CASE STUDY

Making smoking history in Greater Manchester

Elizabeth Benbow,[1] Andrea Crossfield,[1] Matthew Evison,[2] Ben Gilchrist,[3] Kate Pike,[5] Jane Pilkington,[1] Sarah Price,[1] Carolyn Wilkins[4], Charlie Steer[1]

[1] Greater Manchester Health and Social Care Partnership, Manchester, United Kingdom

[2] Wythenshawe Hospital, Manchester University NHS Foundation Trust, Manchester, United Kingdom

[3] 10GM, Manchester, United Kingdom

[4] Oldham Council and Oldham Clinical Commissioning Group, Oldham, United Kingdom

[5] Trading Standards North West, Warrington, United Kingdom

Corresponding author: Andrea Crossfield (email: a.crossfield@icloud.com)

ABSTRACT

When used as intended, tobacco is the only legal product that kills at least one in two. Aimed at protecting populations from the devastating effects of tobacco, WHO introduced the Framework Convention on Tobacco Control in 2003, subsequently publishing its evidence-based model, MPOWER, in 2008.

This case study reviews the efforts made in Greater Manchester (GM), a city-region in England with a devolved health and care system, to deliver a whole-system approach to tobacco control, utilizing the MPOWER model. The Greater Manchester Health and Social Care Partnership (GMHSC Partnership) aims to end an intergenerational cycle of smoking by reducing rates by one third in less than four years and ultimately make smoking history in the region by 2027.

The overall aim of GMHSC Partnership is to rapidly and greatly improve the health and well-being of the 2.8 million people of GM. Under a unique Taking Charge devolution deal GMHSC Partnership brings together the leadership, decision-making and long-term planning needed to achieve this goal.

As part of this ambition, GMHSC Partnership has successfully implemented a comprehensive tobacco strategy delivered at a significant pace and scale and with overwhelming public support, which has led to smoking prevalence falling twice as fast in GM compared to England. For adult smokers the long-standing gap with England is closing and the number of never smokers has increased, indicating fewer young people are starting to smoke. The strategy's achievements to date indicate that GM is on track to meet its bold ambitions.

Keywords: TOBACCO CONTROL, PUBLIC HEALTH, PARTNERSHIPS, HEALTH POLICY AND REGULATION, HEALTH SYSTEM RESPONSES

BACKGROUND

The World Health Organization (WHO) describes tobacco as a major global health hazard and the greatest preventable threat to public health. It kills up to half of its users and causes 8 million deaths each year globally, of which 1.2 million are from exposure to second-hand smoke (*1*). The tobacco industry produces and promotes this lethal product to maximize profits. While Philip Morris International recently purported interest in a "smoke-free future," evidence from internal documents suggests the industry's focus remains on driving company growth and preventing/reversing regulation (*2*).

Global tobacco control measures, led by the landmark 2003 WHO Framework Convention on Tobacco Control (FCTC), which was signed by the United Kingdom of Great Britain and Northern Ireland (United Kingdom) in 2013, aim to protect populations from the devastating effects of tobacco. They centre on reducing the uptake of tobacco use, supporting those addicted to quit and protecting people from second-hand smoke exposure. Consequently, smoking prevalence is mainly declining, though prevalence continues to rise among certain groups of young people and in lower-income countries (*3*). In 2008 WHO launched the multi-strand, evidence-based MPOWER model to accelerate its fight against tobacco-related harm. This model is a package of technical measures and resources intended to assist country-level implementation of tobacco control interventions.

LOCALIZING POLICY AND STRATEGY

This case study focuses on efforts in Greater Manchester (GM), England, to deliver an innovative, whole-system approach to tobacco control based on the WHO MPOWER model within a United Kingdom tobacco policy context.

GM is an English city-region of 2.8 million people consisting of ten district councils working together as the Greater Manchester Combined Authority (GMCA). In 2014 council leaders signed a deal with the government devolving a wide range of powers to GMCA and establishing the role of an elected mayor. GMCA is governed by this mayor and a cabinet made up of the ten district council leaders from the city-region. It leads the strategic direction of the region, working with other local services, including the devolved health and care system, to improve the city-region. Every public service in GM – from housing and transport to health and justice, and employment – has better health as one of its aims.

In 2016 GM was the first (and remains the only) English region to be delegated control of the national health and care budget – with control granted to the Greater Manchester Health and Social Care Partnership (GMHSC Partnership). The GMHSC Partnership comprises the NHS organizations in GM; representatives from primary care; NHS England; the voluntary, community and social enterprise (VCSE) sector; Healthwatch; the GMCA with its ten district councils and the Mayor of GM; Greater Manchester Fire and Rescue Service and Greater Manchester Police.

