Sheffield Tobacco Control Strategy 2022-2027

"Striving for a Smokefree Future for All"

The primary aim of the Sheffield tobacco control strategy is to achieve the government's smokefree ambition. This is to make smoking obsolete or getting to 5% or less smoking prevalence, as quickly as possible and accelerating rates in decline compared to the current trends across all groups**.**

Achieving the government's Smokefree 2030 ambition of adult smoking rates of 5% or less across all social groups would alone deliver the levelling up mission to extend healthy life expectancy by 5 years[1]. However, if current trends continue, we will miss that target by 7 years and miss it by around double for the poorest communities[2]. We welcome the publication of Javed Khan's Independent Review (2022) "Making Smoking Obsolete". We support all the recommendations and aim to implement all of these within our available resource locally.

The public have traditionally been led to understand smoking as a personal lifestyle choice, when in reality this is an addiction, usually beginning in childhood, that is maintained and promoted by industry for commercial gain. It is estimated that 939 11–15-year-olds start smoking in Sheffield annually[3], and that two thirds of adult smokers started before they reached 18 years old[4]. The tobacco industry makes about £1billion of profit every year in the UK, with estimated profit margins of up to 67% off the back of our most disadvantaged communities[5]. The Javed Khan review urged the Government to strictly control the profitability of the tobacco transnationals. Reducing net profit margins from around 50% to no more than 10%, in line with the average for other businesses[6] , this could release £700 million excess profits a year [7] which should be used to fund tobacco control and other levelling up measures[8].

"Tackling smoking effectively through comprehensive tobacco control is part of the solution in lifting people out of poverty, levelling up and reducing health inequalities but also in helping to build resilience in health and social care systems and boosting the local economy" **Greg Fell Director of Public Health Sheffield.**

Who smokes? - In Sheffield around 60,000 (13.3%)[9] adults continue to smoke[10] leading to immense harm. Each year 5200 people are admitted to hospital and tobacco kills around 1000 people, more than Covid19 per year to date.

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[1]References

The Khan review Making smoking obsolete Independent review into smokefree 2030 policies Dr Javed Khan OBE (2022)Making smoking obsolete (publishing.service.gov.uk)

[2] Legal smoking age in England should rise every year, review recommends | The BMJ

[3] Action on Smoking and Health. ASH ready reckoner 2022. https://ash.org.uk/ash-local-toolkit/ash-ready-reckoner-2022/ .

[4] Youth smoking - ASH

[5] Reed H. The economic impact of a smokefree United Kingdom: technical report. 2021. https://ash.org.uk/wp-content/uploads/2021/10/EconomicImpactSmokeFreeUK-...

[6] Corporate Finance Institute. Profit Margin: Profit relative to revenue. https://corporatefinanceinstitute.com/resources/knowledge/accounting/pro...

[7] Featherstone H. Keep Coughing Up: establishing a Smoke-free 2030 Fund. 2021. https://ash.org.uk/wp-content/uploads/2021/06/Featherstone-H.-submission... [Accessed 7th June]

[8] APPG on Smoking and Health. Delivering a Smokefree 2030: The All-Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021. 2021. https://ash.org.uk/wp-content/uploads/2021/06/APPGTCP2021.pdf

[9] This data has been adjusted in 2022 as part of the ONS changes in data collection methodology for the annual adult smoking prevalence survey – now reading at 13.3% compared to 10.3%. Data anomalies relating to the population denominators have occurred also specifically in relation to the number of Sheffield student population recorded in the census data. We are therefore cautiously monitoring trends as we move forward to the next data point.

[10] Local Tobacco Control Profiles Local Tobacco Control Profiles - OHID (phe.org.uk)

Long-term smokers die on average 10 years earlier, but before this many will spend years in poor health living with a serious smoking-related illness. Smokers need social care support ten years earlier than never smokers, accounting for 8% of local authority spending on adult social care[11]. Overall, it is estimated that smoking costs Sheffield £193 million each year including costs of healthcare, social care, lost productivity, and fire costs[12].

The dependence on tobacco and subsequent outcomes are not shared equally across the richest and poorest in society. In the Southeast and North of city we see rates of smoking that are three times higher than in the Southwest of the city[13]. Often it is those who can least afford tobacco that spend the most on their smoking addiction.

People living with social and economic hardship and those with mental health conditions are most likely to find quitting tobacco difficult but are no less likely to make attempts to quit[14]. Smoking is more common in the communities they live in, they tend to have started younger and have higher levels of dependency on tobacco, all of which make it harder to quit successfully. Most people who smoke want to stop and many smokers state they wish they had never started[15]. On average it can take up to 30 attempts for smokers to successfully quit[16].

Cost of living crisis and smoking - We are facing a cost-of-living crisis that will hit the poorest hardest. More and more people are relying on food banks, dealing with debt and increased costs impacting on heating, lighting, utilities to cook and even access to water. The cumulative effects of managing this has ramifications on relationships and how people feel about themselves – feelings of guilt, shame, and low self-esteem with little hope for the future. This also impacts on people's sense of control and agency in the world, worsening mental health, but also affecting people's sense of ability to influence their own health. Whilst smoking will add to these financial pressures, it may also be the catalyst to prompt many more people to attempt to quit.

There has never been a more important time to support smokers to stop.

