BRIEFING	TO:	Health and Wellbeing Board
	DATE:	25th January 2022
	LEAD OFFICER	Gilly Brenner
	TITLE:	Tobacco control update

Background

1.1 Despite a huge decrease in the number of people who smoke in the last 10+ years, **smoking remains the leading cause of preventable and early deaths in the UK and Rotherham**.

Prevalence of smoking in Rotherham is significantly higher than for all-England. Approximately 16.9% of Rotherham adults (around 35,400 people) were smokers in 2021 compared to 13.0% nationally.

From 2017-19, there were **1,272 smoking attributable deaths in Rotherham** – a rate of 271 deaths per 100,000 population. **This is significantly worse than the England rate** of 202 or the Yorkshire and the Humber rate of 239 deaths per 100,000 population

An estimated 13,836 Disability Adjusted Life Years (DALYs) in Rotherham were caused by smoking in 2019 alone. This accounts for 16% of all DALYs in Rotherham - making **smoking the single greatest contributor to the total burden of disease locally.**

Rotherham performs significantly worse than all-England for most indicators used to monitor the impact of smoking on population health.

Indicator	Rotherham	All England
Smoking attributable hospital admissions: Directly standardised rate per 100,000 population (2019/20)	2,023	1,398
Smoking attributable deaths: Directly standardised rate per 100,000 population (2017-19)	271	202
Smoking at time of delivery (2021/2)	12.8%	9.1%

Smoking is the single largest driver of health inequalities in England. The more disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related disease and premature death.

Rates of smoking are considerably higher amongst some groups, including:

- People who work in routine and manual occupations
- People from lower socioeconomic groups
- People with long term mental health conditions
- People with drug and alcohol additions

	• People from some ethnic groups – including mixed ethnic groups and white British populations • LGBTQI+ people **Inequalities in Rotherham that are more pronounced than seen nationally.** For example, the odds of smoking amongst routine and manual workers in Rotherham are 2.45 times those of the general population, compared to an odds ratio of 2.22 nationally.
1.2	Investment in tobacco control is highly cost effective. Every £1 spent on smoking cessation services estimated to deliver a saving of £10 in future health care costs and health gains. Despite this, **there has been a national and local decline in spending on tobacco control**. In **Rotherham, spend on tobacco control per head of population fell by 49% between 2013 and 2018** within the context of overall cuts in PH spending. Local spend on tobacco control per head of population is now lower than for all England, and other authorities in Rotherham's deprivation decile.
1.3	This briefing provides an update on measures being taken locally to improve tobacco control, and seeks approval for: • A 3-year multi-partner tobacco control workplan for Rotherham. • A multi-partner vaping / e-cigarette position paper for Rotherham. • A dashboard of indicators to monitor progress towards a smokefree Rotherham by 2030. • Plans to endorse the NHS Smokefree Pledge and Local Government Declaration on Tobacco Control.
Key Issues	
2.1	Context at local level in 2022: • In early 2022 an **internal audit** and a **health needs assessment** were undertaken to identify gaps in Rotherham's current tobacco control programme. **Both reviews recommended that a group be established to coordinate tobacco control activities and resources**. The reviews also identified a range of measures required to strengthen and align Rotherham's tobacco control work with best practice. • 2022 has also seen the **re-commissioning of community smoking cessation programme** (currently out to tender) and the **re/launch of Health Checks and Lung checks programmes** – both of which identify and refer residents to smoking cessation support services.
2.2	Context at national level in 2022:

	• The Khan Review (an independent review into the government's ambition to be smokefree by 2030) was published, identifying four critical 'must do' national recommendations:
	  ○ Urgently invest £125m per year in interventions to reach smokefree 2030.
	  ○ Raise age of sale of tobacco by one year, every year.
	  ○ Offer vaping as a substitute for smoking, alongside accurate information on the benefits of switching, including to healthcare professionals.
	  ○ The NHS needs to prioritise prevention, with further action to stop people smoking, providing support and treatment across all its services, including primary care.
	
	• The Local Government Declaration on Tobacco Control (originally signed by Rotherham Council in 2014) and the NHS Smokefree Pledge were relaunched to reflect the government's ambition to be smokefree by 2030.
	
	• Publication of a new Tobacco Control Plan for England (originally due in 2020) was further delayed.

2.3	In response to these local and national developments, **a multi-partner Rotherham Tobacco Control Steering Group has been formed** with membership drawn from: • Rotherham Council (Public Health Team; Housing Team; Regulation & Enforcement Team; School Improvement Service; Communications Team; Commissioning) • TRFT (Healthy Hospitals / QUIT team; Specialist midwife team; RDASH) • CCG & PCN • Local Pharmaceutical Committee • South Yorks. Fire & Police services • Get Healthy Rotherham The group is chaired by Gilly Brenner (Rotherham Council Public Health Consultant) and meets monthly to coordinate shared areas of work.
2.4	Since its formation, the Tobacco Control Steering Group has worked to develop a **multi-partner tobacco control work plan for Rotherham (2022-2025) outlining actions required to deliver a smokefree Rotherham by 2030** (i.e. <5% of the population smoking by 2030). The Rotherham tobacco control workplan (attached) draws on recommendations from: • The Khan Review • The What Good Looks Like guidance on tobacco control • The 2022 Rotherham tobacco control audit and health needs assessment • Plans from partner organisations across the Borough.

	The resource implications of the proposed action plan for RMBC are still being reviewed and several items are subject to fund availability.
2.5	To support monitoring of progress towards a smokefree Rotherham, a **dashboard of indicators** has been developed incorporating a range of nationally and locally identified measures (attached).
2.6	In addition, the Tobacco Control Steering group convened local partners to **develop a position paper on e-cigarettes / vaping designed to improve consensus and coordination across the borough**. The position paper (attached) was developed with partner and expert input through a participatory workshop and consultative drafting process coordinated by the Council's Public Health team. The partner workshop sort to generate consensus on how to ensure that there is access to e-cigarettes as an effective harm reduction tool and quitting aid for existing smokers - without inadvertently contributing to a growth in the uptake of vaping amongst non-smokers (especially children and young people) through normalisation, or glamorisation of vaping.
Implications for Health Inequalities	
3.1	The papers presented here seek to address health inequalities caused by variance in smoking rates between socio-economic, ethnic and other groups via a range of measures: • The attached workplan includes an explicit focus on eliminating variance in rates of smoking as one of five strategic aims for tobacco control in Rotherham. • Existing local smoking cessation programmes do explicitly target groups that are disproportionately affected by smoking: • RDASH's specialist smoking cessation programme focuses on people with long term and serious mental health illnesses • The Health Checks programme, which is a major source of referrals to smoking cessation services, is targeted at people living in the most deprived LSOAs in Rotherham. • The existing community smoking cessation programme (delivered by Get Healthy Rotherham) has performance targets focusing on reaching high prevalence groups including routine and manual workers, ethnic groups with a higher prevalence of smoking etc) • There are plans to pilot an e-cigarette programme for drug and alcohol service users. • The monitoring framework includes disaggregated monitoring for high prevalence groups to enable tracking of progress.
Recommendations	

