 million (a fall of 30%).
7. This is why we support a Polluter Pays Smokefree 2030 Fund - a fixed annual charge on the tobacco industry. This money could help provide more funding for local stop smoking services and to further address local health needs.
8. The link between local authorities and local NHS services needs to be readdressed as the current system is locked in a treatment approach and will be subject to increased demands and pressures.
9. We believe that a better funded public health system will allow local authorities and their NHS counterparts to be able to deliver the right health and care services for the individuals who live within their boundaries.

Key Question 2: How should the challenges of accountability, power and control between the NHS and local authorities be addressed in devolved and integrated systems?

Key points - address through the lens of Health Inequalities, national targets, and local health leaders:

1. A key challenge and opportunity must be in addressing health inequalities and deprivation.
2. We are interested in the role of Metro Mayors in helping to provide political will to address local health needs.
3. The example of the role of Cancer Alliances; health devolution on cancer in practice.
4. National targets are often difficult to deliver locally – England has returned some of its worst Cancer Waiting times at end of 2019/early 2020. There is significant variation across the country.

Health inequalities and Deprivation: Health devolution, by placing the individual at the centre, is well placed to deal with the rising challenge of health inequalities.

- There are an extra 15,000 cases of cancer in England each year due to socioeconomic deprivation.
- The risk of presenting through an emergency route is 50% higher for people in the most deprived populations compared to the least deprived, with the risk increasing with every deprivation quintile. It is estimated that there would be thousands fewer emergency presentations of cancer each year if the risk for all deprivation groups was the same as the least deprived.
- Rates of excess weight in children are around three times as high in the poorest groups compared to the richest – and this gap is widening. Evidence shows that being overweight as a child makes one 5 times more likely to be overweight as an adult.
- Smoking prevalence for the most deprived is three times higher than the least deprived. Rates of smoking prevalence are falling slower within more deprived populations in all UK countries. Smoking related cancers show the largest difference between the least and most deprived populations, with lung and laryngeal cancers around 170% higher for the most deprived.
- Research by IPPR also found that England's most deprived communities have borne the brunt of cuts to public health spending, despite them generally having poorer health outcomes - £1 in every £7 of the £871.6 million cut from the public health grant over the last five years has been taken from budgets in the most deprived areas. In less deprived areas, this figure is £1 in every £46.
- Cancer is more likely to affect those from lower socioeconomic backgrounds. Our research shows that socioeconomic inequality is linked to an estimated 15,000 extra cases of cancer

in England and more than 19,000 extra deaths each year. Health inequalities are widening, and the biggest factor contributing to this growing gap is wealth.

- Similarly, across all three national cancer screening programmes (bowel, cervical and breast), those who do not participate tend to be those with protected characteristics and/or from lower socio-economic backgrounds.
- Barriers to screening also include physical and communication barriers, as well as cultural and social factors. An example of a physical barrier may be access to public transport to enable an individual to attend a screening appointment. A communication barrier may take the form of poor health literacy.
- Similarly, access to primary care can be a significant barrier. To be invited to take part in screening, you must be registered with a GP practice. If you are not registered with a GP practice, or your address is not correct, you will not receive an invitation for screening.
- It is important to understand and tackle the barriers specific to the local population, as this has the potential to reduce health inequalities.
- Cancer Research UK recommends local partners develop plans together to raise awareness of screening programmes.
- Public health is key in advocating the value of screening within and outside the local authority. Supporting good health can also play a role in work to grow the local economy. Ill health can lead to a loss of productivity and loss of earnings through sick days, other health-related absences and breaks. Therefore, a preventative approach that supports healthy choices can improve individuals' health as well as supporting local growth.
- This requires effective local partnerships between local commissioners, providers, communities, and the third sector.

Role of Metro Mayors: Metro Mayors are great examples of local leaders being able to marshal a wide range of services and local partners on certain health needs.