Life expectancy in GM is one of the lowest in England and with the aim of addressing this, the University College London (UCL) Institute of Health Equity agreed to support GM in 2019 in becoming the first Marmot City-Region (*4*): the GMHSC Partnership is working with Sir Michael Marmot to reduce inequality and improve health outcomes for all (*5*). Devolution has empowered GM to develop further system-wide approaches through a range of integrated public services, aligned around population footprints of 30 000–50 000 residents and centred around local people and their needs, focusing on prevention, population health and a fairer, more equal society (*5*).

The GMHSC Partnership aims to end the intergenerational cycle of smoking in its most deprived communities and become a global leader in the fight to end tobacco harm. In 2017 the GMHSC Partnership launched *Making Smoking History, A Tobacco-Free Greater Manchester 2017–2021 (6)*. Developed by the GMHSC Partnership and local/system leaders, this strategy recognized that making smoking history in GM offers the single greatest opportunity to improve health outcomes. It set a bold ambition to reduce smoking prevalence at a pace and scale greater than any other major global city: by one third in under four years from 18.4% in 2016 to 13% by 2021, or 115 000 fewer smokers. This will support a tobacco-free generation and ultimately aims to make smoking history (defined as reaching a smoking prevalence of less than 5%) by 2027, ahead of the United Kingdom Government's ambition for England to be smoke-free by 2030.

Delivering the tobacco strategy's goals is key to GM's devolution commitment to significantly improve health, wealth and well-being. The MPOWER model provided a framework for the programme of work put in place to deliver the strategy, with a G added to the model to represent Growth of a social movement as a seventh component (GMPOWER). It reflects GMHSC Partnership's approach to driving change by mobilizing social movements that empower collaboration and change culture. The GMPOWER model is described in Fig. 1 and each individual component of it is discussed below.

GROW A SOCIAL MOVEMENT FOR CHANGE – TOWARDS A TOBACCO-FREE GM

GM has a long history of local social movements and activism, and this is key to changing social norms and shifting power to citizens. In 2018 GMHSC Partnership undertook a large-scale 3-month public engagement campaign as part of its tobacco control strategy called *History Makers*. This work built upon concurrent successful people-powered health initiatives across GM localities, such as the *Wigan Deal*.

A key element of this campaign was an online survey relating to the measures outlined in the strategy. Of a total of 7500 participating residents, recruited through mixed media and communication channels, 1876 individuals were from communities that are not always heard, including Black, Asian and Minority Ethnic (BAME), lone parents, substance users, homeless, long-term unemployed, people with long-term physical and mental health conditions and ex-prisoners. This diversity, in line with observed census diversity, was achieved through partnerships with 84 voluntary sector organizations.

Four out of five survey respondents supported the ambition to make smoking history, including half of those that considered themselves smokers. Similar levels of support for extending

FIG. 1. THE GMPOWER FRAMEWORK FOR MAKING SMOKING HISTORY

GMPOWER TO MAKE SMOKING HISTORY 2017–2021

Tobacco Free Greater Manchester (GM) Strategy sets out a vision that is grounded in the World Health Organisation (WHO) multi component MPOWER model introduced globally in 2008, supported by the UK Government. GM has adapted this global/national framework for local implementation as described below, adding a locally focused component to mobilise social and community engagement, empowering people powered change.

G row a social movement for change – towards a tobacco – free GM

History Makers (HM) consultation involved thousands of local people taking part in a huge public conversation. Local champions, supported by local people, use the conversation findings to create real change and help 'warn about the dangers of tobacco' across their communities, supporting quitting and Making Smoking History.

M onitor tobacco use and prevention policies

We want to make sure everything we do is shaped by people and data. Knowledge and data gathered locally and nationally is helping us to; improve our services, run effective campaigns warning about the dangers of smoking, and helping guide the strategy. This includes a quarterly GM boost to national Smoking Toolkit data.

P rotect people from tobacco smoke

One thing is for sure. There is no safe level of exposure to second-hand smoke. Beyond the 2007 Smoke Free Law, the GM public want to extend smoke-free environments much more widely to denormalise smoking– like parks, playgrounds and areas around schools and hospitals. Communities, the voluntary sector and local government are leading this work.

O ffer help to quit (tobacco use)

The vast majority of smokers do want to quit – and 90% of those who try, do it without any specialist help or intervention. However – the fact is, you're much more likely to successfully quit long term when you've had the right information, support and advice. So a big part of GM's approach connects smokers with self-support channels, as well as directing those who do want to use services into the right support. Support to quit in secondary care has been significantly expanded and linked to community care.

W arn about the dangers of tobacco

Targeted multi media and social marketing campaigns are effective ways of reaching out to large local population groups about the harmful effects of smoking. So we're doing that and tying it in with local people, local shops, local environments and local issues. Our campaigns activity is representative and 'always on' balancing harms and hope messaging. Amplification of national activity such as Stoptober and work with Northern and national partners such as CRUK ensures intensity of messaging.