4.1	It is recommended that the Rotherham Health and Wellbeing Board **approve the attached Tobacco Control Action Plan**, developed by the Rotherham Tobacco Control Steering Group. It is also requested that members of the Board seek to provide the leadership, support and resources required to enable effective implementation of these priority actions within the organisations they represent.
4.2	It is recommended that the Rotherham Health and Wellbeing Board **approve the Tobacco Control monitoring framework and dashboard of indicators** and to review progress against these indicators regularly.
4.3	It is recommended that the Rotherham Health and Wellbeing Board **approve the attached e-cigarette position paper,** developed in partnership with key stakeholders across the Borough. It is also requested that organisation represented at the Board **take steps to endorse the position paper** internally by March 2023 and to subsequently align their own practice with the commitments included in the paper.
4.4	It is recommended that the Rotherham Health and Wellbeing Board **endorse plans to sign the NHS Smokefree Pledge and (refreshed) Local Government Declaration on Tobacco Control**. It is also requested that organisations represented at the Board support a coordinated communications push on March 8th 2023 (national No Smoking Day) promoting the declarations and reinforcing messaging around smokefree sites.

Attachments

1. Tobacco control workplan
2. Tobacco control dashboard of indicators
3. E-Cigarette / Vaping position paper
4. Local Government Declarations on Tobacco Control and NHS Smokefree Pledge

Appendix 1 TOBACCO CONTROL STEERING GROUP – WORK PLAN 2022/23 – 2024/25

This workplan is aligned against five strategic aims designed to deliver a smokefree Rotherham by 2030

Ambition: For Rotherham to become smokefree by 2030 (<5% prevalence)				
A. **Strategy and Coordination.** Deliver a coordinated tobacco control policy, strategy, governance and monitoring system	B. **Quit for good**. Encourage and support smokers to quit for good	C. **Enforcement.** Tackle suppliers of cheap, counterfeit, and illicit tobacco and nicotine-containing-products through delivery of effective enforcement	**D. Reduce variation** in smoking rates by tackling inequalities	E. **Stop the start.** Reduce the number of people taking up smoking, particularly young people
1. Create a shared vision, plan, governance structure, and set of policies for effective tobacco control across Rotherham. 2. Improve the availability and use of local data on tobacco use, exposure, and related health outcomes.	3. Provide high quality community-based smoking cessation support 4. Deliver a smokefree NHS. 5. Eliminate tobacco dependence in pregnant women. 6. Work with local employers to help staff to quit.	7. Create a hostile environment for tobacco fraud and underage sales through intelligence sharing. 8. Tackle illegal activity including sales of counterfeit and illegal nicotine containing products. 9. Change perceptions about illegal tobacco sales and the harms of buying and using illegal vape products.	10. Deliver targeted and tailored smoking cessation services and communications to reach groups with highest prevalence of smoking.	11. Support schools to minimise uptake of smoking and e-cigarette use amongst Rotherham children and young people. 12. Reduce exposure to second-hand smoke and de-normalise smoking by expanding and enforcing smokefree place policies. 13. Use targeted and mass communication to change attitudes and social norms around smoking and increase quit attempts.

Ref	Action	Timescale							Lead (support)	Output	Notes
		2022/3		2023/4				2024/ 2025			
		Q3	Q4	Q1	Q2	Q3	Q4				
A	**Strategy and Coordination. Deliver coordinated tobacco control policy, strategy, governance and monitoring systems across Rotherham**										
1	**Create a shared vision, plan, governance structure, and set of policies for effective tobacco control across Rotherham**										
1.1	Establish Tobacco Control Steering Group (TCSG) with representation from partners across Rotherham	X							**Gill Harrison** (TC Group partners)	Tobacco Control Group Workplan and Terms of Reference developed and approved by HWBB	Complete
1.3	Renew TC Commitments - RMBC – Local government declaration - RMBC – CRUK motion - TRFT – NHS smokefree pledge			X	X				**Gilly Brenner / Cllr Roche** **Mike Smith**	Commitments approved, publicised, and enacted	
1.4	Develop a Rotherham partnership position paper on vaping/e-cigarettes, including use as quit aid and addressing normalisation	X	X						**Kate Gray** (Sam Longley, Gill Harrison, TC Group)	Policy position paper approved by partner orgs	Rotherham LPC confirmed supportive (12/1/23)
1.5	Review validity of and progress of e-cigarette position paper					X		X	**TC Specialist** (TC group)		
1.6	Support development of RMBC Advertising Policy to ensure inclusion of e-cigs and tobacco related restrictions					X			**Kelsey Broomhead** (TC Specialist)	Advertising policy incorporating measures on tobacco control approved	
1.7	Maintain partner awareness and buy-in to workplan and progress: - Prevention and enablers group - HWBB		X						**TC Group Chair** (TC Group)		HWBB Jan 2023 and updates as required

Ref	Action	Timescale							Lead (support)	Output	Notes
		2022/3		2023/4				2024/ 2025			
		Q3	Q4	Q1	Q2	Q3	Q4				
1.8	Review progress against workplan and strategy (annually) and update					X		X	**TC Group chair** (TC Group)		
1.9	Hold regular information sharing and problem-solving sessions to improve coordination between smoking cessation service providers				X			X	**TC Group chair** (TC Group)		
1.10	Link with Personalisation Steering Group to ensure that stop smoking approaches in Rotherham focus on individual patient needs and preferences				X				**Becky Woolley / Jo Martin**		
1.11	Meet with Oral Health Improvement Group to explore opportunities for collaboration			X					**TC specialist** (Sue Turner, Sarah Robertson)		Meeting scheduled for Feb 2023
2.	**Improve the availability and use of local data on tobacco use, exposure, and related health outcomes**										
2.1	Develop dashboard of indicators, progress measures and targets for Rotherham to enable meaningful tracking of progress against the strategy and action plan		X						**TC specialist** (Lorna Quinn)	Dashboard of targets and indicators developed and approved by TCSG	In progress
2.2	Use data from CACI to profile existing smokers in Rotherham / identify areas with high prevalence to inform communications and targeting of work.			X	X				**Lorna Quinn** (TC Specialist)	Local profile of smokers developed to identify groups and geographical areas with highest prevalence	Data now acquired
2.3	Explore opportunities to align Rotherham Schools' Survey questions about smoking		X	X					**Lorna Quinn**		In progress