- They will be able to set smokefree ambitions and bring local partners together to deliver on this. Similarly, they can help to bring together local partners to reduce barriers to participation in cancer screening and pooling budgets for public awareness campaigns.
- Cancer Research UK believes that Metro Mayors can drive improvements in cancer prevention, diagnosis, treatment and survival across England. These improvements will bring not only health benefits, but can also reduce demand on services and increase participation in the local economy. With 1 in 2 people in the UK diagnosed with cancer in their lifetime, action at city-region level has the potential to improve the lives of thousands of residents.
- Sadiq Khan, Mayor of London, helped Cancer Research UK and partners in London to deliver a London-based junk food marketing across the Transport for London network. This included tube stations, tubes and bus stops. Cancer Research UK hopes that Sadiq Khan and the Mayoral team can further build on this campaign in London and further tackle obesity across the city.
- Helping to set up local childhood obesity taskforces (via Metro Mayors) committed to 'closing the gap' in childhood obesity rates will help to minimise unhealthy influences, and wider determinants of health, in local areas.
- Cancer Research UK's work with Metro Mayors is starting to develop, as we look to join a future M9 meeting (of all Metro Mayors across England).

Cancer Alliances: Cancer Alliances are a strong example of efforts to integrate care.

- Composed of local cancer clinicians, service leaders and patients, they seek to implement the 2015 Cancer Strategy for England, for example transforming diagnostic services and reducing unwarranted variation in outcomes. Cancer Alliances will align with ICSs as part of the LTP.

- Cancer Alliances are strongly positioned to draw together key stakeholders, provide strategic direction and deploy resources to deliver transformation to cancer services in their geographical footprint.
- Their leaderships represent clinical expertise across the whole cancer pathway from primary care to post-treatment. They also seek to reflect the diversity of the population across the Alliance geography through commissioners, representatives from arms-length bodies, patient representatives, the third sector and local authorities.
- In a programme of interviews we led with Alliance Managers to support developing CRUK's policy on Cancer Alliances, these relationships were identified as key to the effective functioning of these system-level organisations, allowing for transformation across the pathway and different care settings – as well as across where competencies lie outside the NHS, such as in cooperation in planning with local authorities.
- A recent example of the impact that a systemwide approach has can be seen with Kent and Medway Cancer Alliance. Having often performed poorly against cancer waiting time metrics, by taking a strategic system-wide collaborative and integrated approach – for example in investing in new equipment and staff roles across the pathway – they were able, by the end of 2018, to achieve best performance of any Alliance against the 62-day referral to treatment metric, at 84.8%.
- Further supporting information can be found in the Appendix in Section 1.3

National targets: The NHS is consistently failing to meet many of its core targets, particularly maximum waiting time standards, such as the four-hour A&E target, and Cancer Waiting Times.

- The Department of Health sets maximum cancer waiting time standards for NHS providers in England to meet, aiming to facilitate a shorter diagnostic period for cancer patients.
- In January 2020, 81.7% of A&E patients were seen within the 4-hour target – significantly below the 95% target, and a 20.4% increase on January 2019. Last month also saw 2,846 patients waiting more than 12 hours.
- Also in January, there was a fall in performance across all three main cancer metrics:
  - Two-week wait (2WW) - 91.3%; 93% target
  - 31 day 95.5%; 96% target
  - 62 day 77.4%; 85% target
- Currently, 1 in 10 diagnostic posts in the NHS are vacant, meaning we're not diagnosing people early enough. The earlier a cancer is diagnosed, the more likely it's treated successfully. You are three times more likely to survive cancer if it's caught early.
- Performance against the 62-day standard has declined significantly over the past five years – there is variation in the extent of deterioration in performance, but all areas of the country are affected.
- This is in large part due to a shortage in diagnostic capacity, caused by staff shortages in particular.
- CWT data trends have shown for some years that delays early in the pathway, in particular in diagnostic services, are creating a backlog. This means that the first definitive treatment isn't beginning within 62 days.
- GM, as an example, is not immune from these problems - GM is also not meeting the 62-day target, with November performance in GM deteriorating slightly to 74.1% of patients receiving their first definitive treatment within 62 days of an urgent GP referral, well below the operational standard of 85%.
- Similarly, a 31st January board paper reports that GM performance against the two-week wait (2WW) for breast symptoms was not achieved due to staff shortages in breast radiology.

