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Report of:	*Simon Green, Executive Director, Place*
Report to:	*Cabinet*
Date of Decision:	*15th February 2017*
Subject:	*Tobacco Control in Sheffield: Strategy and Future Commissioning Model*

Is this a Key Decision? If Yes, reason Key Decision:-	Yes	X	No	
- Expenditure and/or savings over £500,000		X		
- Affects 2 or more Wards		X		

Which Cabinet Member Portfolio does this relate to? *Culture, Parks and Leisure; Children, Young People and Families; Health and Social Care;*

Which Scrutiny and Policy Development Committee does this relate to? Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee; Children, Young People and Policy Support

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	X	No	

If YES, what EIA reference number has it been given? *1205*

Does the report contain confidential or exempt information?	Yes		No	x

If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-

*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*

Purpose of Report:
To propose a Tobacco Control Strategy for Sheffield and changes to future commissioning to support the Tobacco Control Strategy.

Tobacco is a social justice, fairness, and health inequalities issue for our city. Smoking is still the biggest killer in the UK and is the biggest cause of health inequalities between rich and poor. Addiction to tobacco begins in childhood and takes hold into adulthood. It is estimated that over 79,000 people in Sheffield smoke tobacco, just under 1 in 5 adults. Tobacco kills 16 people per week in Sheffield – those who smoke can expect to have shorter, less healthy lives.

The current levels of investment in Tobacco Control in Sheffield will be maintained over the 3-5 year term of the strategy. Additional investment in schools prevention, media campaigns, and increasing smokefree sites will be funded through a £120k reduction in stop smoking services. A further £100k has been sourced from the ending of pregnancy relapse programme of which the model was judged to be ineffective; a new pregnancy relapse pilot will end on 31st March 2017 and outcomes will aid a decision about future programmes.

The expected effect of these changes will be a reduction in population prevalence of smoking, which currently is ranked “amber” and “similar” to the England average. This will be achieved through helping young people resist “starting” smoking, and through helping current smokers to stop smoking or swap to e-cigarettes (vaping) as a harm reduction measure.

Recommendations:

1. That the content of this report is noted and approval is given to the Tobacco Control Strategy and the Tobacco Control future commissioning strategy;

2. That the Director of Culture and Environment be authorised to terminate contracts relevant to the delivery of the Tobacco Control Strategy in accordance with terms and conditions of those contracts;

3. That, in accordance with the commissioning strategy and this report authority be delegated to the Director of Financial and Commercial Services to:
   a) in consultation with the Director of Culture and Environment, and Director of Public Health approve the procurement strategy for the services outlined in this report;
   b) in consultation with the Director of Culture and Environment, Director of Public Health and Director of Legal and Governance to award, vary or extend contracts for the provision of services outlined in this report;

4. That the Director of Culture and Environment in consultation with the Director of Public Health, the Director of Legal and Governance, and the Director of Finance and Commercial Services is authorised to take such steps as he deems appropriate to achieve the outcomes in this report.

Background Papers:

(Insert details of any background papers used in the compilation of the report.)

Tobacco Health Needs Assessment 2016
Tobacco & the City: Strategy Summary
Tobacco Control Models Diagrams 2016
Mini Specifications
Local Tobacco Control Profiles for England (http://www.tobaccoprofiles.info/)
Citizen Space Tobacco Strategy Consultation summary of responses

<table>
<tr><th colspan="3">Lead Officer to complete:-</th></tr>
<tr><td rowspan="4">1</td><td rowspan="3">I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.</td><td>Finance: Paul Schofield, HoS Finance & Commercial Services Business Partner Resources and Place</td></tr>
<tr><td>Legal: Sarah Bennett, Service Manager (Commercial),
Nadine Wynter, Legal Service Manager (Governance)</td></tr>
<tr><td>Equalities: Annemarie Johnston
Business Improvement Manager</td></tr>
<tr><td colspan="2">Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</td></tr>
<tr><td>2</td><td>EMT member who approved submission:</td><td>Simon Green, Executive Director, Place</td></tr>
<tr><td>3</td><td>Cabinet Member consulted:</td><td>Councillor Mary Lea, Cabinet Member for Culture, Parks, Leisure</td></tr>
<tr><td rowspan="3">4</td><td colspan="2">I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Decision Maker by the EMT member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.</td></tr>
<tr><td>Lead Officer Name:
Magdalena Boo</td><td>Job Title:
Health Improvement Principal, Place - Culture, Parks, Leisure - Public Health</td></tr>
<tr><td colspan="2">Date: 23rd January 2017</td></tr>
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1. PROPOSAL

1.1 This proposal is for a new Tobacco Control Strategy for Sheffield with a future commissioning model to support the strategy. The proposal is to maintain investment at the current level of £987k for 3-5 years (~£1.1m in total if Clinical Commissioning Group investment of £100k continues).

The new Tobacco Control Strategy aims to reduce population prevalence of smoking in Sheffield through supporting young people to be resilient and not start smoking, through supporting current smokers to quit, and through advising those who currently are not able to or do not want to stop smoking to swap to vaping as a harm reduction measure. This is a change from a focus on individual quits to population prevalence; going forward those receiving the most intensive stop smoking support will be from population groups in Sheffield with the highest smoking prevalence. Ambitious prevalence reduction targets for 2025 are being proposed (<10% prevalence in all adults, <21% for routine and manual, <7.5% smoking at the time of delivery, <4% amongst 15 year olds by 2025); these will be monitored against the Tobacco Control Local Profiles for England.