Ref	Action	Timescale							Lead (support)	Output	Notes
		2022/3		2023/4				2024/ 2025			
		Q3	Q4	Q1	Q2	Q3	Q4				
	and e-cig use with national, validated surveys to enable comparison								(TC lead / Schools survey lead)		
2.4	Conduct targeted behavioural insights / coproduction research with local communities to inform stop smoking service development	X							**Becky Woolley**	Consultation findings included in tender documentation	Complete
2.5	Identify and agree measures for monitoring trends in e-cigarette quit rates and long-term use amongst stop smoking service users				X	X			**Michael Ng** (Lorna Quinn / TC Specialist / Service provider)	Indicators for e-cigarette use included in Better Health supplier's contract and data reported regularly	During Better Health contract mobilisation
2.6	Review JSNA tobacco control data and intelligence ensuring integration of smoking dashboard indicators	X				X		X	**TC Specialist** (Lorna Quinn)		
B.	**Quit for good. Encourage and support smokers to quit for good**										
3	Provide high quality, **community-based** smoking cessation support										
3.1	Ongoing delivery of an effective local smoking cessation service	X	X	X	X	X	X	X	**Michael Ng** (Service Provider/s)	Regular performance monitoring meetings provide assurance of effective delivery	
3.2	Launch new smoking cessation service – including communicating any contract change and adaptations in referral systems for professionals (including Dental Practioners, Housing, Fire and Social Services)					X	X		**Michael Ng** (Service provider / TC Specialist)		Mobilisation of new contract in second half of 2023

Ref	Action	Timescale							Lead (support)	Output	Notes
		2022/3		2023/4				2024/ 2025			
		Q3	Q4	Q1	Q2	Q3	Q4				
3.3	Review and update MECC training, systems and practice to ensure - alignment with current best practice and policy (including e-cigarette policy) - implementation of very brief advice - easy referral to community smoking cessation services (e.g. through online platform)			X	X			X	**TC Specialist and Phill Spencer** (Housing, Social Services, Fire Services, Police etc)	Smoking content for MECC updated to align with best practice and e-cigarette position statement	
3.4	Review opportunities to enhance stop smoking support; and smokefree homes communications to smokers living in social housing (including through very brief advice; referrals to smoking cessation services; targeted messaging) offered through housing services; midwifery services; 0-19 services and other contacts			X	X				**TC Specialist and Housing lead** (TC group)		
3.5	Deliver MECC across council departments and explore wider partner opportunities – ensuring appropriate evaluation	X	X	X	X	X	X	X	**Phill Spencer** (TC Specialist)	MECC commitment in Council plan for 150 attendees/annum	
4	Implement a truly **smokefree NHS**										
4.1	Provide Tobacco Treatment Services to all TRFT secondary care patients	X	X	X	X	X	X	X	**Mike Smith**	Expansion to Outpatient and community services	Criteria aged 12 years and over
4.2	Publish 2022 updated TRFT Policy to Promote a Smoke Free NHS Site			X					**Mike Smith**	Formal policy publication	Updated vaping position required

Ref	Action	Timescale							Lead (support)	Output	Notes
		2022/3		2023/4				2024/ 2025			
		Q3	Q4	Q1	Q2	Q3	Q4				
4.3	Provide Tobacco Treatment Services to household members of admitted children					X			**Mike Smith**	Increased service activity and onward community referrals	Introduction of household member screening required
4.4	Roll out of lung health checks	X	X	X	X	X	X	X	**Michael Ng** (Lung health check provider, ICB)	Smoking cessation referrals from lung health check	In progress, good uptake has so far and referrals to service
4.5	Regularly identify smokers and refer to cessation support through NHS Health Checks	X	X	X	X	X	X	X	**Michael Ng** (NHS Health checks provider/GPs)	Smoking cessations referral from NHS health check	In progress
4.6	Explore potential for quality contract to include focus on smoking and respiratory health – through Core 20+5 agenda			X					**Jo Martin / Rachel Garrison**		
4.7	Deliver training to Primary Care Trusts PLT re. lung health and smoking cessation			X					**Jo Martin**		Scheduled for Jan 12th
5	**Eliminate tobacco dependence in pregnant women**										
5.1	Ongoing deliver of Rotherham-wide service supporting pregnant women and their families to quit smoking during pregnancy	X	X	X	X	X	X	X	**Jo Aitkin / Wendy Griffith (SATOD)** (Michael Ng; Sam Longley)		
5.2	Review feasibility of delivering an evidence-based incentive-to-quit scheme in Rotherham – targeting low-income families		X	X					**Michael Ng / Sam Longley / SATOD Team**		

Ref	Action	Timescale							Lead (support)	Output	Notes
		2022/3		2023/4				2024/ 2025			
		Q3	Q4	Q1	Q2	Q3	Q4				
5.3	Implement findings from incentive programme review				X	X	X	X	**Jo Aitkin / Wendy Griffith**		Application process for regional funding
5.4	Review and strengthen messaging around smoking in pregnancy delivered at pre-conception stage (family planning, nurse family partnerships and other services)				X				**Sam Longley / Best Start and Beyond team** (Sexual health service providers)		
5.5	Strengthen post-partum support for women who have quit during pregnancy						X		**Jo Aitkin / Wendy Griffith** (Sam Longley)		
5.6	Coordinate maternity focused tobacco control work with Local Maternity Neonatal System	X	X	X	X	X	X	X	**Jo Aitkin / Sam Longley**		
6	**Work with local employers to help staff to quit**										
6.1	Expand the BeWell@Work award scheme – working to become a smokefree place		X	X					**Colin Ellis** (TC Specialist)		
6.2	Provide Tobacco Treatment Services to all TRFT staff	X	X	X	X	X	X	X	**Mike Smith**	Increased staff service utilisation and quit rates	Established service, uptake remains low
6.3	Explore opportunities to build smoking cessation support to staff as part of anchor institution commitments.		X						**Becky Woolley**		
C	**Reduce variation in smoking rates by tackling inequalities**										
7	Deliver targeted and tailored smoking cessation services and communications to reach groups with highest prevalence of smoking.										