- Performance in Q1 of 2019/20 on breast cancer across the country was just 77.5% against the 2WW target of 93% – meaning more than 10,000 patients waited too long for their first consultant appointment. This is was the lowest level since the target was introduced.
- However, local areas can take steps to improve their performance by focusing on the issues that are causing poor performance locally. For example, Kent and Medway Cancer Alliance (from previous example on CAs) went from treating 76.4% of patients within 62 days in June 2019 to treating 84.8% of patients within 62 days in October 2019 – this marks a significant improvement and was achieved through focusing on specific issues such as issues they had in urology pathways.
- Even though it is important for local areas to focus on improving their CWT performance, it is important not to penalise areas for poor performance when this may be caused by factors such as demographic factors and higher incidence rates of harder-to-diagnose cancers. It is good that the practice of making the award of transformation funding to Alliances conditional on 62-day wait performance has been stopped.

Appendix

1. Background briefing

1.1 Call for evidence to the Health Devolution Commission

- In the call for evidence, the Commission asked organisations to let the Secretariat know if they would be submitting evidence by the deadline of Monday 16th March. So far, the following have formally informed the Commission that they will be submitting evidence:

    - NHS Confederation
    - Macmillan Cancer Support
    - Alzheimer's Society
    - Nutricia
    - Mark Exworthy, Professor of Health Policy and Management, University of Birmingham
    - The Faculty of Sexual and Reproductive Healthcare
    - The Royal College of Occupational Therapists

- They expect that a number of those organisations giving oral evidence will also make formal submissions including GMH&SCP, London Councils, GLA, King's Fund, PHE, the Health foundation and IPPR.

1.2 Launch of the Health Devolution Commission

- The launch took place on Monday 3rd February with a call for evidence and press release. The latter was picked up by MJ, LGC and LocalGov. There were also op-ed articles by Co-chair Andy Burnham in HSJ and Co-chair Norman Lamb in MJ. Hugh Pym the BBC health correspondent also expressed interest as did Shaun Lintern of the Independent. The website was also launched - www.healthdevolution.org.uk – and a twitter account - @healthdevo. There have been 12 tweets and in total about 100 retweets.

- Overall coverage matched expectations and those in health and local government sectors that need to be aware should have heard about the Health Devolution Commission. They have asked us to continue to promote the Health Devolution Commission through our own media channels including our website and/or twitter accounts. If Commissioners would also like to draft op-ed pieces the Secretariat should be able to find outlets for them.

1.3 Integrated Care Systems and Cancer Alliances

- The *NHS Long Term Plan* (LTP) published in early 2019, and previously the *Five Year Forward View* strategy in 2015, both prioritised better integration of services. The LTP has reinforced the role of integrated care systems (ICSs) in establishing more collaborative working and joined-up care for patients and their local populations. ICSs will cover the whole of England by 2021.

- Integrated care models have the potential to reduce costs and generate better value for services while also improving outcomes for patients by creating systems which enable a range of different health and care providers to collaborate and be held collectively responsible for the delivery of healthcare services.

- Integrating cancer services could offer significant benefits because the route from diagnosis to treatment are complex, with patients often receiving care from multiple organisations. An integrated care model would encourage collaboration between these providers, whilst also allowing greater accountability by creating joint responsibility across the cancer pathway.

- Integrated Care Systems (ICSs) are the main route that the reforms of the LTP will be implemented and will be the main way that more integrated care is brought about.

- ICSs bring together NHS organisations, in partnership with local councils and others. They take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

- Cancer Alliances are also an example of efforts to integrate care. Composed of local cancer clinicians, service leaders and patients, they seek to implement the 2015 Cancer Strategy for England, for example transforming diagnostic services and reducing unwarranted variation in outcomes. Cancer Alliances will align with ICSs as part of the LTP.

- Funding flows in the NHS at present are complicated and do not support partnership working, integration and the better management of demand. We welcome the ambition in NHS Long Term Plan to simplify payment mechanisms and encourage integration through shared budgets and responsibility for achieving financial balance.

