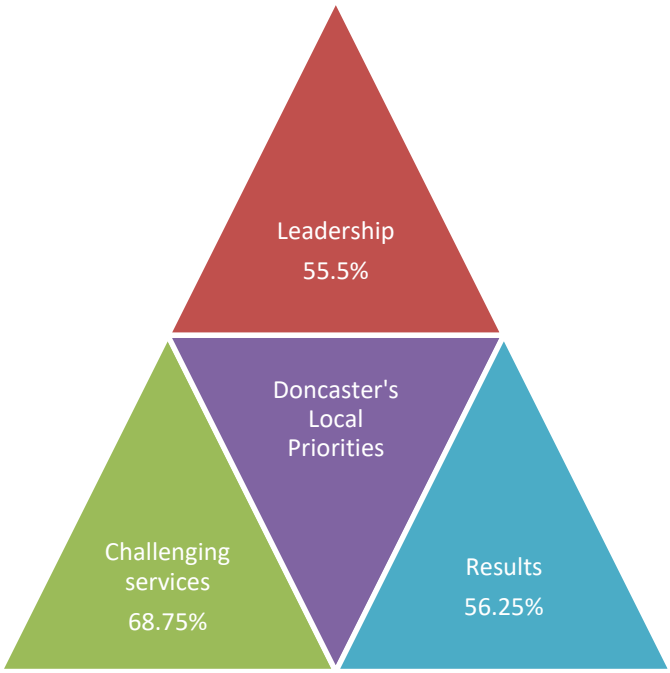
Public Health England

CLeaR thinking

CLeaR model assessment for excellence in local tobacco control

Doncaster Borough Council 19th March 2019



Doncaster's CLeaR scores as a percentage of the total available in each domain

CLeaR Excellence in local tobacco control Developed by ASH

ash action on smoking and health

About Public Health England

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Foreword

CLeaR has been developed by Action on Smoking and Health (ASH) with assistance from partners in Cancer Research UK, the Chartered Institute for Environmental Health, FRESH, the National Centre for Smoking Cessation and Training, Smoke Free South West, the Trading Standards Institute, Tobacco Free Futures and colleagues from the NHS and local authority.

Through their hard work and diligence, they have provided the platform by which every council, upper tier local authority or tobacco control alliance can assess their delivery plans and take assurance from review by their peers, that they are investing their resources wisely and in full knowledge of the evidence which supports this.

Public Health England thanks ASH and their partner organisations for developing such a simple, yet challenging assessment and for their continued dedication to securing a tobacco free future through evidence-based tobacco control.

Duncan Selbie
PHE chief executive

1. CLeaR context

CLeaR is an improvement model which provides local government and partners with a structured, evidence-based approach to achieving excellence in local tobacco control.

The model comprises a self-assessment questionnaire, backed by an optional external challenge process from a team of expert and peer assessors. The purpose of the peer-assessment is to review the scoring and evidence selected by organisations when completing the self-assessment questionnaire and to provide objective feedback on performance against the model.

The report also provides a number of recommendations (CLeaR messages) and the assessment team`s revised scores, accompanied by detailed feedback on specific areas of the model (CLeaR results). In addition, we suggest some resources you may find useful in further developing your work on tobacco control (CLeaR resources).

1.1 CLeaR in Doncaster

Dr Victor Joseph, Consultant in Public Health and Tobacco Control Alliance Chair invited the CLeaR team to validate the CLeaR self-assessment process in Doncaster.

It is intended that this report be used to inform members and officers of various organisations in the Borough of the wider impacts of tobacco consumption; on the health and wellbeing of Doncaster and to generate support at an operational level to develop the alliance leading to more collaborative working and a better understanding of partners' roles and responsibilities.

This report summarises the conclusions of the CLeaR peer-assessment team following their appraisal of the self-assessment; accompanying evidence and discussions during the visit on 19th March 2019. It sets Doncaster's challenge in context, providing information on the economic and other impacts of smoking in the authority.

In carrying out the CLeaR peer assessment we built on the insights into areas that needed improvement, as recognised through your self-assessment questionnaire.

Special thanks go to Victor, Anna Brook and Claire Hewitt for their assistance in organising the assessment visit.

Thanks also go to all those who gave their time as part of the peer-assessment visit for their enthusiasm and willingness to engage with the process. This was greatly appreciated. Some potential interviewees were unable to attend so their views may not be represented here.