Ref	Action	Timescale							Lead (support)	Output	Notes
		2022/3		2023/4				2024/ 2025			
		Q3	Q4	Q1	Q2	Q3	Q4				
7.1	Deliver specialist stop smoking services for people with **mental health conditions**	X	X	X	X	X	X	X	**Emma Hillit / Adam Fretwell**		Ongoing programme of support at RDASH
7.2	Identify opportunities to strengthen referral to smoking cessation services from SMI health checks				X				**TC specialist** (in discussion with PCN leads/RDASH)		
7.3	Incorporate smoking into template for PCN Health Inequalities Action Plans			X					**Jo Martin** (David Clitherow)		
7.4	Consolidate smoking focused actions from PCN health inequalities action plans and identify support needs				X				**TC specialist**		
7.5	Explore opportunities to improve reach **to manual workers** as a group with disproportionately high prevalence of smoking								**TC Specialist** (Colin Ellis)		
7.6	Increase referrals to community smoking cessation services in **high deprivation** LSOAs through targeted health checks programme			X	X	X	X		**Michael Ng**		
7.7	Pilot integration of e-cigarette programme into **drug and alcohol service users**			X	X	X	X		**Michael Ng**		
7.8	Explore opportunities to improve reach **to ethnic groups with high prevalence**				X				**TC Specialist**		

Ref	Action	Timescale							Lead (support)	Output	Notes
		2022/3		2023/4				2024/ 2025			
		Q3	Q4	Q1	Q2	Q3	Q4				
7.9	Explore opportunities to improve reach to **LGBTQI+ people**				X	X			**TC Specialist**		
D.	**Enforcement - Tackle suppliers of cheap, counterfeit, and illicit tobacco and nicotine containing products through delivery of effective enforcement**										
9	**Create a hostile environment for tobacco fraud and underage sales through intelligence sharing**										
9.1	Trial of joint schools' work with RUFC and RMBC Trading Standards to identify sites selling tobacco products and e-cigarettes to under-18s			X	X	X	X	X	**Dave Lodge** (RUFC, Sam Longley)		
9.2	Collaborate with SY police and local partners on intelligence gathering and sharing about sale of counterfeit and illegal tobacco and nicotine-containing products	X	X	X	X	X	X	X	**Dave Lodge** (SY Police)		Planned additional capacity in Q4 for intelligence gathering
9.3	Engage with retailers to improve awareness of legislation around tobacco control, of what to with information about illicit tobacco locally, and implications of operating illegally	X	X	X	X	X	X	X	**Dave Lodge**		
10	**Tackle illegal activity including sales of counterfeit and illegal nicotine containing products (including unlicenced nicotine containing e-cigarettes)**										
10.1	Develop Trading Standards costed action plan for tobacco and e-cigarette enforcement in line with NICE 2021 Tobacco Control guidance, including:				X				**Dave Lodge**		

Ref	Action	Timescale							Lead (support)	Output	Notes
		2022/3		2023/4				2024/ 2025			
		Q3	Q4	Q1	Q2	Q3	Q4				
	• 'Systems' measures of success to monitor plan • Priority activities to maximise impact on local smoking rate – focusing on areas close to schools, and in wards with highest rates of smoking (informed by PH intelligence).										
10.2	Implement tobacco control and e-cigarette enforcement action plan including through targeted test purchasing operations, and investigations of repeat offenders			X	X	X	X	X	**Dave Lodge** (SY Police)		
11	**Change perceptions about illegal tobacco sales and the harms of buying and using illegal vape products**										
11.1	Work with locally e-cigarette retailers to ensure that they offer MHRA-approved products, guidance on safe and effective use of e-cigarettes, and referrals into local stop smoking services.			X	X	X	X	X	**Dave Lodge**		
11.2	Help the public to identify responsible vape shops and retailers						X	X	**Dave Lodge** (Better Health service)		
11.3	Generate comms output using behavioural levers to expose the true nature of the fraud and the consequences for those involved in it				X			X	**Aidan Melville** (Dave Lodge)		

Ref	Action	Timescale							Lead (support)	Output	Notes
		2022/3		2023/4				2024/ 2025			
		Q3	Q4	Q1	Q2	Q3	Q4				
E.	**Stop the start: Reduce the number of people taking up smoking – particularly young people**										
12	**Support schools to minimise uptake of smoking and e-cigarette use amongst Rotherham children and young people**										
12.1	Review status and experiences of implementing school smoke-free policies in primary schools across Rotherham		X	X					**Sam Longley**		
12.2	Adapt, pilot, roll out and evaluate school smokefree toolkit (primary and secondary) – including a focus on vaping - in line with local and national messaging and tools)			X	X	X	X	X	**Sam Longley**		No budget yet identified.
12.3	Provide local PSHE coordinators with information about the prevalence of smoking locally and resources to support anti-smoking education across all age groups.			X	X	X	X	X	**Sam Longley**		
13	**Reduce exposure to second-hand smoke and de-normalise smoking by expanding and enforcing smokefree space policies**										
13.1	Identify opportunities to expand smokefree places in Rotherham eg. new town centre development open space				X				**TC Specialist**		
13.2	Review existing smokefree places policies to integrate e-cig guidance				X				**TC Specialist**		
13.3	Increase signage around smokefree places				X	X	X		**TC Specialist**		No budget yet identified

Ref	Action	Timescale							Lead (support)	Output	Notes
		2022/3		2023/4				2024/ 2025			
		Q3	Q4	Q1	Q2	Q3	Q4				
14	Use **targeted and mass communications** to change attitudes and social norms around smoking and increase quit attempts										
14.1	Develop enhanced tobacco control communications strategy* focusing on social norms change, and inspiring quitting - Horizon scanning and evidence review to identify materials, campaigns and opportunities for collaboration - Identify priority target groups in reference to local data - Produce 3 year comms strategy - Generate / adapt and test tailored messages - Produce comprehensive communications calendar to be utilised and owned by all local partners			X	X	X	X	X	**Comms partners** (Aidan Melville, TC Specialist)	Strategic communications partner identified Costed tobacco control comms strategy developed	No budget yet identified. Working group established for No Smoking Day comms
14.2	Develop and launch a prevention brand and campaign, including smoking cessation messaging and the expansion of RotherHive.		X	X					**Becky Woolley** (Gordon Laidlaw/Aidan Melville)		Provider commissioned, in development

Appendix 2 TOBACCO CONTROL INDICATORS FOR DASHBOARD

Impact level

Indicator	Definition	Target	Data source	Named lead
Smoking prevalence in adults (18+) - current smokers	The number of persons aged 18 + who are self-reported smokers in the Annual Population Survey (APS) as a proportion of Total number of respondents (with valid recorded smoking status) aged 18+ from the APS.	Baseline 2020: 12.5% Target 2030: <5%	Fingertips	Lorna
Smoking status at the time of delivery	The number of mothers known to be smokers at the time of delivery as a percentage of all maternities with known smoking status.	Baseline 2021/22: 12.8% Target 2025: commissioned service is to remain <15% but target has remained lower (better). Target 2030: <5% (National target)	Fingertips	Lorna
Percentage of women who smoked in early pregnancy	Percentage of pregnant women who smoke at the time of booking appointment with midwife	Baseline 2018/18: 27.9%	Fingertips	Lorna
Smoking attributable mortality (35+)	Deaths attributable to smoking, directly age standardised rate for persons aged 35 years + (mortality data and population data are from ONS).	Baseline 2017-19: 271.2 per 100,000	Fingertips	Lorna
Smoking attributable hospital admissions (35+)	Total number of hospital admissions for diseases that are wholly or partially attributed to smoking in persons aged 35 and over (hospital admission data is taken from HES)	Baseline 2019/20: 2,023.5 per 100,000	Fingertips	Lorna
Number of deaths attributable to smoking	Number of deaths attributable to smoking	Baseline 2017-19: 1,272	Fingertips/OHID	Lorna
Rate of deaths from stroke attributable to smoking	Rate per 100,000 people	Baseline 2019/20: 10.8 per 100,000	Fingertips/OHID	Lorna
Rate of deaths from heart disease attributable to smoking	Rate per 100,000 people	Baseline 2017-19: 36.3 per 100,000	Fingertips/OHID	Lorna
Number of hospital admissions attributable to smoking	Number of hospital admissions attributable to smoking	Baseline 2019/20: 3,239	Fingertips/OHID	Lorna