E nforce tobacco regulation (Enforce bans on tobacco advertising, promotion and sponsorship)

Our local regulatory teams work together to ensure national tobacco legislation is effectively enforced locally. We're using existing powers to restrict smoking on stage and create more smokefree spaces through restrictions on local government land. We want to see a proper licensing system introduced for tobacco to retailers selling tobacco if there is evidence of illicit or underage sales and for the age of sale to rise to 21. We are working with national partners to advocate for a range of new national legislation aligned to our strategy.

R aise the real price of tobacco (Raise taxes on tobacco)

Given the impact that price can have on tobacco use – we're making a strong case for tobacco duty to be raised nationally. But at GM level our focus is on the need to keep up the pressure on reducing demand and supply of cheap, illegal tobacco. GM's one public service model works at neighbourhood level to protect children and young people and vulnerable adults from illicit tobacco through a GM programme that connects into local and national work. This work is critical to tackling inequalities.

smoke-free spaces, helping people to stop smoking and further tobacco control regulation, including a polluter pays levy on the tobacco industry were also observed, suggesting a tipping point in the population's culture and beliefs about smoking. Ten percent of respondents signed up to be local *History Makers* in their communities, becoming the local faces/champions of the engagement activity. These *History Makers* actively engage in advocacy at local, GM and national levels, meeting with both local and national politicians and catalysing powerful conversations through a focus on community well-being and a compelling vision of a place where we make history, by making smoking history together.

To further develop public support, the programme funds the voluntary sector to work with communities, drive change and advance health literacy, drawing on community assets and providing grants to support smoke-free spaces, as well as supporting quit attempts. This includes a partnership with the lesbian, gay, bisexual, transgender (LGBT) Foundation, recognizing that LGBT communities have a higher smoking prevalence (*7*).

MONITOR TOBACCO USE AND PREVENTION POLICIES

Intelligence and performance data is vital to implement and evaluate effective tobacco control policies. GM utilizes national data sources to monitor and evaluate overall programme success. This includes the Annual Population Survey (APS), Smoking Status at Time of Delivery (SATOD) data and Young Peoples Smoking, Drinking and Drug Use survey. The Trading Standards North West Children's Survey provides further local data on young peoples' tobacco and e-cigarette uptake.

Additionally, the GM enhanced sample (1260 interviews per quarter) of UCL/Cancer Research United Kingdom Smoking Toolkit Study (STS), run by the market research company Ipsos MORI, provides regular data on smoking behaviours through household surveys of representative samples of the English adult population aged 16+. The STS tracks critical variables relating to smoking and quitting to assess trends and the impacts of policies, events and campaigns and the effect of cessation methods. This data informs an understanding of population behaviour change, programme delivery and development.

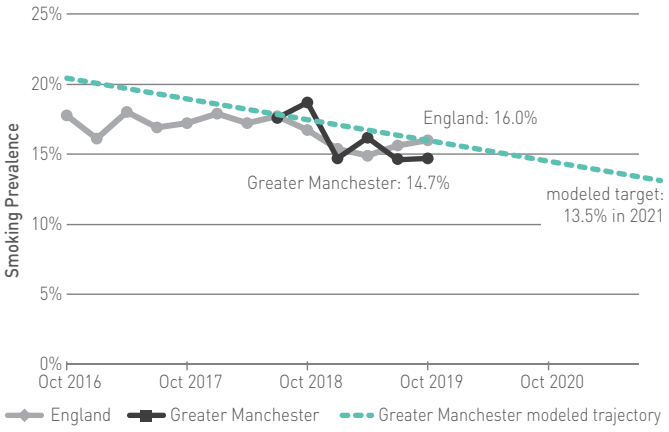
APS data released in July 2019 (*8*) showed that smoking prevalence had fallen twice as fast in GM than across the rest of England since the programme commenced, leading to the gap between England and GM prevalence rates shrinking from 2.9% in 2016 to 1.8% in 2018. Fig. 2 shows smoking prevalence in GM fell to 16.2% in 2018, from 18.4% in 2016, showing an accelerated reduction in smoking prevalence and closing the gap with England. This equates to 46 000 fewer smokers since the GMHSC Partnership programme began.

APS data also indicated that the overall number of adult never smokers continues to rise, increasing to 59.1% in 2018 compared to 57.3% in 2017. This trend is mirrored within routine and manual occupations, where never smokers increased from 49.5% in 2017 to 51.2% in 2018, indicating that fewer young people are starting to smoke across all social groups.

Trends in the reduction of smoking prevalence are likewise seen in the STS. Fig. 3 shows the data from England along with the GM target trajectory based on expert modelling, and actual GM data since the survey boost in the area. The data indicates GMHSC Partnership is on track to deliver, if not exceed the target.