Stopping smoking benefits hard-pressed families, reducing poverty by increasing disposable household income. It helps create jobs, increases productivity, reduces NHS waiting lists and improves health and wellbeing[17]. Once smoking is obsolete in Sheffield the £122m- £305m that is spent on tobacco each year will be going back into communities' and families' pockets[18]. Quitting tobacco helps our most disadvantaged smokers restore family budgets, break the cycle of smoking addiction across generations, providing much needed funds that can be spent on household needs and in the local economy rather than on tobacco industry profits or tax[19]. Furthermore 11,000 fewer children will live in poverty in our city[20].

Reducing smoking is also good for the planet. Reductions in smoking prevalence positively impact on climate change. The tobacco supply chain is extremely environmentally harmful on a global scale. This

[11] Up in Smoke How Tobacco Drives Economic and Health Inequalities Sheffield Position ASH 2022.
[12] Action on Smoking and Health. ASH ready reckoner 2022. https://ash.org.uk/ash-local-toolkit/ash-ready-reckoner-2022/
[13] Sheffield Tobacco Needs Assessment 2021
[14] Up in Smoke How Tobacco Drives Economic and Health Inequalities Sheffield Position ASH 2022.
[15] Royal College of Physicians and Action on Smoking and Health. ASH at 50: stubbing out smoking since 1971. London: RCP, ASH 2021 Smoking and health 2021_full report_0 (4).pdf
[16] End of Smoking 2019 The-End-of-Smoking_final.pdf (ash.org.uk)
[17] Up in Smoke How Tobacco Drives Economic and Health Inequalities Sheffield Position ASH 2022.
[18] Action on Smoking and Health. ASH ready reckoner 2022. https://ash.org.uk/ash-local-toolkit/ash-ready-reckoner-2022/
[19] Legal smoking age in England should rise every year, review recommends | The BMJ
[20] Up in Smoke How Tobacco Drives Economic and Health Inequalities Sheffield Position ASH 2022.

impact is particularly felt through the consequences of cultivation/farming, curation, and manufacturing, pollution, soil degradation, biodiversity losses, deforestation, cigarette litter[2122].

The secret of our success - In delivering the 2017-2022 tobacco control strategy we have shifted away from a focus solely on individual behaviour change and focused on delivering more population level interventions. As a result, we have significantly reduced prevalence at a faster rate than before, falling from 17.6% (2017) in adults down to 13.3% (2021)[23].

Fundamental ways of working – Our approach to delivering the Sheffield Tobacco Control Strategy includes a mix of smokefree policy, services, action on illicit tobacco/age of sale, communication campaigns and harm reduction. These interventions impact on a range of environmental, social, economic, and behavioural factors that influence smoking behaviour and make it easier for smokers to stop and harder for children to start smoking. A multicomponent approach to tackling tobacco is required to meet the needs of the whole smoking population, not just to those who attend community Tobacco Dependence Treatment Services.

Our approach is underpinned by behavioural science models (COM-B and EAST)[24] to make it as easy as possible for people to quit their addiction for good. This includes creating more opportunities to quit, environments that make smokefree the norm and neighbourhoods that are not blighted by cheap and illicit tobacco, all of which can make it harder to break the addiction.

Campaigns use 'fresh starts and points throughout the year (e.g., New Year and Stoptober) to maximise motivation and create a sense of hope that resonate with smokers. We are person centred, community focused, compassionate, and non-judgemental. We meet smokers where they are at, placing our services at the heart of communities within voluntary sector organisations, primary care, housing, social care, debt advice agencies and secondary care and many more where smokers can access support.

Key achievements and evaluation of 2017-2022 strategy **During the last 5 years we have:**

- Implemented comprehensive smokefree site policies covering external grounds across many of our major public institutions in the city including Sheffield Teaching Hospitals, Sheffield Health and Social Care, Sheffield City Council, Sheffield Children's Hospital, Sheffield Hallam University, Sheffield Clinical Commissioning Group.
- Delivered over 30 smokefree campaigns targeting high prevalence groups (pregnancy, routine manual workers, children and young people, smokers with mental health conditions, disadvantaged smokers) with significant success reaching thousands of smokers via social media, targeted interventions, radio and ITV On Demand. Campaigns include "We care", "Closer each time", "You are strong enough", "QuitforCovid", "Smokefree mum's and families" more details can be found here www.SmokefreeSheffield.org
- Since the inception of the Smokefree Sheffield website in 2018 we have had 25,000 people visiting the site and 45,000 unique page views, with the support page being the most visited. This demonstrates audiences searching for our website showing a raised awareness of brand and desire to access information.
- Supported 4500 adult smokers to achieve a 12-week quit via our Stop Smoking Service.
- Supported around 750 women to quit smoking during pregnancy.

[21] Zafeiridou et al. 2018). https://doi.org/10.1021/acs.est.8b01533.
[22] https://ash.org.uk/uploads/Tobacco-Environment.pdf
[23] Local Tobacco Control Profiles Local Tobacco Control Profiles - OHID (phe.org.uk)
[24]

- Trained over 176 children to become Smokefree peer educators across Sheffield's secondary schools and supported 138 children to achieve a 4-week quit.
- The Sheffield Trading Standards Team during the last few years have closed 10 premises by revoking alcohol licenses and legal prosecutions. During 2021/22 alone they removed 804,000 cigarettes and 259kg of loose tobacco from the streets of Sheffield.
- Implemented the QUIT screening programme in secondary care with a range of partners and during the last 6 months generated around 400 referrals for continued support with the Community Stop Smoking Service
- Developed a comprehensive harm reduction approach and e-cigarette policy for the city including and e-cigarette friendly service.