Output level

	Indicator	Definition	Target	Data source	Named lead
A. Strategy and Coordination. Deliver a coordinated tobacco control policy, strategy, governance and monitoring system					
A1	Annual RMBC spend on tobacco control per head of population		Baseline: tbc 2022: tbc 2023: tbc 2024: tbc 2025: tbc	SPOT tool returns / RMBC finances	Gilly
A2	% of annual actions in TC action plan completed		>90%	TC action plan	Gilly
A3	Frequency with which dashboard updated		Quarterly		Lorna
A4	TBC – indicator related to availability and use of local disaggregated data to inform service delivery				
B. Quit for good. Encourage and support smokers to quit for good					
B1	Smokers setting a quit date	Crude rate per 100,000 aged 16+ (count)	Baseline (2019/20): 2,951 (1,126) 2020/21: tbc 2021/22: tbc 2022/23: tbc 2323/24: tbc 2024/25: tbc	Fingertips / returns from commissioned services	Lorna Q / Michael Ng
B2	Smokers that have successfully quit at 4 weeks (CO validated)	Data includes all services: NHS Digital Stop Smoking Services data, Annual Population Survey, PHE Population Health Analysis Team, RDASH, SATOD and QUIT.	Baseline (2019/20): 2,951 per 100,000 smokers aged 16+. 2020/21: tbc 2021/22: tbc 2022/23: tbc 2323/24: tbc 2024/25: tbc	Fingertips / returns from commissioned services	Lorna Q / Michael Ng

	Indicator	Definition	Target	Data source	Named lead
B3	% of 4 week quitters still quit at 3 months / 6 months / 12 months	% of quitters from community smoking cessation service (Healthy lifestyles / Better health) who remain smokefree at 3, 6 and 12 months post quit date	Baseline: 42% / 20% / 16% 2021/22: tbc 2022/23: tbc 2323/24: tbc 2024/25: tbc	Commissioned services (Healthy lifestyles / Better Health service) *Nb – baseline taken from Better Health service spec)	Michael Ng
B4	Loss to follow up rate for community smoking cessation service	Number of Smoking cessation (Component 2) interventions offered after Brief Intervention	Baseline: 11% (low is good) 2022/23: tbc 2323/24: tbc 2024/25: tbc	Commissioned services	Michael Ng
B5	*The proportion of patients who smoke, who receive a specialist tobacco treatment assessment within 5 days** **Please note the definition is subject to change due to reporting methods.*		TBC	RDASH	Emma Hillitt / Adam Fretwell
B6	*SATOD - The number of appointments where smoking is discussed at booking of appointment as a proportion of total appointments booked** **Please note the definition is subject to change due to reporting methods.*		TBC	SATOD	Jo Aitken
B7	*Proportion of smokers where quitting is discussed at inpatient admission** **Please note the definition is subject to change due to reporting methods.*	Number of patients who smoke, where quitting is discussed at admission as a proportion of all inpatient admissions where a patient smokes.	TBC	TRFT – indicator in prevention and health inequalities work.	Mike Smith
B8	% of PCPs achieving smoking related targets in quality contract		tbc	Quality Contract returns	Lorna / Rachel Garison
B9	*tbc - % of quitters who used e-cigarettes as quitting aid still vaping at X months*	To be determined in discussion with contracted provider for Better Health Services	Tbc	Commissioned Services (Better Health provider)	Michael Ng

	Indicator	Definition	Target	Data source	Named lead
C. Enforcement. Tackle suppliers of cheap, counterfeit, and illicit tobacco and nicotine-containing-products through delivery of effective enforcement					
C1	Volume of illegal tobacco seized per year by enforcement team	Includes counterfeit tobacco products, genuine non-UK duty paid tobacco products, products not for legitimate retain in the UK and raw tobacco	Baseline 2021: 38,000 sticks and 7.75kg of hand rolling tobacco 2022: 2023: 2324: 2025:		Dave Lodge
C2	Volume of Illegal e-cigarettes seized per year by enforcement team				Dave Lodge
C3	Number of responsible retailer visits undertaken per year by enforcement team				Dave Lodge
C4	Number of underage sales test purchases undertaken per year by enforcement team				Dave Lodge
D. Reduce variation in smoking rates by tackling inequalities					
D1	4 week quit rate for people who live in the 20% most deprived areas compared to quit rate from the rest of the population (CO validated).	The number of quits from 20% most deprived as a proportion of all people trying to quit in the 20% most deprived compared to the number of quits from the rest of the population as a proportion of the total number of people trying to quit in this population – validated through CO testing.	Baseline: Tbc 2023: tbc 2024: tbc 2025: tbc	Commissioned service	Michael Ng
D2	*The number of substance misuse service users who successfully engage with the e-cig pilot** **Please note the definition is subject to change due to reporting methods.*	The number of substance misuse service users who successfully engage with the e-cig pilot.	Baseline 2022: 0 2023: tbc 2024: tbc 2025: tbc	Commissioned service	Michael Ng