The new strategy and commissioning model changes maintain investment at the current levels for a further 3-5 years, but this investment is shifted so that there is greater expenditure on wider tobacco control (£220,000 investment shift). This includes increased investment in additional prevention work in schools, media campaigns and smokefree sites. Investment in combatting the availability of cheap and illicit tobacco in Sheffield will continue at current levels. These new developments will be funded through an £120k reduction in stop smoking services. A further £100k has been sourced from the ending of pregnancy relapse programme of which the model was judged to be ineffective; a new pregnancy relapse pilot will end on 31st March 2017 and outcomes will aid a decision about future programmes.

The services that will be funded are shown on the *Tobacco Control Models Diagrams 2016,* a brief description is provided below and mini-specifications are offered as an appendix.

Smokefree "Stop Smoking" Service
Stop smoking services remain the largest component of the Tobacco Control commissioning model, receiving £580k annual investment (down £120k from the 2016/17 £700k investment). However, there will be changes to the way services are commissioned. In the proposed model, the emphasis will be on achieving a 26 week (6 month) quit beyond the Department of Health's 4 week quit target.

The vision is that it will become standard in some settings, such as health

and social care settings, to be offered Very Brief Advice (VBA) on smoking status using the National Centre for Smoking Cessation and Training (NCSCT) “Ask, Advise, Act” model. Individuals will be asked if they smoke (Ask), advised of the health harms of smoking and the financial costs to them as an individual (Advise) and offered an immediate referral to the appropriate stop smoking support for them (Act). Individuals who are not currently willing or able to stop smoking will be advised to swap to vaping as a harm reduction measure. Providing Very Brief Advice in a range of settings will maximise the opportunity to reach smokers, of whom surveys show 2/3 want to quit (ASH, 2016, Smoking Statistics).

Two different levels of stop smoking support will be offered in Sheffield, the *Universal Service* and the *Priority Quits Service*. This approach is aimed at reducing population prevalence, reducing health inequalities and providing the most intensive support to those who need it most.

The “Universal” Stop Smoking service is aimed at groups where there is low smoking prevalence, such as students, those in professional occupations, and those living in more affluent areas of the city. The Universal Service will offer weekly groups with geographical coverage across the city. Universal Service users will have full access to group support, telephone, and digital media support but will be asked to fund their own over-the-counter stop smoking medications e.g. Nicotine Replacement Therapy. The rationale is that these individuals have more social capital to achieve a successful quit, may be less addicted, are less surrounded by others who smoke heavily and have a higher disposable income to invest in self-funded quit aids. Although we do not have data for Sheffield students ASH found that older young people are less likely to smoke and smoking in young people is declining (July 2015, Young People and Smoking). 13% of people in managerial and professional occupations smoke, compared to 30% in routine and manual occupations (ASH, Feb 2016, Who smokes and how much?). There is a strong link between smoking and socio-economic status (ASH, Feb 2016, Who smokes and how much?) and Sheffield’s Neighbourhood Profiles made available on the Sheffield City Council website confirm this e.g. Arbourthorne, which is in a less affluent area of the city has significantly high smoking prevalence, smoking attributable mortality rates and the highest neighbourhood rate of mothers recorded as smokers at delivery whereas Dore which is one of the most affluent areas in the city has very low smoking prevalence and mortality due to smoking.

The “Priority Quits” Service will offer intensive and sustained stop smoking support to those groups in Sheffield that have the highest prevalence, for example staff in routine and manual occupations, people living in less affluent neighbourhoods within Sheffield, people with severe and enduring mental illness. The “Priority Quits Service” will include fully funded stop smoking medications, individual face to face support, face to face groups, telephone and digital media support. The rationale is that this offers the greatest support and investment in those who are likely to be most addicted, most surrounded by heavy smokers, most likely to

have multiple complexities which would lessen their success at quitting without intensive support, most likely to need multiple quit aids, and least able to afford quit aids at the level and for the duration these will be required. Whereas in the past, a 4 week quit has been the clinical "standard" in line with Department of Health guidance, in future in Sheffield a 26 week (6 month as a measure for lifetime abstinence from smoking) sustained quit will be the goal and there will be ongoing support to prevent relapse into smoking. A range of reliable studies have found around 90% of people are still abstinent from smoking at 1 year after having quit for 3 months or longer.

The stop smoking services will be resourced entirely on a "payment by results" (PbR) basis. This means that only successful quits attract payments, not quit attempts. In line with Department of Health monitoring guidance, a "4 week quit" (carbon monoxide verified) will continue to attract a payment and will be the main measure for the Universal Service. However, the proposed Sheffield Model is to encourage a sustained quit with a stronger focus on relapse prevention. To achieve this, the Priority Quits Service provider will be paid a rate per quit which is considerably higher than the benchmark for South Yorkshire but with funding weighted to support longer term quits. This reflects the complexity and more entrenched use expected in those eligible for the Priority Quits Service.