Evaluation of impact

The Smokefree Children's Service overall has not impacted significantly on our current rates of uptake and smoking prevalence amongst children and young people during the last 5 years, and many of our major public institutions in the city have now introduced Smokefree site policies. Therefore, we ended the funding for these two elements of the programme and have redistributed the money upstream on prevention and early intervention for the next 5-year strategy. Specifically, incentives to support pregnant women to quit smoking and increased investment in SCC Trading Standards enforcement. Investment in Trading Standards tackles the availability and accessibility of cheap and illicit tobacco to prevent children from starting to smoke and reduce access to age restricted cigarettes and vapes.

We have also increased investment in Tobacco Treatment Services, now known as the Tobacco Dependency Treatment Service, to ensure the service can deal with increasing demand arising from the QUIT programme - treatment of tobacco dependency in secondary care. See Appendix A for strategy model 2022-2027. An even more assertive local Tobacco Control Strategy is needed if Sheffield is to see a step change in reducing smoking prevalence and continuing to accelerate the trend in reductions across all social groups.

National Strategy and Indicators

In 2017 the government Tobacco Control Plan for England: Achieving a Smokefree Generation, set out three ambitions to be achieved in their 5-year plan[25]. Sheffield's performance is measured against these national indicators and RAG rated below. These include:

* Reduce the prevalence of 15-year-olds who regularly smoke from 8% to 3% or less. *Current Sheffield prevalence is 5% in 2022 was 8% in 2017 (red)*

* Reduce smoking prevalence amongst adults in England from 15.5% to 12% or less. *Current Sheffield prevalence in 2022 is 13.3% was 17.6% in 2017 (green)*

* Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population. *Current prevalence in 2022 in Sheffield is 19.9% compared to 27.7% in 2017(green). However still twice as likely to smoke as general population (red)*

* Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less by the end of 2022. *Current Sheffield Smoking in pregnancy rate is 9.4% in 2022 and was 12.7% in 2017 (amber)*

Smoking rates in the adult population and routine and manual workers have dramatically reduced in Sheffield between 2017 -2022. However routine and manual workers are twice as likely to smoke than the general population and there is work to do to reduce the inequality gap here.

[25] National policy, Healthy Lives, Healthy People: A Tobacco Control Plan for England 2015 *https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england*

We have missed the national targets in children (15-year-olds), and pregnancy, although we have still seen good progress made in both these areas. For example, there are around 373 fewer women smoking in pregnancy each year and rates of children smoking are at an all-time low, an estimated 2% of 11–15-year-olds smoking and 5% of 15-year-olds. Sheffield ranks the third lowest smoking prevalence in pregnancy in Yorkshire and Humber and is in line with the national average of 9.1%.

In 2016 Action on Smoking and Health UK also recommended that the following target was set "*Smoking among people with a mental health condition declines to be less than 5% by 2035, with an interim target of 35% by 2020".*

In 2019, local data held by Sheffield Health and Social Care (SHSC), showed that 37.9% of service users on the Serious Mental Illness register were smokers compared to 40.1% of people in 2017 suggesting improvement over the last 5 years, but rates that are significantly higher than the Sheffield average of 10.3%. Amongst service users on Acute Mental Health Wards, smoking prevalence is significantly higher at 55%, which has reduced from 66% in 2016/17 according to Insight work undertaken by SHSC.

The delivery of the Tobacco Control programme contributes to the achievement of the Sheffield Joint Health & Wellbeing Strategy 2019-2024 overarching commitment to reducing, and one day eliminating, health inequalities in Sheffield.

Forward Projections

Sheffield is one of the highest performing and proactive Local Authorities in the country in relation to the delivery of comprehensive tobacco control and impacts on smoking prevalence. We have the 6th lowest prevalence in Yorkshire and Humber region and lowest in South Yorkshire and are in line with the England average of 13% Local Tobacco Control Profiles – Data – OHID (phe.org.uk).

The refreshed multi-agency strategy will build on the achievements of the 2017-2022 strategy which has already contributed to significant reductions in adult smoking prevalence in Sheffield, with smoking rates now at around 13.3% (2021) compared to 17.6% in 2017. This decline has been seen across all social groups, and the 4.3% reduction equates to around 20,000 smokers quitting over the 5-year period. This is a 0.8% reduction each year compared to a national average decline of 0.4%.

This success demonstrates the level of work undertaken across the programme and by the multiagency partnership as we are measured against many areas which are much more affluent than Sheffield and will start from a baseline of fewer smokers.

Over this five-year period the number of smoking related deaths from heart disease, stroke, COPD and lung and oral cancer have also continued to fall, as has the prevalence of heart disease[26]. Furthermore, from those who have successfully quit, we estimate that £100m in savings is now back in the pocket of local families and available to be spent each year in the local economy on other goods. We hope to get to the 5% smoking prevalence target by 2027, three years faster than the government ambition. However, this early target achievement aim should not detract from the urgency to deliver. We must strive to support our most vulnerable communities out of an addiction that traps them in a cycle of poverty and illness across generations to realise the wide-ranging health and economic benefits as early as possible.