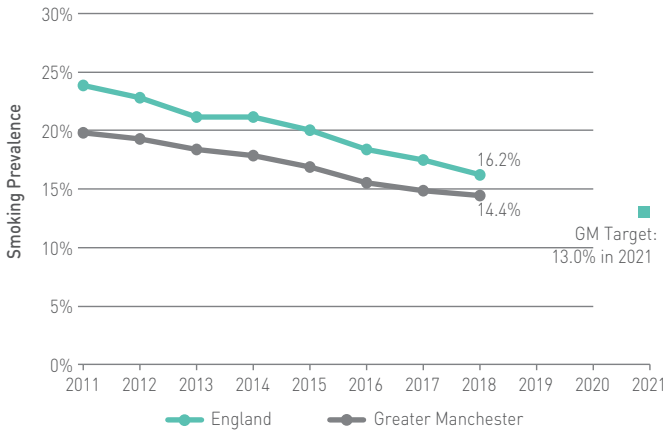
SATOD data (Fig. 4), shows that the proportion of pregnant women known to be smokers at the time of delivery in GM fell from 12.8% in early 2017 to 10.8% in spring 2019: a decline of 2% over the programme implementation period, which is greater than the 0.5% decrease observed nationally.

FIG. 3. SMOKING PREVALENCE: HOW MANY ADULTS (16+) CURRENTLY SMOKE TOBACCO



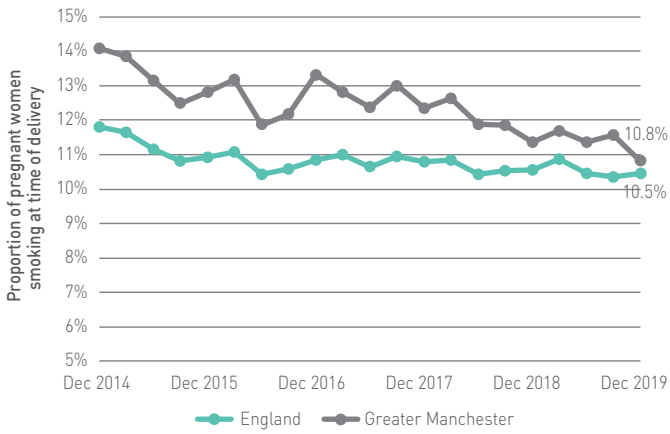
Source: The Smoking Toolkit Study

FIG. 2. SMOKING PREVALENCE: HOW MANY ADULTS (18+) CURRENTLY SMOKE TOBACCO



Source: ONS Annual

FIG. 4. SMOKING AT TIME OF DELIVERY: GREATER MANCHESTER AND ENGLAND



Source: NHS Digital

PROTECT PEOPLE FROM TOBACCO SMOKE

The GMHSC Partnership programme has prioritized voluntary implementation of smoke-free spaces to protect children, young people and vulnerable adults from second-hand smoke exposure and support the denormalization of smoking. The Partnership works as a system to engage citizens to create new smoke-free spaces and events through a local approach and a centralized smoke-free programme fund, which is administered by the voluntary sector.

This critical connectivity between the voluntary and public sectors has been enabled through devolution, is supported by a joint memorandum of understanding and is vital in successfully tackling inequalities in smoking.

To date, many district councils have required all local-government-owned property and land, including parks and sports grounds, to be smoke-free. They also engage with year-round smoke-free events, such as festivals, carnivals and sports events, and are a part of GM's smoke-free summer and events programme including Manchester delivering its 2019 Pride festival on a smoke-free site. Through the smoke-free fund, over 40 new organizations have bid for funding, extending the future number of spaces and events.

While it may be challenging to evaluate the impact of these interventions on smoking prevalence reduction and uptake, the *History Makers* consultation confirmed significant public support for extending smoke-free spaces. The fact that organizations from across all GM councils are continuing to access the smoke-free fund has shown ongoing support for smoke-free spaces and events and indicates the success of the programme. Medium-term impacts will be determined by further changes to smoking attitudes and behaviours in these no smoking areas.

OFFER HELP TO QUIT TOBACCO USE

The GMHSC Partnership has pioneered innovative stop smoking offers across secondary care and community settings. Discussed below, these are evidence-based and clinically led and recognize the critical roles of health-care professionals to drive transformation and, as National Health Service (NHS) cited best practices, are expected to be adopted across England.

GM introduced the CURE programme in October 2018 at Manchester University NHS Foundation Trust's Wythenshawe Hospital. Inspired by the Ottawa Model for Smoking Cessation (*9*), this programme recognizes hospital admission as a unique teachable moment to provide comprehensive tobacco addiction treatment to smokers admitted to acute care settings. During a six-month pilot phase:

- 96% of smokers received very brief advice to quit and 61% received a behavioural change intervention;
- 1 in 5 of all smokers admitted into hospital (22%) reported abstinence from smoking 12 weeks after discharge (*10*).

CURE is being implemented in six further hospitals across GM during 2020, alongside a pilot in mental health inpatient settings.