Smokefree Sites

The Sheffield Tobacco Control Strategy aims to make Sheffield a city where smoking is unusual and children and young people do not grow up seeing adults around them smoking. To achieve this aim, public spaces in Sheffield will increasingly become smokefree. This is not about the harm from second-hand smoke, which is not believed to be significant in outdoor spaces, but about de-normalising tobacco use – this is known as a "social norms" approach. In 2016/17 considerable efforts were made by two of the city's NHS Foundation Trusts to make their premises smokefree. Sheffield Health & Social Care NHS Foundation Trust (SHSC), the local mental health trust led the way for the NHS in Sheffield by going completely smokefree on all its sites, grounds and vehicles. This was a significant challenge requiring vision and leadership. There may be up to 70% smoking prevalence amongst those with severe and enduring mental illness such as probable psychosis (ASH, 2016, The Stolen Years) and people with serious mental illness smoke heavily, spending up to 40% of their income on cigarettes and tobacco (PHE, 2015, Smoking Cessation in Secure Mental Health Settings). The example of SHSC has encouraged other NHS organisations in the city to follow suit. Sheffield Teaching Hospitals NHS Foundation Trust will pilot smokefree policy on three of its sites in 2016/17 (Charles Clifford, Jessops, Weston Park). In Summer 2016/17 children's play areas in Sheffield's parks went smokefree following a public consultation. In 2016/17 a survey was conducted with the Sheffield public regarding attitudes to more sites becoming smokefree and in addition a public consultation was held on this aspect of the Tobacco Control Strategy (SOAR 2016, SCC Citizen Space 2016-17). This gave a clear mandate from Sheffield residents to see more public spaces become smokefree, particularly places where children and

young people spend time, such as the Peace Gardens. In each are where smokefree policy is proposed, further extensive consultation will take place on each site, prior to a voluntary or mandatory code being put into place, with vaping considered separately.

Smokefree Children & Young People
There will be increased investment in smokefree children and young people with a focus on stopping young people starting; smoking in young people continues to decline, but it is estimated that 5 children a day still start smoking in Sheffield, and some young people are less resilient to tobacco marketing than others (Hopkinson et al 2013, Thorax). For a number of years, Sheffield has commissioned a peer-education programme in schools based on the evidence-based ASSIST model. The current contract resources work in 4 schools per year, and it is proposed that increased investment will allow the programme to run in 8 schools per year, as well as in ”out of school” environments for young people who are vulnerable to exclusion or excluded. The additional resource also allows a pilot with primary age children (Y5 and 6) which will be carefully evaluated with a research partner. This is strongly supported by Sheffield Tobacco Control Programme Board who are very concerned at initiation into smoking of very young children in some areas of the city with highest smoking prevalence. There is little evidence for work with primary age children and therefore this pilot will be developed in collaboration with a research partner (e.g. University) to ensure the study builds the evidence base for tobacco control in a way which will have benefit not just for Sheffield but for other similarly placed Local Authorities.

Cheap & illicit tobacco
There will continue to be a focus on eradicating cheap and illicit tobacco from Sheffield neighbourhoods and the investment in this service will remain the same. Cheap and illicit tobacco makes smoking affordable, can be the means of introducing young people into a lifelong addiction, and keeping smokers in addiction. It is estimated that smoking prevalence would drop by 10% if all cheap and illicit tobacco were eradicated. Cheap and illicit tobacco introduces serious organised crime into Sheffield neighbourhoods and occupies retail space and housing which would otherwise enable neighbourhood growth and prosperity. Most unfairly, it is the already deprived neighbourhoods where cheap and illicit tobacco thrives, widening the health and social inequalities in Sheffield. For this reason, the Tobacco Control Strategy seeks to eradicate cheap and illicit tobacco from Sheffield.

Marketing and Communications
In recent years, there has been a reduced investment nationally in mass media stop smoking campaigns and this, along with the growth in popularity of e-cigarettes is believed by experts to be part of the reason for the decline in uptake of stop smoking services. In the California Tobacco Control Programme, mass media campaigns contributed significantly to the reduction in smoking prevalence but this initial effect did not persist, with reasons given being reduced programme funding overall and increased Tobacco Industry marketing, whilst political

pressure was brought on legislators to reduce or reject anti-smoking media campaigns (Pierce et al, September 1998, JAMA). In Sheffield, the focus of media campaigns will be on those areas where the Tobacco Health Needs Assessment has identified the greatest challenges e.g. smoking in pregnancy, staff in routine and manual occupations. There will also be a focus on ensuring clear harm reduction messages are conveyed regarding swapping vaping for smoking in line with the best current evidence, both to the general public and to health professionals.

The current position is that there is roughly a 60/40 split between stop smoking (cessation) and prevention work across the Local Authority and the Clinical Commissioning Group. Currently £700k per annum is spent on stop smoking services, £107k per annum on combatting cheap and illicit tobacco, £40k on work in 4 secondary schools per year in Sheffield, £40k on smokefree homes and cars. There has previously been a collaborative contract for media campaigns with other South Yorkshire Local Authorities, but in 2016/17 this funding was re-purposed for work to support NHS sites in Sheffield to become entirely smokefree following the lead of Sheffield Health & Social Care NHS Foundation Trust. In addition, there is dedicated Sheffield City Council (Public Health, Communications) officer time to tobacco control. Sheffield Clinical Commissioning Group invests £100k in stop smoking services in pregnancy and this has been matched by investment at the same level from the Local Authority in a relapse prevention and smokefree Jessops pilot for this group which if successful will inform future programmes.