Our Vision **-** we wish to eliminate the harm smoked tobacco products cause our communities by transforming Sheffield to a smokefree city by 2030 in which to live, work and play. We want to create a smokefree generation. Sheffield people live longer and healthier lives, smokefree. Sheffield children will grow up in a city where smoking is unusual.

[26] Sheffield Tobacco Needs Assessment 2021

Our Goal **-** in line with the Government ambition Smokefree 2030, we wish to make smoking obsolete, and accelerate declines in prevalence in adults to 5 percent or less across all social groups However we wish to get there by 2027

Our local approach - has been designed utilising a comprehensive needs assessment, service evaluation, behavioral science, national and international research, evidence reviews and guidance. It is developed in collaboration with the tobacco control board partners, a wide range of city stakeholders, Action on Smoking and Health UK and the Office for Health Improvement and Disparities (previously Public Health England).

Our programme of interventions is based on the best global evidence, the World Health Organisation MPOWER model. The model has six strands, and our approach is based on these:

* stopping the promotion of tobacco.
* making tobacco less affordable.
* effective regulation of tobacco products.
* helping tobacco users to quit.
* reducing exposure to second-hand smoke.
* effective communications for tobacco control.

In addition, evidence from countries where a real term reduction in population prevalence has occurred have been considered. These are countries and states that have implemented comprehensive tobacco control programmes i.e., the MPOWER model, and have the lowest smoking prevalence in the world e.g., USA, specifically New York and California, as well as New Zealand and Australia[27][28][29][30].

Our three aims:

1. **Increase the number of smokers who attempt to quit and achieve success each year**
   It is hard to stop smoking and overcome tobacco addiction. We need to do more to make it easier for people who smoke to quit. We need to change the environment we live in to enable more people to overcome that tobacco addiction.

2. **Create a smokefree generation by increasing the number of children and young people who never smoke**
   Smoking harms children and young people and most smokers start in childhood. We need to prevent children and young people from starting to smoke and we need to help their parents and the adults around them to quit smoking.

3. **Eliminate inequities in smoking rates and smoking-related illnesses**
   Smoking impoverishes, amplifies, and drives inequalities harming some people more than others. This includes people living in the most deprived areas of Sheffield and in poverty, those who live in social housing, routine and manual workers, black Asian and ethnic minorities, and people with mental health conditions. Smoking during pregnancy is also more common in disadvantaged groups and younger mothers. We need to remove these inequities and prioritise action amongst these groups.

[27] New York Tobacco Control Programme *https://www.health.ny.gov/prevention/tobacco_control/program_components.htm*
[28] California Tobacco Control Programme *http://www.cdph.ca.gov/programs/Tobacco/Pages/default.aspx*
[29] Australia Tobacco Control Programme http://www.tobaccoinaustralia.org.au/14-3-tobacco-control-campaigns-in-australia-experi
[30] New Zealand Tobacco Control Programme Tobacco control in New Zealand | Ministry of Health NZ

We will achieve these aims by:

Delivering comprehensive marketing and communication campaigns:
Communication and campaigns are a critical component of the comprehensive Sheffield tobacco control programme[31]. They assist in influencing population level quits outside of the Tobacco Treatment Service, reaching beyond the 5% who attend the service. The focus of media and communication campaigns will be on those populations where the Tobacco Health Needs Assessment 2021 has identified the highest prevalence or greatest challenge e.g., those smoking in pregnancy, routine and manual occupations, smokers living in deprived communities and poverty, people with mental health conditions and children.

Campaigns will focus on attitude shifting, harms from tobacco, changing beliefs, communicating hope, educating smokers about what support is available locally, generating, nudging towards, and increasing quit intentions[32]. Campaigns aim for high reach and consistent exposure over time with mix of positive and negative approaches[33] [34]. We have a track record of delivering highly effective and wide-reaching campaigns motivating quit attempts. Significant engagement examples include "Quit for Covid", "We Care", "Closer Each Time" and "You are Strong Enough" which can be found on our Smokefree Sheffield website www.SmokefreeSheffield.org.

***One Stop Shop Advice for all smokers*:**
We will continue to provide a wide range of information via our Smokefree Sheffield website. This is the one stop location for smokers to access information on stop smoking support available, positive quitting stories, nicotine replacement therapy, vaping, media reports on cheap and illicit tobacco, information on Smokefree homes and much more. We will continue ensure information about our services and interventions are easily accessible for all smokers and make reasonable adjustments as appropriate.

Tackling Cheap and Illicit Tobacco:
Cheap and illicit tobacco is more affordable, enabling people to maintain their habit and making tobacco in reach of children at pocket money prices. It is estimated that smoking prevalence would drop by 10% if all cheap and illicit tobacco were eradicated. Indirectly, this would reduce crime in Sheffield neighbourhoods and free-up retail and housing space which would otherwise have a legitimate use. There will continue to be a focus on eradicating cheap and illicit tobacco from Sheffield neighbourhoods and we will measure by getting the street price of illegal tobacco as close to the true retail price (current average £10.80 a packet of 20 cigarettes [2022]). This will ensure our efforts to support smokers to quit is not undermined
We will deliver enforcement regulations by Trading Standards i.e., illegal, and underage sales, proxy purchasing, and point of sale display for both tobacco and e-cigarettes. Actions include:

- Trading standards will provide technical and sophisticated surveillance operations as well as 'test' purchasing to reduce illegal sales of cigarettes and tobacco products.