The GMHSC Partnership's Smokefree Pregnancy programme provides a stop smoking pathway throughout pregnancy utilizing the evidence-based BabyClear model (*11*). It embeds system-wide organizational change and includes a risk perception intervention when the first scan appointment is made, along with an incentive scheme targeting a defined group of vulnerable women that supports them to remain smoke-free for up to 12 months postpartum. Key results of this programme to date include 250 additional smoke-free babies born in the programme's implementation period (*12*); increases in carbon monoxide (CO) screening in early pregnancy from 20% to over 90%; referrals to stop smoking services increased by up to 170% in some localities; increased numbers of pregnant smokers achieving CO-validated four-week quits, with an average quit rate of 54% and a maximum rate of 84% in one hospital trust, compared to the England average of 26%; increases of >50% in recruiting significant others to try to stop smoking; increases in smoke-free homes; and over 1200 women signed up to the incentive scheme.

GM has also co-produced, with clinicians, a comprehensive primary care very brief advice (VBA) e-learning module for prescribers about medication, nicotine replacement therapy and e-cigarettes. An additional VBA module is in place for community staff that supports every public service worker to have conversations with smokers and address inequalities.

GM has also supported innovative approaches to use e-cigarettes as a stop smoking aid, recognizing that e-cigarettes are now the most popular route to quitting in England (*13*). The Salford *Swap to Stop* e-cigarette pilot enabled 1000 smokers, living in social housing, to access a free e-cigarette

starter kit, alongside local stop smoking support. In total, 60% continued to engage with local stop smoking support and 62% achieved a CO-validated four-week quit. Compared to the results from the same quarter the year before, NHS services that participated in the pilot saw four times as many people and achieved four times as many successful CO-verified quits at four weeks, which included five times as many successful quits for the most deprived quintile.

A wider offer of support to quit in GM includes access to the Stop Smoking helpline seven days a week and the GM Health Hub where smokers can access support, advice and information.

Ongoing work includes programmes to support rough sleepers to quit and the development of specialist community stop smoking services to support those with mental health issues in line with the smoking cessation intervention for severe mental illness (SCIMITAR) trial recommendations (*14*).

WARN ABOUT THE DANGERS OF TOBACCO

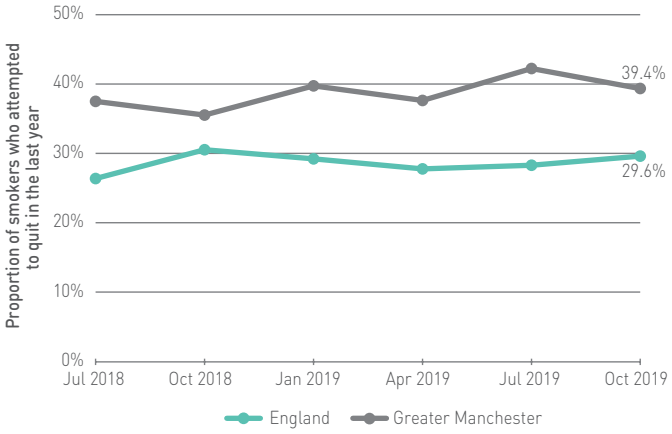
GM has invested heavily in mass/multi-media campaigns aiming to reach large population groups to present the harmful effects of smoking, change attitudes/beliefs, increase quit attempts and reduce adult/youth smoking prevalence.

GM recognizes that tailored campaigns and communications can resonate locally and in 2018 invested in robust insight and segmentation research based on demographics, smoking behaviour and attitudes, and attempts to quit, in order to deploy targeted interventions and communication methods/messages. The analysis provided a clearer understanding of how campaigns can reach smokers and enact behaviour change.

This included a focus on hard-hitting, engaging, positive, non-patronizing messages, featuring GM voices and local people telling their stories about stopping smoking. GM has since developed the quit brand and identity *YouCan*, and the use of local voices and settings in these media campaigns aims to create a sense of ownership often perceived as missing in national campaigns. Since 2019 GM has delivered high profile multimedia bursts of activity supported by geodemographically targeted always-on social and digital activity. This has included the local amplification of the national *Stoptober* campaign.

There is evidence that extensive investment into campaigns across GM is associated with increased quit attempts. Data from the GM STS shows that GM has had a significantly higher quit attempt rate (around 40%) compared to the England average since the always-on activity commenced in 2019 (Fig. 5).