The need for change comes from recognition that there is a diminishing resource for Tobacco Control as funds to Local Authorities reduce and this must be used effectively to reduce population prevalence. This strategy and future commissioning plan instead draws on evidence from California, Australia and New York where impressive results were delivered through wider tobacco control, including a strong focus on media campaigns, schools work, and work in the policy arena e.g. smokefree legislation. However, it is important to note that the per capita investment for these programmes was significantly higher than Sheffield is able to achieve, and that smoking prevalence rose when investment in tobacco control was reduced. In these programmes it was a combination of what was done *and* how much of it was done, for example New York invested 4x and California 3X what Sheffield currently spends per capita (Sheffield Tobacco Health Needs Assessment, 2016-17). There is a risk that, due to austerity, Sheffield will do the right things at too small a scale to make the desired impact.

Previous Tobacco Control strategies and plans in the city have focussed on individual ‘4 week’ quits as a way to reduce smoking prevalence in the city. The new focus is on reducing prevalence at a population rather than an individual level through wider tobacco control measures. As resources are limited, this change in emphasis will be funded through shifting investment from quits into wider tobacco control, whereas if funds were less restricted the city would maintain its investment in quits at 2016/17 levels *as well as* investing more in wider tobacco control. There is

considerable debate on this issue and Sheffield's plans, particularly the focus on prevention (stopping young people starting) have been questioned by ASH and the Yorkshire and Humber Regional Tobacco Lead; however these changes are strongly supported by the Sheffield Tobacco Control Board. Local clinicians have been offered voice and influence to shape the proposed changes. The changes in prevalence will be measured through publicly available tools such as the Tobacco Control Local Profiles for England, as well as through local service evaluation and research.

On average, smoking prevalence in Sheffield has been reducing at levels of between 0.4-1% per year. If we continued to apply a business as usual strategy then it is likely that smoking prevalence would continue to gradually decline, but a more assertive local Tobacco Control Strategy is needed if Sheffield is to see a step change in reducing smoking prevalence and in achieving a smokefree generation by 2025, in line with Breathe 2025.

The evidence used to develop the Tobacco Control Strategy and Future Commissioning Model includes an assessment local need and demand, national and international guidance, best practice and best evidence. The new strategy and future commissioning model are based on a detailed Tobacco Health Needs Assessment 2016-17 which has been developed in collaboration with partners in the city, through the Tobacco Control Board. In addition, evidence from International exemplars has been considered, where a real reduction in population prevalence has occurred including New York, Australia and California. Proposed commissioning is in line with the current best global evidence and adherence to national & international guidance (including WHO's 6 strands MPOWER).

2. HOW DOES THIS DECISION CONTRIBUTE ?

2.1 The proposal will contribute to achieving a number of the ambitions within the Corporate Plan.

The vision of the proposed new Tobacco Control Strategy is that Sheffield people live longer and healthier lives, smokefree; there is a smokefree generation in Sheffield by 2025 (in line with the ambition of Breathe 2025); that Sheffield children grow up in a city where smoking is unusual; and that Sheffield is a smokefree city in which to live, work and play.

The proposal will mean that Sheffield increases its profile as a smokefree city. Those who live, work and learn in the city will enjoy smokefree public spaces. Those who visit the city will be able to visit family-oriented and sporting attractions and key public spaces which are free from cigarette smoke and smoking related litter.

This proposal will reduce inequalities and make Sheffield fairer. Tobacco is a major cause of health inequalities, leading to ill-health and early death. Those in more deprived areas of the city who may be least able to afford an addiction to tobacco, tend to be most addicted and least able to quit as they are surrounded by other people who smoke heavily. The most deprived areas of the city are targeted by those selling cheap and illicit tobacco which brings serious organised crime into neighbourhoods and drives out legitimate businesses. This proposal aims to reduce inequalities caused by tobacco by investing most heavily in those areas and groups where smoking prevalence is highest, where smoking is one of many complexities, where those who want to quit will require the most intensive support, and where those who smoke are least able to afford to quit.

There is no impact on climate change.

This proposal has economic impact in that it aims to hold the price on tobacco and eradicate cheap and illicit tobacco from neighbourhoods. This will free business units for legitimate use which will support thriving neighbourhoods, rather than illicit use which brings serious organised crime into neighbourhoods.

3. HAS THERE BEEN ANY CONSULTATION?

3.1 There has been consultation over a 12 month period with partners through the Tobacco Control in developing the proposals which are now put before Cabinet.

There has been a 6 week public online consultation through Citizen Space regarding specific proposals and the model. This has been widely advertised to key stakeholders including voluntary, community and faith sector partners. Consultation responses received through Citizen Space are summarised in brief in an appendix to this report. 266 people took part in the online survey, 82% of those who responsed were in favour of more work in schools, 64% were in favour of increased smokefree public places, 48% were in favour of more mass media campaigns, 45% were in favour of providing intensive support for the most addicted groups to quit, 46% were in favour of stop smoking medication being funded for the most addicted individuals, 50% were in favour of promoting vaping as a harm reduction measure.

Key NHS partners such as Community Pharmacy Sheffield, the Clinical Commissioning Group and the Local Medical Committee have been offered the opportunity to meet and discuss the proposals and shape the strategy and future commissioning model.

The smokefree spaces proposals have been consulted upon in detail through a separate survey led by a local commissioned VCF organisation

with a sample size of 2,000 Sheffield residents including current, ex-smokers, non-smokers and vapers (SOAR, 2016).

Sheffield's proposed future commissioning model has also been shared with South Yorkshire Local Authority Commissioners and the Regional Tobacco Lead for Yorkshire and the Humber.

Further consultation will be undertaken on proposed service re-design.