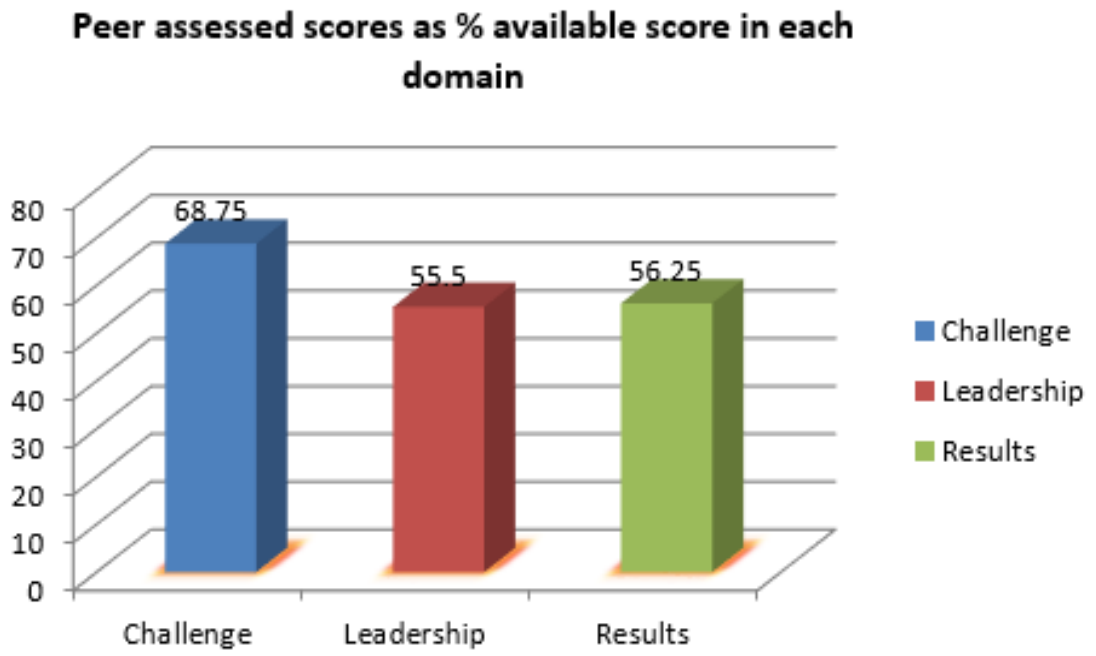
The CLeaR Peer Assessment Team consisted of Paul Hooper, iPiP (Core Assessor); Sarah Hepworth, Health Improvement Principal Place – Culture, Environment & Leisure – Public Health, Sheffield City Council and Sue Smith, Public Health Specialist (Lead for Tobacco Control, Oral Health Improvement and Dementia)

Interviewees from Doncaster (various sessions)

- Robert Suckling, Director of Public Health
- Victor Joseph, Consultant in Public Health and Chair of Tobacco Control Alliance
- Anna Brook, Public Health Registrar
- Councillor Nigel Ball, Cabinet Member for Public Health, Leisure and Culture
- Councillor Rachael Blake, Chair of the Health and Wellbeing Board and Cabinet Member for Social Care
- Dave McMurdo, Trading Standards Manager, Trading Standards
- Peter Jones, Partnership Officer, Fire Service
- Steve Betts, Communications Officer with focus on public health.
- Carrie Wardle, Public Health Theme Lead on Children and Young People
- Victoria Shackleton, Public Health Officer
- Carys Williams, Public Health Improvement Officer, Wider Determinants Team
- Simon Lister, Service Manager Yorkshire Smokefree Service, South West Yorkshire Partnership NHS Foundation Trust
- Zahra Velji, Specialist Yorkshire Smokefree Service, South West Yorkshire Partnership NHS Foundation Trust
- Debby McKnight, Nursing and Midwifery, Hospital QUIT Lead, Doncaster and Bassetlaw Teaching Hospital
- Emma Brown, Public Health Officer, Vulnerable Lives
- Helen Conroy, Public Health Theme Lead Vulnerable Lives
- Caroline Burrows, QUIT lead, ICS

NOTE: The term ‘Doncaster’ refers to the areas covered by Doncaster Borough Council throughout.

2. CLeaR messages



CLeaR domain	Max score	Self-assessment score	Peer-assessment score
Leadership	36	23	20
Challenge services	48	36	33
Results	32	18	18

2.1 Your insights

The following section includes key information provided in the self-assessment and associated evidence and what the peer-assessment team heard on the visit:

- Adult smoking prevalence in Doncaster is higher than the regional and national averages. There is also higher than average prevalence in certain groups including pregnant women; routine and manual workers and young people. There are also certain geographic communities where smoking prevalence is particularly high.
- In a challenging environment there are ambitious targets for reducing smoking prevalence in Doncaster, but most partners seemed to be unaware of them. The current tobacco control strategy and plan do

not match the ambitions and therefore the targets are unrealistic, based on current/planned activity.