FIG. 5. QUIT ATTEMPTS: HOW MANY ADULT (16+) SMOKERS ATTEMPTED TO QUIT IN THE LAST YEAR



Source: The Smoking Toolkit Study

ENFORCE TOBACCO REGULATION

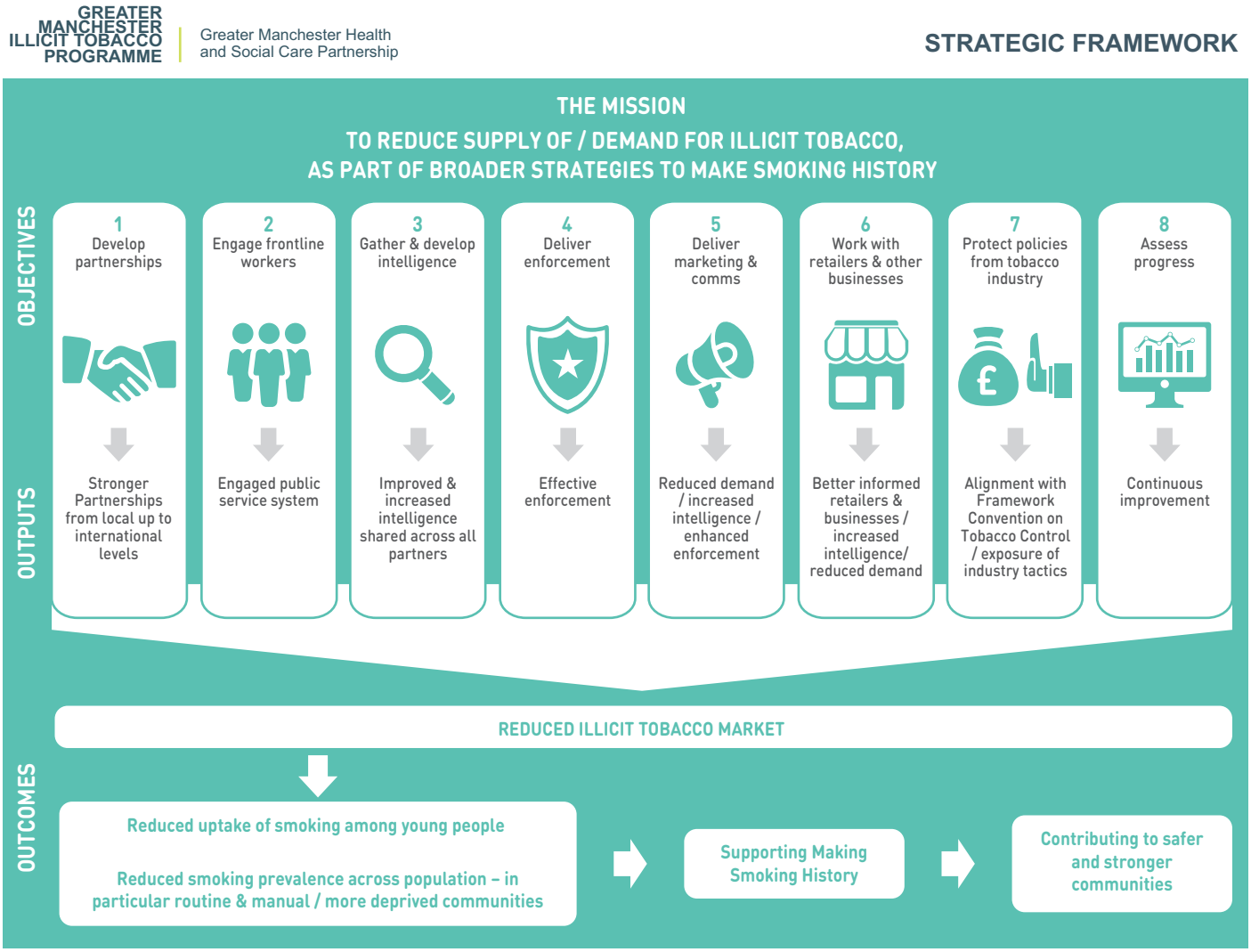
The King's Fund highlights the cost benefits of tackling public health through legislation and regulation (*15*), with significant population-wide impacts on health. GM localities, supported by responsible retailers, actively enforce existing tobacco control legislation and regulation. GM has also imposed a new condition on its grants to theatres to restrict smoking on stage to counter exemptions in national smoke-free law.

In 2019 the GMHSC Partnership reviewed proposals for introducing a tobacco retail licensing scheme for GM and extending smoke-free spaces through local legislation. In the context of a parliamentary timetable dominated by Brexit, where taking local legislation forward was challenging, GMHSC Partnership instead determined to align with the proposals of the All Party Parliamentary Group on Smoking and Health (*16*) and the Smokefree Action Coalition (SFAC) (*17*), in aiming for national legislation for further tobacco regulation that supports the ambitions in the GM strategy.

RAISE THE REAL PRICE OF TOBACCO

Increasing the price of tobacco through taxation remains the single most effective lever for reducing smoking prevalence. As poorer and younger smokers are more sensitive to

FIG. 6. THE ILLICIT TOBACCO PROGRAMME STRATEGIC FRAMEWORK



price increases, fiscal intervention can also help to reduce inequalities in smoking prevalence. GM makes its voice heard as part of the SFAC, supporting the Treasury budget submission and building a strong case for United Kingdom tobacco duty escalator increases.