- Increasing investment in Trading Standards for more technical and sophisticated surveillance operations. Traders have changed tactics from large stocks on site to smaller supplies which means longer surveillance operations are required to secure robust prosecutions.

- Enforcement, inspection and 'test purchasing' to combat illegal sales of vapes and e-cigarettes. This includes under-age sales and sales of non-compliant or counterfeit products. This is particularly

[31] The Behaviour Change Wheel Book - A Guide to Designing Interventions Michie, S., Van Stralen, M. M., & West, R. (2011). The behaviour change wheel: a new method for characterising and designing behaviour change interventions. Implementation science, 6(1), 42
[32]
[33] Optimising tobacco control campaigns within a changing media landscape and among priority populations | Tobacco Control (bmj.com)
[34] Evidence into Practice: Motivating quitting through behaviour change communications 2021Communications-Evidence-Into-Practice.pdf (ash.org.uk)

important currently as use of e-cigarettes amongst 11–17-year-olds has increased over the past year.

De-normalising tobacco use and Smokefree Spaces and Places:
Smokefree homes and outdoor policies help to change social norms around smoking by reducing the visibility and acceptability of smoking, whilst discouraging young people from starting to smoke. Smokefree policies contribute to a reduction in the amount that people smoke, increase the number of people who quit and support relapse prevention. Cochrane reviews found consistent evidence of reduction in hospital admissions for cardiac events following the implementation of smokefree laws, as well as reductions in cigarette litter.

Current smokefree legislation 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.

As a local survey identified that the majority of the Sheffield public support outdoor smoke-free environments, smokefree policies will be reviewed with partners and officers will be allocated time to continue policy work to ensure they remain in place and are enforced.

Targeted work in workplaces and public open spaces will continue in a variety of settings:

- Extending and maintaining smokefree public spaces - SCC, hospitals, CCG, University campuses, transport hubs and large workspaces/public spaces e.g. The Peace Gardens
- Smokefree School Sites
- Smokefree City events (e.g., Sheffield by the Sea)
- Survey and consultation to understand behaviors, attitudes, public opinion, and programme evaluation

Increasing Smokefree homes:
In England in 2018, 55% of children aged 11 to 15 reported being exposed to second-hand smoke at home, with 13% being exposed daily. 23% of children were exposed to cigarettes in cars, with 3% exposed to tobacco smoke on a regular basis. Exposure to second-hand smoke also correlates with smoking prevalence in 11–15-year-olds, with 44% of regular smokers having been exposed to second-hand smoke compared to 11% of non-smokers (SDD, 2018).

Smokefree homes brief interventions will continue to be delivered across the 0-19 pathway in community, primary and secondary care settings and across SCC housing. There will be additional focus on under 5's and the Roma Slovak Community where rates of smoking in the home are very high (at around 60% in Sheffield).

Exposure rates are also significantly higher among children and babies from poorer backgrounds, and children living in social housing are 3-4 times more likely to be exposed to tobacco smoke. Awareness of the dangers of second-hand smoke in homes and cars is low among deprived groups and so brief interventions will utilise Make Every Contact Count (MECC) opportunity to talk to residents about second-hand smoke.

Screening Very Brief Advice, Ask, Advise, Act:
We aspire that very brief advice will become standard in settings such as social care, housing, citizens

advice, food banks, voluntary and community and faith sector, and substance misuse services. Primary and secondary health care professionals should also be offering Very Brief Advice.

***Tobacco Treatment Services (Adults and Children*)**:
Previously known as the Stop Smoking Service, the service will change name to the Tobacco Dependency Treatment Service to reflect the treatment of addiction, reframing away from a false concept of "lifestyle choices". The service will continue to offer a range of intensive tobacco treatment interventions (face to face, online, video conferencing and telephone support) targeting high prevalence groups. The services provide behavioural support and free Nicotine replacement Therapy or e-cigarettes (vapes) or Champix via prescription to achieve a 12-week carbon monoxide verified quit in adults. In 11–17-year-olds, a 4-week carbon monoxide- verified quit will be achieved with support of NRT will be achieved (in line with the evidence base). Service optimisation will be informed by the youth council, and we will maximise the use of social media platforms to promote the local offer, as well as working closely with local schools.

We have undertaken behavioural insight work with Sheffield Hallam University to understand the enablers and barriers in stopping smoking and accessing support in high prevalence groups. The findings from the report by Thorneloe et al (2022)[35] will shape the way the programme is delivered to meet their needs. We will review the effectiveness of this through the lifetime of the strategy. Examples are how this work has shaped provision include:

- Smokers will be able to access cut down to quit programmes to increase and develop their readiness to quit.
- Stress management and coping skills will be central to the delivery of all programmes, and this will be promoted to all smokers.
- Communications to educate on the service offer will focus on use of role models to increase confidence, change social norms and perceptions around who accesses the service to increase uptake amongst our priority groups "People like you successfully quit, cut down or switch with us".