- Evident from the useful tobacco control dashboard, Doncaster's steady decline in adult smoking, smoking among routine and manual worker groups and rates of smoking at the time of delivery (SATOD) have flatlined or even started to increase.
- Tobacco control does not feature specifically in the Council's Corporate Plan (which is light on health issues generally).
- Although Doncaster has a lead in public health and a supporting team, tobacco control and smoking cessation commissioning are only part of their roles and this work has diminished as work in other areas has expanded.
- There are various funding streams for both cessation and tobacco control work. Some are secure and others may be affected by general reductions.
- Tobacco Control may be seen by some organisations as a public health responsibility only. The Tobacco Control Alliance in Doncaster is well established but attendance at meetings and commitment to targets by some partners could be improved.
- There is a tobacco control action plan but it does not seem to be fit for purpose (i.e. to achieve targets).
- Tobacco control's contribution to the overall health and financial wellbeing of Doncaster District is not as well understood as would be desired.
- Although the stop smoking services are only one part of the broader tobacco control delivery, and evidence would suggest that wider tobacco control has the biggest impact on reducing prevalence, there seemed to be an expectation that the services would play a major part in delivering the prevalence targets.
- You recognise that opportunities exist to build a broader consensus for tobacco control across a wide range of council functions and partnership agendas. For instance, highlighting the contribution tobacco control makes to priorities such as community safety, children and young people, debt management, and economic prosperity.

- Boundaries of organisations (such as health trusts and the local authority) are not always co-terminus, but they are not overly complicated.

2.2 Your strengths:

The following two sections include key highlights from the peer assessment and the reflections and observations of the peer assessment team.

- Active support for the tobacco control agenda in Doncaster is reflected in practice through senior leadership and your committed team from whom we saw enthusiasm and passion for delivering quality innovative work.
- Key elected members are supportive of actions that will lead to a reduction in the impact of tobacco on the overall health and prosperity of the borough.
- Doncaster Council signed the Local Authority Declaration on Tobacco Control in April 2015 and is therefore a member of the Smoke Free Action Coalition. It was suggested that the CLeaR process could be a catalyst for refreshing commitments.
- Your public health supported regulatory services have made progress on illicit and underaged sales.
- There is some level of sub-regional joint working especially with regard to regulatory services (e.g. illicit tobacco, ‘fakes cause fires’, home safety fire checks)
- The Doncaster stop smoking service, a separately commissioned part of a larger group of services for South Yorkshire, is well-established achieving good 4-week quit outcomes with a focus on high prevalence groups.
- Yorkshire Smokefree service has been performing well to a revised specification that prioritises high prevalence groups.
- Electronic cigarettes are incorporated into the cessation offer.
- Public health expressed commitment to raise the profile of tobacco control and to provide support and leadership of the alliance.

- You are keen to review progress and develop your plans further and interviewees were clearly committed to improving Doncaster and spoke with genuine enthusiasm around their areas of responsibility.
- Some clinical champions have been identified particularly in secondary care.
- Investment has been made in maternity services to improve referrals and communication. Combined with a stop smoking service that works closely with maternity, this should contribute to a reduction in rates of smoking at the time of delivery. A health visitor led service enables follow up into 0-5 year olds' environments, extending the relapse prevention period and enhancing your smoke free homes work.
- There is some understanding of how tobacco control can address local health inequality issues.
- Smokefree homes work is being based on a pragmatic approach through the housing provider.

2.3 Opportunities for development

- You have an opportunity, thorough the Health and Wellbeing Board and other groups, to influence understanding of the way tackling tobacco can impact on other priorities (e.g. inequalities, economic growth). However, key strategic documents are disconnected. You may consider tobacco-specific reports in order to ensure the importance of the topic is not lost.
- There are opportunities to ensure a wider ownership of the strategic goals (both by individuals and organisations) and to strengthen the governance arrangements for monitoring progress. A starting point may be to review the strategy itself.
- In particular you should revise the vision of 'reducing nicotine dependence' which contradicts your open view of electronic cigarettes.
- You appear to concentrate on secondary prevention. Consideration should be given to broadening the scope of tobacco control activities to incorporate local elements of the MPOWER six-strands of comprehensive tobacco control. https://www.who.int/tobacco/mpower/en/

- There is an opportunity to further encourage the development of tobacco control champions from partner organisations and opportunities to increase understanding in partner organisations on which policy levers and interventions will be most impactful on their priorities (e.g. CCG)

- The current targets within the tobacco control strategy are unrealistic and as we get nearer to the critical dates consideration should be given to how expectations of elected members and partners can be managed to avoid the positive progress made being discredited. Your intention to schedule discussions with partners to identify gaps and how to narrow them will help to make your tobacco control plan more realistic and achievable.