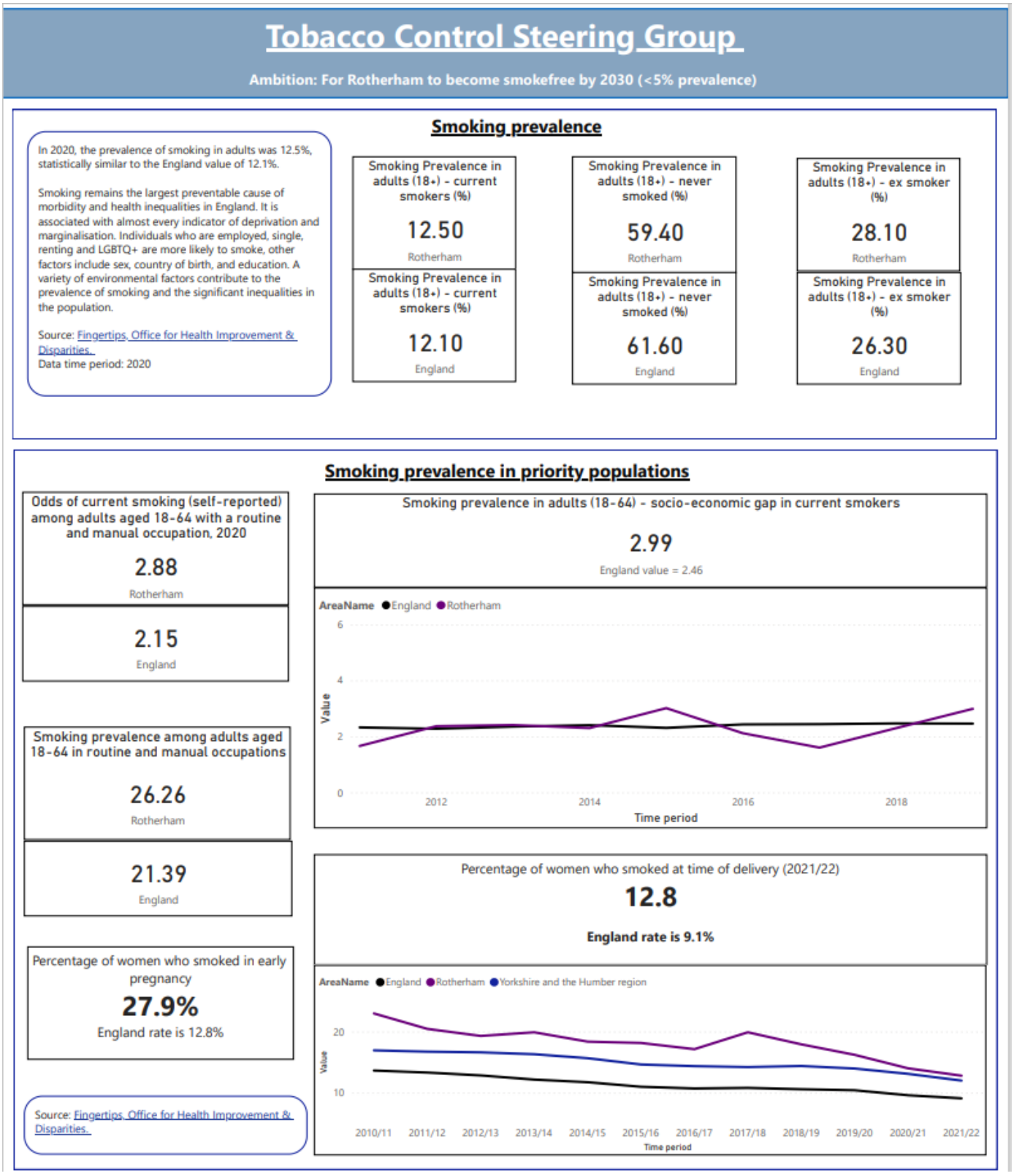
	Indicator	Definition	Target	Data source	Named lead
D3	The number of people from Ethnic communities with a disproportionally high rate of smoking, who set a quit date. - Mixed ethnicity - White ethnicity	The number of people from Ethnic communities with a disproportionally high rate of smoking, who set a quit date. - Mixed ethnicity - White ethnicity	Baseline: Tbc 2023: tbc 2024: tbc 2025: tbc	Commissioned service	Michael Ng
D4	The percentage of SMI Patients receiving the smoking status health check assessment in the last 12 months.	The number of SMI Patients receiving the smoking status health check assessment as a proportion of all SMI patients, in the last 12 months.	Baseline: 2023: tbc 2024: tbc 2025: >90%	Reported through Prevention and Health Inequalities – source ICB	Lorna/Alex H-D
D5	Smoking prevalence among adults aged 18-64 in routine and manual occupations	Prevalence of current smokers among persons aged 18-64 years in the routine and manual group	Baseline 2020: 26.3% 2023: tbc 2024: tbc 2025: tbc	Annual population survey, Office of National Statistics.	Lorna
D6	Smoking prevalence in adults who rent from the local authority or housing association.	Smoking prevalence in adults who rent from the local authority or housing association.	Baseline (2020): 37.7% 2023: tbc 2024: tbc 2025: tbc	Annual population survey, Office of National Statistics.	Lorna
D7	Odds of current smoking among adults aged 18-64 with a routine and manual occupation.	Previously named 'Smoking prevalence in adults (18-64) – socio-economic gap in current smokers'. Smoking prevalence in adults (age 18-64 years) - gap between current smokers in routine and manual occupations and other occupations	Baseline (2020): 2.88%	Fingertips	Lorna
D8	The number of people from the LGBTQI+ community who set a quit date.	The number of people from the LGBTQI+ community who set a quit date.	TBC	TBC	TBC
D9	% of PCNs in Rotherham with smoking related actions included in health inequalities action plans		>90%	PCN health inequalities action plans	Jo Martin
E. Stop the start. Reduce the number of people taking up smoking, particularly young people					

	Indicator	Definition	Target	Data source	Named lead
E1	Estimated prevalence of smoking amongst yr 7 school children in Rotherham (wording to be aligned with Schools Survey)		Baseline 2019: 4% 2023: tbc 2024: tbc 2025: tbc	Rotherham Schools Survey	Lorna Quinn / Bev Pepperdine
E2	Estimated prevalence of smoking amongst yr 10 school children in Rotherham (wording to be aligned with Schools Survey)		Baseline 2019: 14% 2023: tbc 2024: tbc 2025: tbc	Rotherham Schools Survey	Lorna Quinn / Bev Pepperdine
E3	% of Rotherham primary schools with smokefree policies in place	% of Rotherham primary schools with smokefree policies in place	Baseline: Tbc 2023: tbc 2024: tbc 2025: >90%	Intelligence from schools	Sam Longley
E4	% of Rotherham secondary schools with smokefree policies in place	% of Rotherham primary schools with smokefree policies in place	Baseline: Tbc 2023: tbc 2024: tbc 2025: >90%	Intelligence from schools	Sam Longley
E5	*TBC - Estimated annual reach of multi-media output (indicator to be finalised based on monitoring metric for multi-media contract)*	tbc	2022: 0 2023: tbc 2024: tbc 2025: tbc	Commissioned service (BCC multi-media contract)	Manager of mass media contract
E6	Annual no. of click throughs from Rotherhive pages on smoking support		2022: 0 2023: tbc 2024: tbc 2025: tbc	Rotherhive / reported through Prevention and Health Inequalities	Becky Woolley

Key:

	Indicator aligned with Prevention and health inequalities monitoring framework

Dashboard example

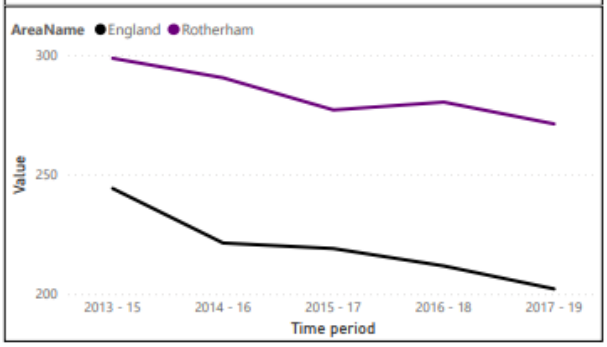


Smoking related mortality and ill health

Smoking attributable mortality, rate per 100,000

271.19

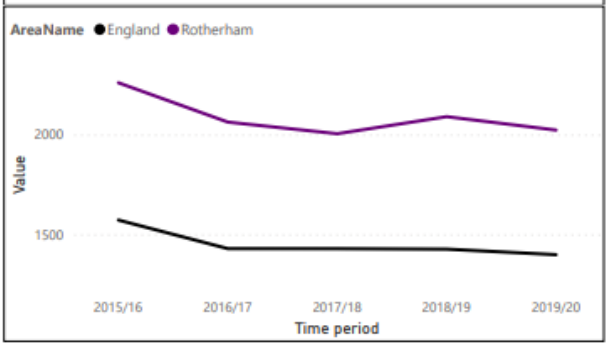
England value = 202.2



Smoking attributable hospital admissions, rate per 100,000

2023.45

England value = 1,397.98



1,272

Number of deaths attributable to smoking (2017-19)

560.8

Rate of emergency hospital admissions for COPD per 100,000 people (2019/20)

England rate is 415.1

10.8

Rate of deaths from stroke attributable to smoking 100,000 people (2019/20)

England rate is 9.0

36.3

Rate of deaths from heart disease attributable to smoking per 100,000 people (2017-19)

England rate is 29.3

3,239

Number of hospital admissions attributable to smoking (2019/20)

Source: Fingertips, Office for Health Improvement & Disparities.

Appendix 3

Rotherham Position Paper on Electronic Cigarettes / Vapes

This position paper is informed by the best current evidence from Public Health England, Royal College Physicians, Action on Smoking and Health, National Centre Smoking Cessation Training and NICE/NHS guidance. The aim of this statement is to develop an agreed consensus in Rotherham on electronic cigarettes (referred to here as e-cigarettes or vapes) that all local partners are signed up to. This is to ensure that the public receive clear, evidenced based and consistent advice on e-cigarettes.

We acknowledge evidence that:

E-cigarettes are significantly safer than cigarettes and are a valuable harm reduction tool and quitting aid for adults.

- Smoking is the leading cause of premature death, disease, and disability in our communities (1).
- Vaping is significantly less harmful than smoking tobacco and switching completely from smoking to vaping offers significant health benefits.
- When combined with standard behavioural support, nicotine containing e-cigarettes are effective smoking cessation and reduction aids (2).
- Nicotine-containing e-cigarettes are the most popular quitting aid used by smokers in England (1).
- The long-term implications of e-cigarette use not fully understood. As such, people who have never smoked should be encouraged not to smoke or use e-cigarettes (1).
- Unfortunately, the public are increasingly likely to incorrectly believe that e-cigarette use is as harmful as smoking. These misperceptions are particularly common among smokers who do not vape and may prevent them from using vaping products as a stop smoking aid (3).

Young people should be discouraged from e-cigarette use.

- In children and adolescents, the consumption of nicotine, including via e-cigarettes, potentially has a detrimental impact on brain development (3).
- Although the available evidence does not suggest that trying vaping products leads to regular smoking, there is widespread concern that young people who develop a nicotine addiction through e-cigarette will go on to smoke (3).
- Children exposed to smoking are significantly more likely to take up smoking themselves (5). There is concern that, similarly, exposure to e-cigarette use will normalise and increase the uptake of vaping amongst young people.

E-cigarette use amongst pregnant people is safer than tobacco smoking - but is not risk-free.

- Use of e-cigarettes as a quit aid in pregnancy has a harm reduction impact for mother and the unborn baby due to the elimination of exposure to the known carcinogenic chemicals present in cigarettes. However, the impact of e-cigarette use in pregnancy is poorly understood and licensed nicotine replacement therapy products are the recommended first option to stop smoking during pregnancy (4).

A better balance is needed between minimising promotion of e-cigarettes to young people, whilst allowing promotion to adults who smoke.

- E-cigarette manufacturers, including those owned by tobacco companies, have a commercial interest in maximising the widespread use and uptake of vapes.
- Advertising restrictions in England regulate the promotion of e-cigarette products on media platforms, including on television, radio, newspapers, and magazines (7).
- There has been an overall increase in young people reporting noticing e-cigarettes promotions - most prominently marketing on billboards and posters, taxis, buses, and public transport, which are permitted channels in England. Worryingly, young people who have never smoked or vaped notice e-cigarette marketing at a consistently higher rate than adults who smoked (8).

We don't have all the answers now, but on balance there is sufficient evidence to take action to improve the health of local people.

- Patterns of use, behaviours, and social norms around e-cigarette use are rapidly evolving, including amongst young people and children.
- National and international guidance on the safety and long-term health impacts of e-cigarette use continue to change and evolve.

We welcome:

- The Government's ambition to make England smokefree by 2030 and tackle health inequalities in smoking prevalence.
- The proportionate regulation of e-cigarettes through the UK Medicines and Healthcare products Regulatory Agency (MHRA), under the Tobacco and Related Products (TPR) Regulation.
- Ongoing efforts to develop and approve medically licensed e-cigarette products available through NHS prescription.
- The development and adaptation of national guidance around the safe, effective, and cost-effective use of e-cigarettes as a quitting aid.
- The development of national guidance and evidence around how to minimise uptake amongst young people and never-smokers.
- Proposals for legislation requiring plain packaging of vapes to help frame e-cigarettes as a quit aid rather than a glamorous lifestyle product which is appealing to children and non-smokers.
- The development of guidance on how to best support under 18s who smoke, including pregnant smokers, to access e-cigarettes legally and safely.

In recognition of the available evidence, we commit to:

1. **Ensure that vaping is effectively integrated into stop smoking services and campaigns across Rotherham, to maximise quit rates and reduce harm caused by tobacco smoking,** including by:
    a) Ensuring that all smoking cessation services (including those available through community, hospitals, antenatal, and mental health services) are aligned with latest guidance from NICE/NHS on e-cigarettes.
    b) Providing accurate information and guidance about the safe and effective use of e-cigarettes as a quit aid alongside information about other methods, so that smokers can make an informed decision about which approach to use.
    c) Offering behavioural support to people who chose to use e-cigarettes as a quit aid.
    d) Ensuring that the value of switching to vapes from tobacco smoking is understood and effectively communicated by non-health professionals as part of the Making Every Contact Count programme.
    e) Minimising inequality in access to effective quit aids including e-cigarettes.

f) Ensuring that all local smoking cessation services offer advice to people who want to reduce or quit vaping.