Work will be undertaken to understand the groups that may find it difficult to use existing local services because of their social circumstances, gender, language, or culture, and service improvements will be put in place to reduce these barriers.

The tobacco dependency treatment service shall ensure that it offers a reasonable adjustment under the Equality Act to service delivery, where appropriate, to ensure ease of use for all client's groups, including those with a learning disability, mental illness, autism, and physical disability or sensory impairment. This may include, but not be limited to, the offer of remote delivery, posting out of materials and treatment (e.g., NRT), out of hours service delivery including evenings, longer appointment times, easy to read information, information in alternative formats etc.

QUIT programme -Screening for Tobacco Dependency in Secondary Care:
We will continue to have QUIT in secondary care for screening, identification, and treatment of tobacco addiction in hospital. These patients will then be referred onwards to Community Tobacco Treatment Services. This covers Sheffield Teaching Hospitals, Sheffield Health, and Social Care and also Sheffield Children's Hospital.

[35] Thorneloe., R.J., Lamb, M., Humphreys, H., Clarke, E., & Arden, M. (2022). Understanding the enablers and barriers in stopping smoking and accessing support in high prevalence groups. A report commissioned by Sheffield City Council.

Stopping use of smokeless tobacco:
We will provide training to local stakeholders about Smokeless tobacco and what support is available via the service. Alongside this we will identify people who use smokeless tobacco so referrals from GPs, dentists, pharmacists, and other healthcare professionals can be generated.
The Tobacco Treatment Service will provide support/advice as part of its comprehensive specialist offer, and these will be delivered in a range of healthcare and community settings (for example, GP or dental surgeries, community pharmacies and community centres.

A particular piece of work will be completed to consult with local voluntary and community organisations that work with, or alongside, South Asian communities to understand their specific issues and needs in relation to smokeless tobacco and ensure service provision is culturally appropriate and accessible.

Approach to children and education – prevention and education toolkit for schools:
We will develop a legacy toolkit for schools which will include resources for guiding schools through developing a whole school approach to tobacco and e-cigarettes. This will include examples of smoke and vape-free policies including parents, contractors a staff and pupils, Very Brief Advice training for staff and a comprehensive ASDAN peer education programme. The toolkit will include information on delivering tobacco and e-cigarette education within the curriculum and assemblies as well as myth busting information and presentations tailored for families and young people.

Harm reduction
Vaping is significantly less harmful than smoking, as you don't inhale the toxic tar and carbon monoxide you get from tobacco smoke. But they're not risk-free! However, those adults who switch will reduce their chances of developing smoking related illness. [36].

We will promote switching from tobacco to vaping in line with current evidence from OHID and support will be offered via the Tobacco Treatment Service. Support to quit is always the first approach however for individuals who are not currently willing or able to stop smoking, they will be encouraged to switch to vaping or use of nicotine replacement therapy as a harm reduction measure.

We continue to recommend that smokers who wish to use vapes to quit (and are not accessing support via the Tobacco Treatment Service) should purchase their products from a retailer that is committed to selling products that are registered with Medicines and Healthcare Products Regulatory Agency (MHRA) under the Tobacco Products Directive 2016. The Sheffield e-cigarette/vaping policy position statement outlines the evidence base and our commitments***.***

According to the recent survey by ASH UK current vaping among children 11-17 is up from 4% in 2020[37], around the time of the first lockdown, to 7% in 2022. While the increase is a cause for concern, and needs close monitoring, 92% of under 18s who've never smoked, have also never vaped and only 2% have vaped more frequently than once or twice. Disposables are now the most used product among current young vapers, up from 7% in 2020 to 52% in 2022, with Geek Bar and Elf Bar overwhelmingly the most popular brands. Despite it being illegal to sell vapes to under 18s, the most common source of supply for underage vapers is shops (47%). Over half (56%) of 11–17-year-olds reported being aware of e-cigarette promotion, most frequently in shops, or online (Tik Tok, then Instagram were the most frequently mentioned sources).

We will continue monitoring of trends and surveillance of youth vaping at a local level and we have added more funding for enforcement action and age of sale of vapes and tobacco. We will undertake an

[36] Royal College of Physicians report on e-cigarettes:
https://www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction-0
[37] Use-of-e-cigarettes-among-young-people-in-Great-Britain-2022.pdf (ash.org.uk)

awareness raising campaign to get the facts straight on vaping for schools, children, and parents. We will also stand up a local operational (CYP) vaping group to coordinate action and share intelligence including representation from Trading Standards, Safeguarding, Public Health, Tobacco Treatment Service, the Corner, Learn Sheffield, Youth Council and Youth Strategy.

Vapes are an age restricted product as a precautionary measure as the long-term effects are unknown. We will advocate nationally for strengthening of e-cigarette regulations to prohibit child-friendly packaging and labelling of vaping products and to prevent heavy promotion of vaping on social media and at point of sale. However, e-cigarettes are much less harmful than smoking and they remain an important tool for helping adult smokers to stop. Regulation needs to be balanced to both protect children and support adult smokers.