- Barriers to partnership working across NHS and local government, with misaligned incentives and a lack of statutory underpinning increasing the likelihood that organisations default to legal duties rather than system working.

- Cancer Research UK believes that all organisations across an integrated care system should be given the resource, regulatory frameworks and support to have the capacity to develop an effective model of integrated care for their local health economy.

1.4 Greater Manchester and health devolution

- Greater Manchester is the largest conurbation in the North of England, with a population of 2.8 million - fractionally smaller than the population of Wales and greater than that of Northern Ireland. Its economy exceeds that of both places.

- However, health outcomes in GM are generally poorer than the England average. Variation is a particular issue in GM, where more deprived localities in the North of the city-region have poorer outcomes (e.g. higher smoking rates, lower screening uptake), compared to more affluent localities in the South.

- GM was the first combined authority area to sign a devolution deal with Government in 2014, building on its history of working collaboratively as a combined authority. In February 2015 this resulted in an MoU between the Government, the Greater Manchester on health and social care. This health devo deal saw GM take control of a £6 billion budget to 2021.

- The GM Health and Social Care Partnership was established as a key NHS body designed to deliver health and social care devolution, in conjunction with the broader GM system. The GM health and social care system also operates as a Sustainability and Transformation Partnership (STP)/Integrated Care System (ICS).

- In 2016 Greater Manchester Cancer was created as a single system-wide board for cancer, with members including commissioners, local authorities, people affected by cancer, GPs, public health, clinicians, research and education, and provider trusts. GM Cancer operates as the GM cancer alliance.

- It is worth noting that responsibility for prevention and some early diagnosis work sits with the Population Health team of the GM Health and Social Care Partnership.

- One practical example of how Greater Manchester has been leading the way in trialling new approaches is through the Lung Health Check pilot. This was founded on the opportunities for closer collaboration between clinical and community-based services. It was made possible by the health devolution in GM and close partnership working with the NHS, Local Government and the third sector.

- Initial results from the pilot suggested it had had quadrupled early diagnosis rates. So strong was their 'proof of concept', that lung health checks were later awarded £70 million of NHS funding and extended to 10 sites across the country as part of the NHS Long Term Plan earlier this year.

1.5 Making Smoking History in Greater Manchester

- Since 2015, the Local Public Affairs team has been an instrumental partner in the development and implementation on the Making Smoking History plan. The team works with partners at Public Health England and GM Health and Social Care Partnership and engages with councillors and public health teams from all ten local authorities. Alongside driving support for Stop Smoking Services, we also provide evidence on e-cigarettes – helping to bring a pilot e-cigarette campaign to Greater Manchester in early 2018.

- Smoking prevalence is higher in Greater Manchester than the rest of England. Smoking continues to be the greatest cause of ill-health and death in Greater Manchester; 4,500 people die from smoking-related illness in Greater Manchester each year. Lung cancer remains the largest cause of cancer death in Greater Manchester, of which the vast majority of cases are linked to smoking.

- The burden of tobacco-related ill-health and death in Greater Manchester, combined with a well-established evidence base and strong leadership across health and local government partners, provided the Partnership with a compelling case to prioritise system-wide tobacco reform.

- The Greater Manchester Tobacco Control plan, 'Making Smoking History' was published in July 2017 following extensive expert and stakeholder consultation and coproduction in 2016. This bold plan outlines an ambition to reduce adult smoking prevalence to 13% by 2021 in order to close the gap between smoking rates in Greater Manchester and the rest of England.

- The plan hinges on concerted regional action to increase the number of people successfully quitting smoking and reduce the number taking up smoking. Based on 2017 data, by slashing adult smoking prevalence by a third there will be 115,000 fewer smokers in Greater Manchester by the end of 2020.