Illegal tobacco's low price undermines high taxation and makes it easier for children to start smoking. A 2018 GM unpublished survey of 1520 GM adults aged over 16 weighted by gender, age and smoking prevalence indicated that in GM 63% of illicit buyers are from lower socioeconomic groups; 43% of smokers had been offered illicit tobacco; and 20% of smokers buy illicit tobacco some or all of the time at around half the average retail price. Action on illicit tobacco is essential to drive down smoking rates in poorer smokers and other vulnerable groups with high smoking rates. Evidence and GM insight work suggest that it undermines progress towards making smoking history and impacts community cohesion more broadly through its wider links to criminality. GM's Illegal Tobacco Programme, which launched late in 2018, is delivered through a strategic framework (Fig. 6). A multimedia campaign (*Keep It Out*) aimed at reducing both population level comfort with illicit tobacco in communities and the demand for illicit tobacco in the smoking population is leading to increased reporting and intelligence. Activity in the first quarter of 2019 led to seizures equalling those in the previous year – 637 000 illicit cigarettes and over 150 kg of illicit, hand-rolling tobacco with subsequent legal action.

The programme is supporting the GM model of integrated public service through mature local collaborative relationships across sectors including trading standards, housing, immigration, customs and police partners. Partners share information, intelligence, tools and powers to disrupt – in the short, medium and long term – individuals and groups who are committing serious and complex crime, and prevent those who may be vulnerable to becoming involved in such behaviour from doing so. GM's Illegal Tobacco Programme

has identified organized criminality, including child sexual exploitation and immigration frauds.

LESSONS LEARNT TO DATE

WHAT HAS MADE THE PROGRAMME WORK?

The United Kingdom has scored highly on successive EU Tobacco Scales (*18*), and any regional programme must consider its national programme and policy context. GM is an active member of the SFAC, which aims to make England smoke-free by 2030. This vision is now shared by the United Kingdom Government (*19*).

In this context, delivering the GMPOWER programme at pace and scale has been made possible by a case for change and significant investment to deliver a comprehensive and evidence-based tobacco control programme, facilitated by health-care devolution and a GM model of unified public services including the third sector.

GM has navigated a shared vision and journey across a strong partnership of ten GM localities while maintaining a focus on person-centred and place-based approaches supported through the convening power of a city-region mayor. Success is attributable to the programme's ability to work system-wide. GM has established strong relationships, partnerships and distributed leadership across third, private and public sector workforces, providing openness and transparency for everyone to come together, share best practice, expertise and innovation within the evidence-based framework of the GMPOWER model. GM's strong relationships with SFAC partners and active participation in a range of regional and national forums have provided a strong foundation for the programme.

THE CHALLENGES FACED

The pace of implementation has challenged capacity, flexibility and creativity. GM's short-term ambition to reduce smoking prevalence by a third by 2021 creates intense system performance pressure.

Funding cuts to public health budgets within localities have affected the ability to provide successful stop smoking services and impacted broader locality tobacco control plans in some GM localities. This has created a disconnect between the shared vision and ambition, and what is being funded and delivered at the locality level, as while the programme adopts a comprehensive and whole-system approach to tobacco control, it does not directly fund locality community stop smoking services.

THE FUTURE TRAJECTORY IS BRIGHT

Such a sustained reduction in smoking prevalence has never been achieved anywhere in a city-region at this pace. December 2019 STS data (Fig. 3), taken together with 2018 APS data (Fig. 2) indicate that smoking prevalence is continuing to fall and is on track to meet the 2021 target of 13%. The new national ambition is to make smoking history (prevalence of < 5%) by 2030. As a pioneer, GM remains bold in its goal to be the first global city-region to achieve this by 2027.

Securing a framework for programme sustainability beyond 2021 will be vital in achieving this. National commitment and phased funding for comprehensive stop smoking services in acute, maternity and mental health settings will be available from 2020/21 through the NHS England Long Term Plan. An alternative regional and local funding route may be possible by making tobacco manufacturers pay for tobacco control in line with a polluter pays levy, under consideration by the United Kingdom Government (*19*).

Future devolution may also offer alternative funding opportunities. GM was involved in the recent UK2070 Commission report (*20*) that argued for a United Kingdom Renewal Fund not skewed in favour of transport and infrastructure at the expense of science, health and regeneration.

To succeed, GM must continue to invest in a whole-system approach, to build insights into its smoking population and deliver a programme that tackles both social and geographical inequalities and disparities in smoking across GM communities. GM has identified prevention as a priority for a thriving green economy and has modelled the positive return on investment delivered through comprehensive tobacco control.

Most importantly, for GM to succeed, it must continue to recognize the importance of people and place, be adaptable, flexible and innovative, and to provide a skilled, informed workforce. This will critically empower and support every smoker who wants to quit so that GM truly becomes the first global city-region to make smoking history.

Acknowledgements:

None declared.

Disclaimer:

The authors alone are responsible for the views expressed in this publication and they do not necessarily represent the decisions or policies of the World Health Organization.

Conflict of interests:

None declared.

Sources of funding:

None declared.