Finally, we will undertake mitigation action to reduce the environmental impacts of Vapes/e-cigarettes. E-cigarettes will be sourced from reputable brands and retailers registered with the Medicines & Healthcare products Regulatory Agency and who are committed to recycling policies, setting up disposal points to ensure appropriate disposal of batteries. These retailers' products will last longer and will not need replacing as often will promote positive recycling habits and prevent waste from entering the environment.

Smokefree pregnancies - Giving babies and children best start in life:
Smoking in pregnancy is associated with low-birthweight, miscarriage, stillbirth, and postnatal deaths. These adverse outcomes mean it is essential to support women to quit during pregnancy and reduce relapse to smoking after birth. It also provides an opportunity to prevent future uptake in children by increasing number of smokefree homes.

We will continue to support pregnant women and their families to stop smoking via our Specialist Midwifery Tobacco Treatment Service run by Sheffield Teaching Hospitals, Jessop Wing. This will include behavioral support and deliver direct supply of nicotine replacement therapy for pregnant women and their families each year. Women in hospital will also be offered nicotine management. Smokefree homes interventions and onward referral to Health Visiting relapse prevention service will be standard.

There is a very strong evidence base for incentives in pregnancy. They are nationally recommended by the Smoking in Pregnancy Challenge group (developed by ASH and OHID)[38] and NICE (2022)[39]. SCC will also fund incentives in pregnancy to support increases in the number of women who quit during pregnancy. In Greater Manchester incentives increased quitting from 30% to 70% and increased engagement by women into the service from 41% to 69%[40].

How will we know if this is working? **Measures of success**

Measures of success of this Tobacco Control Strategy for Sheffield will include:

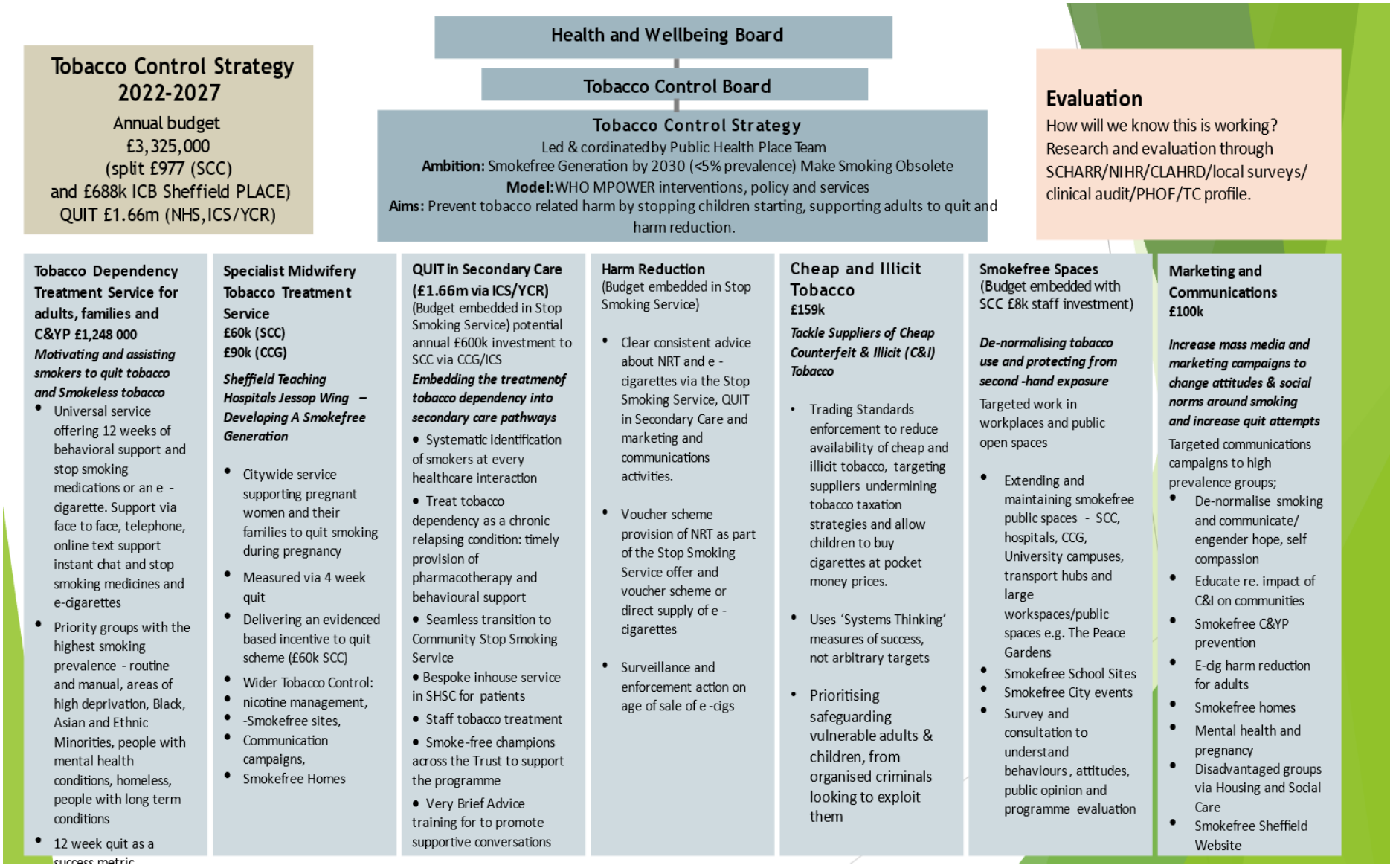
▪ Tobacco Control Profiles for England (produced by Office of Health Improvement and Disparities)