- The plan sets out an evidence-based framework, the GMPOWER model, to achieve this ambition. The model is based on the World Health Organisation's MPOWER model, which advocates a comprehensive, multi-component approach to tackling tobacco. The GMPOWER model incorporates an additional seventh component to capitalise on coproduction and citizen engagement in the Greater Manchester communities. The plan commits the partners to several actions under each of the framework's components:

  Grow a social movement for a Tobacco Free Greater Manchester
  Monitor tobacco use and prevention policies
  Protect people from tobacco smoke
  Offer help to quit
  Warn about the dangers of tobacco
  Enforce tobacco regulation
  Raise the real price of tobacco

- Since July 2017 the Greater Manchester Tobacco Control plan has achieved:

  - **A reduction in smoking prevalence:** The latest data shows that adult smoking prevalence across Greater Manchester has reduced from 17.5% in 2017 to 16.2% in 2018, with 27,000 fewer people smoking across the region. This means Greater Manchester is closing the smoking prevalence gap with the England average and is on track to achieving the 13% target by 2020/21.

  - **Providing better support for smokers:** People who smoke in Greater Manchester now have more choices to quit smoking than ever before with a digital platform in place in September 2017, a new Stop Smoking Helpline open since January 2018 and tobacco addiction treatment being delivered in Wythenshawe Hospital since late 2018, with plans to expand across Greater Manchester.

  - **Better alignment and collaboration:** Localities are aligning local tobacco control plans and stop smoking commissioning with the wider Making Smoking History plan, with areas increasingly pooling tobacco control resources and budget to improve efficiency. A new Greater Manchester-wide standardised local stop smoking service offer will mean that people who smoke will have equitable access to evidence-based cessation service no matter where they live. Data suggests that smoking prevalence has fallen in 7 out of 10 local authorities.

- A number of recommendations have been developed as a result of the success of the Making smoking History programme:

  - **Make a compelling, evidence-based argument** for a whole system approach to tobacco control, with arguments underpinned by improving general population health, wellbeing and productivity. This will provide a better understanding of the magnitude of the issue and the benefits of reducing smoking on not only the health and wellbeing of the population, but also reduces demand on other public services and provides benefits to the wider economy. This evidence base will help to build support from potential partners and respond to opposition to local tobacco control in your area. Evidence should underpin all tobacco control activity.

  - **Build a groundswell of support to promote action across key local stakeholders,** including clinical, political, academic and system-leader groups. Reducing the impact of

tobacco locally has benefits beyond improving public health; engagement should be broad across a range of partners including local government, health and public bodies, the NHS, trading standards, fire and rescue services, schools, and the voluntary sector.

- **Identify and engage local champions and leaders** from the NHS (clinical and non-clinical), third sector, local government and the combined authority who are committed, influential and accountable - to promote the tobacco control agenda in their area. Senior-level buy-in across these audiences is critical to orient all parts of the system towards shared goals.

- **Engage, co-design and co-produce with the public.** Genuine and ongoing consultation with the voluntary sector and the public is integral to build a vision or actions that are tailored to the needs and wants of the local community and can promote a social movement around tobacco control in your area. This social movement was key to developing and delivering Greater Manchester's system-wide tobacco control vision.

- **Consult and collaborate widely and often**, ensuring all relevant stakeholders are heard and the right people have a seat at the table. This may require the development of new partnerships, governance structures and working groups that include stakeholders from across the health and social care system and the public.

- **Develop formal governance structures early** to assign roles and responsibilities, in order to prevent confusion or disagreements in the future. This is especially important in a complex governance system.

- **Set ambitious targets and agree a vision** early to inspire positive, unified change from stakeholders and measure tobacco control successes within the context of your area.

- **Innovate and integrate** by thinking outside of existing organisational silos, infrastructure and budgets. This requires shared goals, commitments and joint ownership from across local government and the NHS. The move to integrated planning and commissioning structures, including Integrated Care Systems, provides opportunities for regions to collaborate and innovate to deliver strong tobacco control plans and actions.

1.6 Devolution White Paper

- The Devolution White Paper will provide further information on the Government's offer for enhanced devolution across England, levelling up the powers between Mayoral Combined Authorities and increasing the number of mayors and doing more devolution deals. With more powers and funds must come more local democratic responsibility and accountability.