4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

4.1 Equality of Opportunity Implications

4.1.1 The proposal aims to make Sheffield fairer and reduce inequalities through effective control of Tobacco which is a major cause of inequalities. The future commissioning model proposal for stop smoking services specifically aims to reduce health inequalities through investing more heavily in those high prevalence groups who are most addicted, those with the most complex needs and those least able to afford to quit without significant investment and intensive support.

Overall, the changes set out in the strategy and future commissioning model are significantly positive for those in high prevalence smoking groups who will be most impacted by the changes. This includes:

- Men in high prevalence groups (e.g. routine and manual workers, men who have sex with men)
- Black and ethnic minority groups
- Children and young people
- Households of pregnant women
- Those with severe and enduring mental illness
- Armed forces veterans
- Those in areas of high deprivation with high smoking prevalence

Those who have less complex needs from low prevalence groups will receive a Universal Service offer which offers less intensive support than the current offer (group not 1-1, self funded NRT) but this is still a good offer. Fewer quits will be purchased but these will involve more intensive support and be better targeted to those in highest need.

The future commissioning model for cheap and illicit tobacco targets resources at more deprived neighbourhoods where cheap and illicit tobacco is more prevalent.

The future commissioning model for smokefree children and young people will focus efforts on primary schools which are feeders schools for

areas with higher smoking prevalence, on secondary schools in areas with higher smoking prevalence and on out of school environments for children and young people who are not consistently present at school through exclusion or disengagement with formal learning.

The future commissioning model for mass media and marketing will focus on those areas where the Tobacco Health Needs Assessment has identified highest need.

4.2 Financial and Commercial Implications

4.2.1 The changes proposed require no additional investment but require a commitment to maintain investment in Tobacco Control at the current levels (£987,000) for 3-5 years, despite a diminishing Public Health grant and Local Authority funding. This demonstrates a strong commitment to control Tobacco as the biggest killer and greatest threat to Public Health in Sheffield. However, in doing so, the proposed future commissioning model shifts investment away from individual quits into wider tobacco control and furthermore focusses investment to areas of greatest need in line with the Tobacco Health Needs Assessment.

All procurement and contract award activity will be delivered via a procurement professional from Financial and Commercial Services. The contract(s) will be monitored against agreed performance indicators to ensure value for money and effective use of the Public Health budget.

4.3 Legal Implications

4.3.1 Section 2B of the National Health Service Act 2006, requires each local authority to take such steps as it considers appropriate for improving the health of the people in its area. The steps that may be take to achieve this include:

a) providing information and advice:
b) providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way):
c) providing services or facilities for the prevention, diagnosis or treatment of illness;
d) providing financial incentives to encourage individuals to adopt healthier lifestyles;
e) providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment;
f) providing or participating in the provision of training for persons working or seeking to work in the field of health improvement;
g) making available the services of any person or any facilities;

Approval and implementation of the Tobacco Control Strategy and commissioning strategy will allow the appropriate steps to be taken to improve the health of people in the area.

The Council has a duty under section 149 of the Equality Act 2010 (the public sector equality duty) in the exercise of its functions to have regard to the need to:

a) eliminate discrimination, harassment, victiminsation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristics and persons who do not share it;
c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

This duty has been taken into account in drawing up the Tobacco Control Strategy, and in carrying out the consultation. Regard has been had to the responses to the consultation in finalising the strategy.

Under Section 111 of the Local Government Act 1972 local authorities have the power to do anything (whether or not involving the expenditure, borrowing or lending of money or the acquisition or disposal of any property or rights) which is calculated to facilitate, or is conducive or incidental to, the discharge of any of their functions.

The procurement of any goods, works or services by the Council which will flow from this strategic decision must be undertaken in accordance with all relevant provisions of the Council's Constitution including Contracts Standing Orders and all applicable procurement rules, including where applicable the Public Contracts Regulations 2105, and the Leader's Scheme of Delegations.

4.4 Other Implications

4.4.1 These proposals have been developed by Sheffield City Council Public Health officers from across different Portfolios in collaboration with key stakeholders and partners on the Tobacco Control Board, and with consultation of NHS partners such as the Clinical Commissioning Group, the Local Medical Committee and the Local Pharmaceutical Committee (Community Pharmacy Sheffield).

5. ALTERNATIVE OPTIONS CONSIDERED

5.1 Do nothing – business as usual re-commissioning or extend current contracts. This option will not provide the greatest opportunity to respond to changing need as evidenced by the Tobacco Health Needs Assessment, and to the diminishing resources available and will not provide the best opportunity to re-consider how to address population prevalence.

Collaborative commissioning as a sub-region of South Yorkshire - this

option is not recommended as the timescales are not conducive to be able to do so, and the aims and ambitions of the different Local Authorities are sufficiently different that there is not a good match.

Increase investment overall in Tobacco Control from additional NHS partner contributions - this remains an aspiration, as tobacco dependency is a chronic relapsing condition that usually starts in childhood and which is currently under-treated. The London Senate describe treating tobacco dependency as *"the highest value intervention for today's NHS and Public Health system, saving and increasing healthy lives at an affordable cost*" http://www.londonsenate.nhs.uk/helping-smokers-quit/ . However, further local NHS investment has not yet been agreed within the timescales for this procurement. These conversations will continue and will be led by the Director of Public Health.

6. REASONS FOR RECOMMENDATIONS

(Explain why this is the preferred option and outline the intended outcomes.)