▪ Public Health Outcomes Framework (produced by Office of Health Improvement and Disparities)

[38] Smoking in Pregnancy Challenge Group (2019) Evidence into Practice Supporting smokefree pregnancies through incentive schemes 2019-Challenge-Group-Incentives-Briefing_v4-FINAL.pdf (smokefreeaction.org.uk)
[39] Tobacco: preventing uptake, promoting quitting, and treating dependence 2021. NICE Overview | Tobacco: preventing uptake, promoting quitting, and treating dependence | Guidance | NICE
[40] Tappin et al (2015) Financial incentives for smoking cessation in pregnancy: randomised controlled trial | The BMJ

- Locally commissioned research, service data, surveys, evaluation, insights

Appendix A


Tobacco Control Strategy 2022-2027
Annual budget
£3,325,000
(split £977 (SCC)
and £688k ICB Sheffield PLACE)
QUIT £1.66m (NHS,ICS/YCR)
Health and Wellbeing Board
Tobacco Control Board
Tobacco Control Strategy
Led & cordinated by Public Health Place Team
Ambition: Smokefree Generation by 2030 (<5% prevalence) Make Smoking Obsolete
Model: WHO MPOWER interventions, policy and services
Aims: Prevent tobacco related harm by stopping children starting, supporting adults to quit and harm reduction.
Evaluation
How will we know this is working? Research and evaluation through SCHARR/NIHR/CLAHRD/local surveys/ clinical audit/PHOF/TC profile.
Tobacco Dependency Treatment Service for adults, families and C&YP £1,248 000
Motivating and assisting smokers to quit tobacco and Smokeless tobacco
• Universal service offering 12 weeks of behavioral support and stop smoking medications or an e - cigarette. Support via face to face, telephone, online text support instant chat and stop smoking medicines and e-cigarettes
• Priority groups with the highest smoking prevalence - routine and manual, areas of high deprivation, Black, Asian and Ethnic Minorities, people with mental health conditions, homeless, people with long term conditions
• 12 week quit as a success metric
Specialist Midwifery Tobacco Treatment Service
£60k (SCC)
£90k (CCG)
Sheffield Teaching Hospitals Jessop Wing – Developing A Smokefree Generation
• Citywide service supporting pregnant women and their families to quit smoking during pregnancy
• Measured via 4 week quit
• Delivering an evidenced based incentive to quit scheme (£60k SCC)
• Wider Tobacco Control:
• nicotine management,
• -Smokefree sites,
• Communication campaigns,
• Smokefree Homes
QUIT in Secondary Care (£1.66m via ICS/YCR)
(Budget embedded in Stop Smoking Service) potential annual £600k investment to SCC via CCG/ICS
Embedding the treatmentbf tobacco dependency into secondary care pathways
• Systematic identification of smokers at every healthcare interaction
• Treat tobacco dependency as a chronic relapsing condition: timely provision of pharmacotherapy and behavioural support
• Seamless transition to Community Stop Smoking Service
• Bespoke inhouse service in SHSC for patients
• Staff tobacco treatment
• Smoke-free champions across the Trust to support the programme
• Very Brief Advice training for to promote supportive conversations
Harm Reduction
(Budget embedded in Stop Smoking Service)
• Clear consistent advice about NRT and e - cigarettes via the Stop Smoking Service, QUIT in Secondary Care and marketing and communications activities.
• Voucher scheme provision of NRT as part of the Stop Smoking Service offer and voucher scheme or direct supply of e -cigarettes
• Surveillance and enforcement action on age of sale of e -cigs
Cheap and Illicit Tobacco
£159k
Tackle Suppliers of Cheap Counterfeit & Illicit (C&I) Tobacco
• Trading Standards enforcement to reduce availability of cheap and illicit tobacco, targeting suppliers undermining tobacco taxation strategies and allow children to buy cigarettes at pocket money prices.
• Uses 'Systems Thinking' measures of success, not arbitrary targets
• Prioritising safeguarding vulnerable adults & children, from organised criminals looking to exploit them
Smokefree Spaces
(Budget embedded with SCC £8k staff investment)
De-normalising tobacco use and protecting from second -hand exposure
Targeted work in workplaces and public open spaces
• Extending and maintaining smokefree public spaces - SCC, hospitals, CCG, University campuses, transport hubs and large workspaces/public spaces e.g. The Peace Gardens
• Smokefree School Sites
• Smokefree City events
• Survey and consultation to understand behaviours, attitudes, public opinion and programme evaluation
Marketing and Communications
£100k
Increase mass media and marketing campaigns to change attitudes & social norms around smoking and increase quit attempts
Targeted communications campaigns to high prevalence groups;
• De-normalise smoking and communicate/ engender hope, self compassion
• Educate re. impact of C&I on communities
• Smokefree C&YP prevention
• E-cig harm reduction for adults
• Smokefree homes
• Mental health and pregnancy
• Disadvantaged groups via Housing and Social Care
• Smokefree Sheffield Website