2. **Minimise the incidence of e-cigarette use amongst young people as part of ongoing efforts to create a smokefree generation**, including by:
   a) Scaling-up enforcement of existing laws which prevent retailers from selling e-cigarettes or e-liquids under 18s and prevent adults from buying or attempting to buy e-cigarettes on behalf of a child ('proxy purchasing').
   b) Supporting schools and colleges to implement smokefree and e-cigarette free policies.
   c) Incorporating messaging about the harms of e-cigarette use into local youth-focused anti-smoking campaigns and materials.
   d) Ensuring that there is support available to reduce e-cigarette use and / or quit for young people who vape.

3. **Restrict public messaging, advertising and promotions relating to e-cigarettes to ensure a focus on the value of e-cigarettes as a quitting tool, whilst avoiding promoting individual brands, or glamorising vaping amongst non-smokers, especially children and young people.** This will involve:
   a) Remaining vigilant and ensuring that any work relating to e-cigarettes is aligned with our ongoing commitment to protect tobacco control activity from the vested interests of the tobacco industry (as set out in WHO FCTC Article 5.3).
   b) Preventing advertising of all commercial vape products on publicly owned or contracted advertising spaces.
   c) Restricting reference to vapes, vape products and vaping on publicly owned sites to public health messages focusing on the value of e-cigarettes as a harm reduction tool and quitting aid.

4. **Support employers and organisations who manage outside public spaces to develop and expand Smokefree policies** which de-normalise the use of e-cigarettes, whilst ensuring that they are a preferable option for smokers to switch or quit, by
   a) creating an environment where smoking and vaping are not visible to support de-normalisation of everyday social use.
   b) supporting smokers to stop smoking, such as providing visible signposting to quit services.
   c) responding to the harm reduction and health needs of people living in secure and other restricted settings.
   d) aligning smokefree policies with national smokefree law and policy.

5. **Take measures to minimise the use of potentially unsafe e-cigarette products, including by;**
   a) Ensuring that local stop smoking services recommend that service users who wish to use e-cigarettes to quit or switch should purchase products that are registered with the MHRA and are compliant with the requirements of the TPD. This includes requirements for products to:
      i. Have child resistant and tamper evident packaging.
      ii. Be protected against breakage and leakage and capable of being refilled without leakage.
      iii. Deliver a consistent dose of nicotine under normal conditions.
      iv. Include tank and cartridges that are no more than 2ml in volume and contain liquids that have no more than 20mg of nicotine (this must appear on the label).
      v. Have packaging which is covered by a health warning that covers at least 30% of packs.

vi. Contain an information leaflet on use of the product and ingredients within the e-liquid.

b) Enforcing trading restrictions preventing the sale of unsafe products
c) Working with locally e-cigarette retailers to ensure that they offer MHRA-approved products, guidance on safe and effective use of e-cigarettes, and referrals into local stop smoking services.
d) Promoting the Yellow Card reporting scheme (which enables consumers and healthcare professionals to report side effects and safety concerns about e-cigarettes or refill containers) through local stop smoking services.
e) Helping the public to identify responsible vape shops and retailers.

6. Respond to evolving trends and evidence, including by:

a) Monitoring the trends in e-cigarette use amongst young people through local and national surveys.
b) Collecting and reviewing data on trends in e-cigarette quit rates and long-term use amongst community service users.
c) Regularly reviewing and updating this policy position as evidence and guidance around the safety and use of e-cigarettes continues to emerge.

Accessing support

Local stop smoking services are free and can increase the chance of quitting for good. Expert advisers are available to provide accurate information, give advice on stop smoking aids including vaping products, and support quit attempts.

Find Your Local Stop Smoking Service (LSSS) - Better Health - NHS (www.nhs.uk) Call the free Smokefree National Helpline on 0300 123 1044

Contact Get Healthy Rotherham for more information about services locally: www.gethealthyrotherham.co.uk

Endorsements

To follow

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Appendix 4 PLEDGES

Local Government Declaration on Tobacco Control

As public health leaders, we acknowledge that:

- Smoking is a leading cause of premature death, disease and disability in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely starting in childhood, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the tens of thousands of people its products kill in England every year; and
- The illicit trade in tobacco funds organised criminal gangs and gives children access to cheap tobacco.

We welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Government's ambition to make England smokefree by 2030 and tackle inequalities in smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health organization's framework convention on Tobacco control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- NHS Long Term Plan commitments to provide all smokers in hospital, pregnant women and long-term users of mental health services with tobacco dependence treatment.

We commit _____ from this date _____ to:

- Act at a local level to reduce smoking prevalence and health inequalities, to raise the profile of the harm caused by smoking to our communities and in so doing support delivery of the national smokefree 2030 ambition;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities and to join the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

Signatories:

Leader of Council	Chief Executive	Director of Public Health

The NHS Smokefree Pledge

As local health leaders we acknowledge that:

- Smoking is the leading cause of premature death, disease, and disability in our communities
- Smoking places a significant additional burden on health and social care services and undermines the future sustainability of the NHS
- Healthcare professionals have a key role to play in motivating smokers to try to quit and offering them further support to quit successfully
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities
- Smoking is an addiction starting in childhood with two thirds of smokers starting before the age of 18
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the tens of thousands of people its products kill in England every year

We welcome:

- The Government's ambition to make England smokefree by 2030 and tackle health inequalities in smoking prevalence
- The NHS Long Term Plan's commitment for all smokers in hospital, pregnant women, and long-term users of mental health services to be offered NHS funded tobacco dependence treatment by 2023-24
- NICE public health guidance on tobacco

In support of a smokefree future, _____ commits from _____to:

- Treat tobacco dependency among patients and staff who smoke in line with commitments in the NHS Long Term Plan and Tobacco Control Plan for England
- Ensure that smokers within the NHS have access to the medication they need to quit in line with NICE guidance on smoking in secondary care
- Create environments that support quitting through implementing smokefree policies as recommended by NICE
- Deliver consistent messages about harms from smoking and the opportunities and support available to quit in line with NICE guidance
- Actively work with local authorities and other stakeholders to reduce smoking prevalence and health inequalities
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Support Government action at national level
- Publicise this commitment to reducing smoking in our communities and join the Smokefree Action Coalition (SFAC), the alliance of organisations working to reduce the harm caused by tobacco

Signed by:

Chair	**Chief Executive**	**Medical/Clinical Director**