6.1 The proposal set before Cabinet is the preferred option because:

It is based on detailed analysis of local need through a Tobacco Health Needs Assessment in line with commissioning good practice;

It is evidence based, drawing on good practice and evidence of what works in international contexts including the World Health Organisation MPOWER approach;

It has been developed over a 12 month period with the Sheffield Tobacco Control Board partners and is supported by the board;

It has been tested through a 6 week public consultation through Citizen Space and through specific consultation events with key stakeholders, including NHS partners;

An important caveat is that these proposals are not supported by the Yorkshire and Humber Regional Lead for Tobacco Control or by ASH, as they include a reduction of investment in individual quits which have a strong evidence base. Sheffield City Council recognises the expertise of ASH and the Regional Lead and welcomes this challenge. Where investment has been earmarked for projects with a less strong evidence base than 4 week quits, a research partnership will be sought to robustly evaluate the projects and add to the evidence base, not just for Sheffield but for wider Tobacco Control. The Director of Public Health will continue a dialogue with local NHS partners regarding increased NHS investment in stop smoking services.

Appendix 1 - Tobacco & the City: Strategy Summary

Tobacco & the City –Tobacco Control Strategy for Sheffield (A4 Summary)

WHY:

Smoking is still the biggest killer in the UK and is the biggest cause of health inequalities between rich and poor. Addiction to tobacco begins in childhood and takes hold into adulthood. We want significant reductions in prevalence across all groups (adults, routine & manual, pregnant women, 15 year olds) by 2025.

Vision

 Sheffield people live longer and healthier lives, smokefree A smokefree generation in Sheffield by 2025 (in line with the ambition of Breathe2025) Sheffield children will grow up in a city where smoking is unusual Sheffield will be a smokefree city in which to live, work and play

WHAT will be delivered locally?

A comprehensive local Sheffield Tobacco Control Programme including services, policy and communications. ***Services*** will focus on screening, prevention, cessation, and harm reduction and will be targeted to those most vulnerable to the health harms of tobacco and groups who smoke the most:

Smoke screening (Very Brief Advice, Ask, Advise, Act): 70%[1] of people who smoke want to quit. It will be routine in certain settings, such as health and social care and housing services (because of fire risk), to be asked about smoking status, advised to stop smoking, and offered a referral to stop smoking support.

Stopping starting (Prevention): It is estimated that 5 children per day start smoking in Sheffield, we aim to reduce this to zero by 2025 through targeted prevention and peer education in-reach in schools and youth settings.

Stopping Smoking (Cessation): Around 79,000 people in Sheffield smoke tobacco, just under 1 in 5 adults. Around 1 in 4 routine and manual workers smoke. We will offer a range of stop smoking support services, with more intensive and longer duration interventions targeted at highest prevalence groups. We will "pay by results".

Swapping Smoking for vaping (Harm Reduction): Electronic nicotine delivery systems ("e-cigarettes") are a significantly safer alternative to combustible tobacco. We will promote swapping as a harm reduction alternative for those who can't or won't stop smoking.

Policy change is considered a key area of Tobacco Control. Sheffield City Council as the Local Authority has opportunities to lead in this area in line with Corporate Plan goals to improve health & wellbeing:

Smokefree City: "It will be as normal to be in a smokefree space as it is now to wear a seat belt". Most young people do not remember a time when it was possible to smoke on buses, trains, planes, in cinemas, theatres and restaurants or not wear a seatbelt in cars; these once controversial public policy measures have become "normal". Current smokefree legislation

[1] References for statistics used in this summary can be found in the Sheffield Health Needs Assessment for Tobacco.

covers enclosed spaces but outdoor public spaces are not covered. A voluntary code in 2016 was agreed for Sheffield Children's Playgrounds in public parks for these to be smoke and vape free. Sheffield Health & Social Care NHS Foundation Trust was the first NHS Trust in the city to be completely smokefree including its grounds. We want to agree voluntary codes to extend smokefree status and make smokefree the new "social norm" in Sheffield e.g. all major city centre spaces and events targeted at children, young people and families; all health and social care premises; all learning environments; all sporting events and venues.

Holding the price on tobacco: we want to eradicate cheap and illicit tobacco from Sheffield's neighbourhoods. Cheap and illicit tobacco brings crime to Sheffield's neighbourhoods, and blights neighbourhoods by occupying retail and housing space which would otherwise have a legitimate use. It makes tobacco more affordable, and therefore accessible to younger people, and enables people to maintain their habit. It is estimated that smoking prevalence would drop by 10% if all cheap and illicit tobacco were eradicated. We will continue to disrupt the trade in cheap and illicit tobacco in Sheffield, working with neighbouring Local Authorities.

Social Norms approaches will be used to emphasise that over 80% of Sheffield adults do not smoke and that those smoking tobacco are a minority and declining. A communications strategy - including mass and social media campaigns- will support smokefree social norms and encourage people to stop smoking, or swap to an e-cigarette.

HOW will this be achieved?

Sheffield City Council Cabinet will be a leading voice for tobacco control in Sheffield. The Local Authority will work with ***Strategic Partners*** through its ***Tobacco Control Board***, as well as with wider partners, such as Public Health England. We will work with and consult with key stakeholders in the city.

Sheffield City Council will build upon the ***Tobacco Control Programme of 2014-17***. We will harness what worked best and learn from evidence regarding successful tobacco control programmes elsewhere. Our local strategy will be built on the foundation of the World Health Organisation's (WHO) six components of effective tobacco control (MPOWER): (1) Monitor tobacco use and prevention policies; (2) Protect people from tobacco smoke; (3) Offer help to quit tobacco use; (4) Warn about the dangers of tobacco; (5) Enforce bans on tobacco advertising, promotion and sponsorship; (6) Raise taxes on tobacco.