REFERENCES[1]

1. The world health report, Key facts. Geneva: World Health Organization; 2020 (https://www.who.int/news-room/fact-sheets/detail/tobacco)
2. Phillip Morris International. 10 Year Corporate Affairs Objectives and Strategy. Reuters News; 2017 (https://www.documentcloud.org/documents/4333395-10-Year-Corporate-Affairs-Objectives-and.html)
3. Drope J, Schluger N, Cahn Z, Drope J, Hamill S, Islami F, et al. The Tobacco Atlas. Atlanta: American Cancer Society and Vital Strategies; 2018. (https://tobaccoatlas.org/topic/prevalence/)
4. The Greater Manchester Model. Doing things differently. Our white paper on unified public services for the people of Greater Manchester. Greater Manchester: Greater Manchester Combined Authority; July 2019 (https://www.greatermanchester-ca.gov.uk/media/2302/gtr_mcr_model1_web.pdf)
5. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J. The Marmot Review 10 Years On. London: IHE; 2020. (http://www.instituteofhealthequity.org/the-marmot-review-10-years-on)
6. Making Smoking History. A Tobacco-Free Greater Manchester 2017–2021. Greater Manchester: Greater Manchester Health and Social Care Partnership; (https://www.gmhsc.org.uk/wp-content/uploads/2018/04/Tobacco-Free-Greater-Manchester-Strategy.pdf)
7. Smoking and the LGBT community. London: Action on Smoking and Health; 20 July 2016 (https://ash.org.uk/information-and-resources/health-inequalities/health-inequalities-resources/smoking-and-the-lgbt-community/)
8. Adult smoking habits in the UK: 2018. Office for National Statistics; 2019 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2018)
9. Mullen KA, Manuel DG, Hawken SJ, Pipe AL, Coyle D, Hobler LA, et al. Effectiveness of a hospital-initiated smoking cessation programme: 2-year health and healthcare outcomes. Tob Control. 2017 May;26(3):293–9. . .doi: http://dx.doi.org/10.1136/tobaccocontrol-2015-052728 PMID: 27225016
10. Evison M, Pearse C, Howle F, Baugh M, Huddart H, Ashton E, et al. Feasibility, uptake and impact of a hospital-wide tobacco addiction treatment pathway: Results from the CURE project pilot. Clin Med (Lond). 2020 Mar;20(2):196–202. doi: http://dx.doi.org/10.7861/clinmed.2019-0336 PMID: 32188658
11. Bell R, Glinianaia SV, Waal ZVD, Close A, Moloney E, Jones S, et al. Evaluation of a complex healthcare intervention to increase smoking cessation in pregnant women: interrupted time series analysis with economic evaluation. Tob Control. 2018 Jan;27(1):90–8. . .doi: http://dx.doi.org/10.1136/tobaccocontrol-2016-053476 PMID: 28202783
12. Transforming the health of our population in Greater Manchester – Progress and Next Steps. Greater Manchester: Greater Manchester Health and Social Care Partnership; 2019 (https://www.gmhsc.org.uk/wp-content/uploads/2019/08/GMHSCP-Population-Health-Plan-FINAL-1.pdf)
13. McNeill A, Brose LS, Calder R, Bauld L, Robson D. Vaping in England: An evidence Update February 2019. London: Public Health England; 2019. (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/821179/Vaping_in_England_an_evidence_update_February_2019.pdf)
14. Gilbody S, Peckham E, Bailey D, Arundel C, Heron P, Crosland S, et al. Smoking cessation for people with severe mental illness (SCIMITAR+): a pragmatic randomised controlled trial. Lancet Psychiatry. 2019 May;6(5):379–90. . .doi: http://dx.doi.org/10.1016/S2215-0366(19)30047-1 PMID: 30975539
15. Population health: towards a healthier future. London: The King's Fund; Nov 2018 (https://www.kingsfund.org.uk/sites/default/files/2018-11/A%20vision%20for%20population%20health%20online%20version.pdf)
16. Delivering the vision of a smokefree generation - The All Party Parliamentary Group on Smoking and Health response to 'Prevention is better than Cure'; February 2019 (https://ash.org.uk/wp-content/uploads/2019/03/2019-APPG-report.pdf)
17. Kills SS. London: Action on Smoking and Health; 2015 (https://ash.org.uk/information-and-resources/reports-submissions/reports/smoking-still-kills/)

[1] All references were accessed 1 June 2020.

18. The Tobacco Control Scale 2016 in Europe. In: Tobacco Control Scale [website]; 2016 (https://www.tobaccocontrolscale.org/2016-edition/)

19. Advancing Our Health – Prevention in the. 2020s. Cabinet Office and Department of Health and Social Care; 2019 (https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s)

20. Make NLP. Acting at Scale for a Fairer and Stronger Future. Sheffield: UK2070 Commission; 2020 (http://uk2070.org.uk/wp-content/uploads/2020/02/UK2070-FINAL-REPORT.pdf) ■