Sheffield City Council will use the opportunities afforded by being in a city with two universities to increase the evidence base for what is clinically efficacious, game-changing, and resource effective. A comprehensive health needs assessment for tobacco for Sheffield will guide decisions. In a difficult and austere environment, Sheffield City Council will strive to maintain its current levels of invest in tobacco control and seek increased investment from other partners in the city, including NHS partners.

How will we know if this is working?

Measures of success of this Tobacco Control Strategy for Sheffield will include: Tobacco Control Profiles for England (produced by Public Health England) Public Health Outcomes Framework (produced by Public Health England) Locally commissioned research, service data, surveys, evaluation, insight

SO WHAT?

Tobacco dependency is a chronic relapsing condition that usually starts in childhood and is currently under-treated. Treatment for tobacco dependency is the highest value intervention for todays' NHS and Public Health system, saving and increasing healthy lives at an affordable cost.

Effective Tobacco Control supports 4/5 priorities of the Sheffield City Council Corporate Plan: Strong economy; Thriving Neighbourhoods and Communities; Better Health & Wellbeing; Tackling Inequalities. Tobacco is a social justice, fairness, and health inequalities issue for our city 5 children a day in Sheffield start smoking Tobacco kills 16 people per week in Sheffield, and those who smoke can expect to have shorter, less healthy lives.

Tobacco is the most harmful, in health terms, to the most vulnerable in our city 12.5% of pregnant women in Sheffield smoke at the time their baby is born Tobacco makes life economically harder for those on low incomes Lower paid workers are more likely to smoke (e.g. routine and manual workers) 40% of people with mental health issues smoke, and spend proportionally more of their income on tobacco 77% of homeless people smoke

Our 7 "asks" to national government: 1) License tobacco retailers in the same way as alcohol retailers 2) Strengthen sentencing for profiting from cheap & illicit tobacco 3) Extend smokefree legislation to outdoor public spaces 4) Increase investment in national mass media 5) Restrict smoking in films/TV to 18+ certificates or after 9pm watershed 6) Impel the tobacco industry to share marketing and sales data by postcode.

Appendix 2 – Tobacco Control Models Diagram

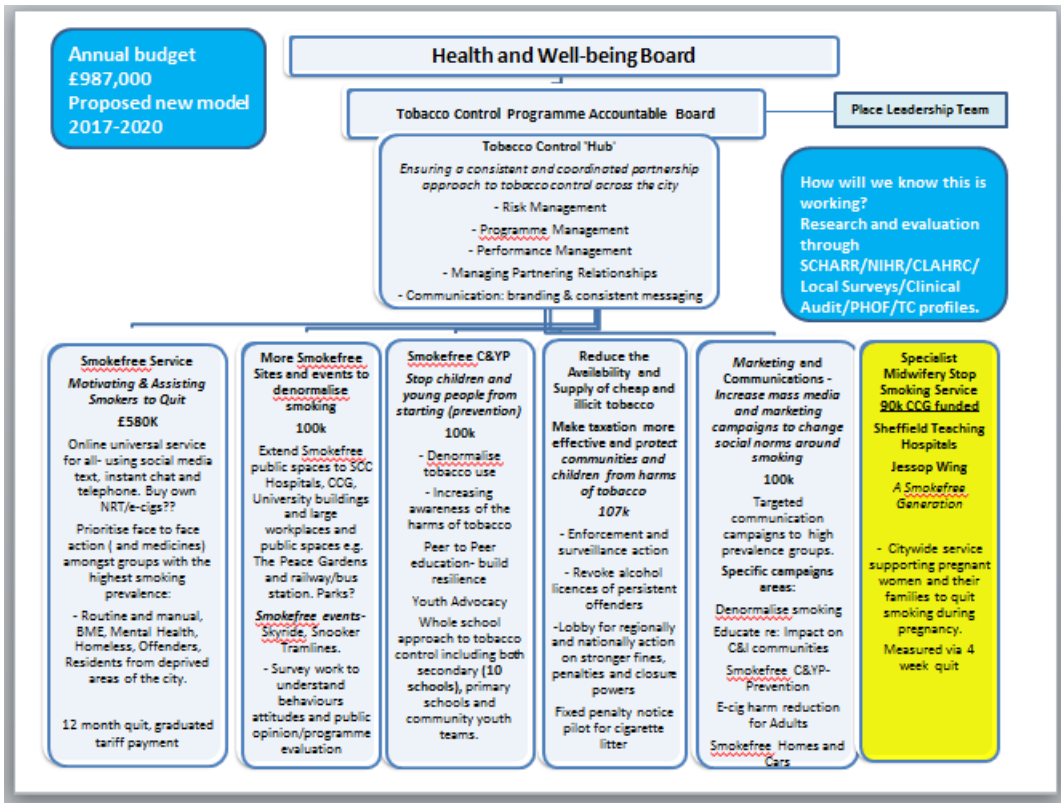

Figure 1 (above): proposed new model

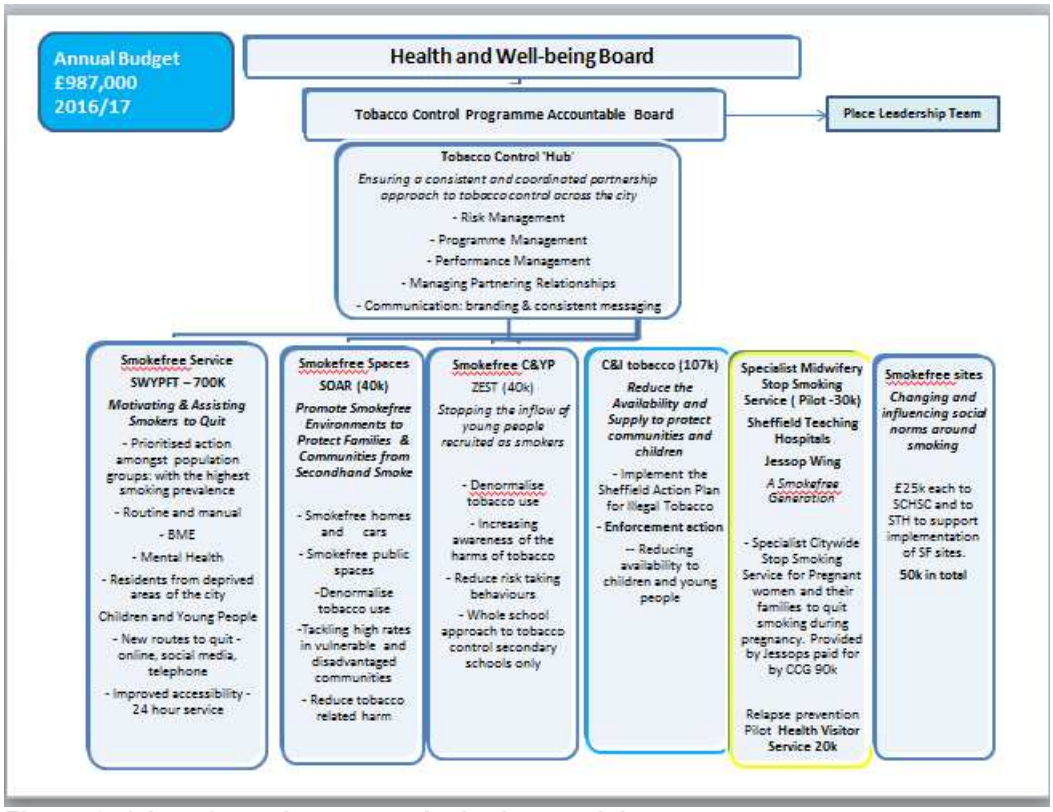

Figure 2: (above) previous commissioning model

Appendix 3 – Citizen Space Tobacco Control Consultation: Results "at a glance"

The Sheffield Tobacco Control Strategy Consultation 2017- 2022 - Results

Sheffield City Council and partners are refreshing the Tobacco Control Strategy for 2017-2022. On the 31st of March 2017 all our current tobacco control contracts are due to end. This provides an opportunity to review what we have in place, and consider what we can do better to support smokers in the city to stop, and children and young people not to start.

We offered a 6 week public consultation to understand views and opinions about the proposed new strategy. The results from the public consultation are below.

Who took part?

- 266 people took part via the online Citizen Space platform
- 45 % of the sample were males and 51% were females
- A cross section of responses were received from across the city
- Action on Smoking and Health UK (ASH) also responded to the consultation as a key partner

Age

1% of responses were from people aged 16-18 year olds,
10% of responses were from people aged 19-30 years,
23% of responses from people aged 31-40 years
28% of responses from 41-50 years
25% of responses aged 51-60,
10% of responses from people over 60
Less than 1% of responses did not record an age range

40% of the sample were parents and had children living with them who were under 18.

A high proportion of people who took part were White British 88% and 12% of responses were from black and minority ethnic communities.

Number of responses by Smoking Status:

Ex-smokers	32%
Never Smoked	43%
Smoker	12%
E-cig user (only using e-cigs)	6%
E cig user and smoker	6%
Not answered	0.8%

The proportion of consultation responses from specific population age groups are in line with the 2011 Sheffield Census population estimates for people of working age and older people; however young people were under represented in the consultation, as were men and black and minority ethnic communities (Sheffield Joint Needs Assessment 2017). Smokers are also underrepresented within the sample 12% of smokers took part. Current smoking prevalence amongst adults is 17% in Sheffield (Tobacco Control Profiles PHE).

We will do more work with groups under-represented in the sample to hear their views.

The Sheffield Tobacco Control Strategy Consultation: Results at a Glance

Of the 266 people who took part…….

82% of people are in favour of us doing more work in schools to prevent children from starting to smoke

64% are in favour of us doing more work to increase the number of Smokefree outdoor sites in the city (e.g. outside NHS buildings, hospitals, universities, Councils, leisure centres, at events such as Skyride/Sheffield half marathon/Christmas light switch on)

48% of people are in favour of us funding more work on mass media campaigns; targeting those who find it the most difficult to quit smoking and who are the most addicted (i.e. routine and manual workers, black and ethnic minorities, people with mental health conditions, pregnant women, children and young people, people living in deprived communities).

45% of people are in favour of us supporting only the most addicted groups who find it very difficult to quit smoking, rather than having a universal service that anyone can access

46% of people are in favour of us funding stop smoking medication (e.g patches, gum etc) for the groups of smokers who smoke the most, are the most addicted and find it hardest to quit.

50% of people are in favour of promoting vaping to current smokers as a harm reduction method

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