- In order to aid monitoring of progress you may wish to develop interim actions and ensure outputs from the alliance are measurable.

- You may consider modelling potential outcomes as part of the process of setting new interim targets.

- The alliance needs to be clearer about its purpose and perhaps give more direction as opposed to passive receipt of progress updates. Consideration should also be given to whether a change in chair, perhaps an elected member, might provide a degree of independence and scrutiny to the Alliance. The selection of the chair of a reinvigorated alliance may determine how others perceive the group.

- The corporate plan and other high-level documents have little or no mention of tobacco control ambitions but there are various elements to which tobacco control might play a positive role. Consideration should be given to re-making the case for tobacco control to internal and external partners. These can be framed as ‘business’ decisions for increased productivity and/or reduced costs as opposed to purely health improvement.

- The Director of Public Health and relevant elected members could be key influencers to revitalise partnership working on tobacco control, but they may have limitations on their time. A revised comprehensive tobacco control plan linked to corporate objectives may help keep tobacco on relevant agendas.

- Elected members may wish to make use of the new Councillors’ network as part of the LGA Declaration on tobacco control resources.

- Understanding of the potential issue of tobacco industry interference was strong. It may be helpful to develop a deeper understanding and awareness

of the tobacco industry amongst a broader group of elected members and wider stakeholders. This would support framing tobacco control activities around a childhood protection and prevention focus and help increase support for future actions.

- You have a strong public health team supported by a number of other partners who, if the available time devoted to tobacco control is not reduced, could make considerable progress on a revised plan. At this critical point in time you may wish to designate responsibility for revising the plan and working more widely on smokefree Doncaster to a full-time post.

- You may wish to consider commissioning a new tobacco control JSNA and linking it to the Health and Wellbeing Board and other key groups.

- Careful consideration should be given to which other organisations and individuals would be essential for a viable alliance and to actively seek their support and attendance.

- There is an opportunity to capitalise on and develop tobacco control champions from partner organisations to increase understanding in partner organisations on which policy levers and interventions will be most impactful for themselves and the tobacco control agenda in general.

- The impact of a 'holistic' public health approach to communications is difficult to measure. In addition, there is currently no partnership communications plan for tobacco control. Consideration should be given to the development of a comprehensive communications plan for the alliance which would allow for greater notice of events and campaigns and enable partners to use their respective resources to support each other.

- All partners could review their online communications around tobacco control to ensure quick and easy wins were being realised.

- You may wish to consider introducing a local campaign to target specific groups or areas.

- There is an opportunity to further use insights to determine prevailing attitudes and knowledge of smokers and other audiences. This may help guide activity.

- The QUIT and other programmes show promise and there is a real opportunity to support a concerted effort to embed a smokefree NHS regime

that supports in patients to abstain and quit. This could be extended to primary care settings.

- Training on VBA has been undertaken in many settings, but it was not clear what the outcomes are. You may wish to evaluate these programmes to ensure that you are receiving a reasonable return on your investment.

- As part of a smokefree Doncaster vision there may be opportunities to work more closely with businesses, especially those with routine and manual workers to promote smokefree businesses and the benefits of a reduced prevalence workforce and tackle inequalities.

- The CLeaR process provides an opportunity to review all public sector smoking policies to ensure they are consistent with the latest evidence regarding electronic cigarettes and include more active support for those wishing to quit.

- Consideration should be given to removing any barriers to receiving stop smoking medication for those making a quit attempt (e.g. people who do not qualify for free prescriptions).

- Consideration could be given to a limited application of incentive schemes where this would have an impact on inequalities (e.g. smoking in pregnancy).

- The stop smoking service is largely following best practice guidance and is responsive to the need to adapt and change practice. There are opportunities for partner organisations to support the service in increasing referrals specifically primary care.

- There are specific opportunities for more systematic and robust referral pathways from acute health trusts into the local support to quit service as part of the drive towards a smokefree NHS.

- Action could be taken that would engage more with local communities, perhaps through the voluntary sector, regarding the ambition to create more smokefree outdoor areas. You may wish to prioritise tackling the high levels of smoking outside the local college.

- The use of the CLeaR peer assessment in a local networking event may help to maintain focus and provide opportunities to explore joint working and

the formation of a new tobacco control alliance. This may lead to the use of other CLeaR tools.

- The accredited ‘positive approaches’ course could be useful for a number of professions who are working with the public.

- Consideration should be given to the recommendations of the RCP report ‘Hiding in Plain Sight’ (June 2018).

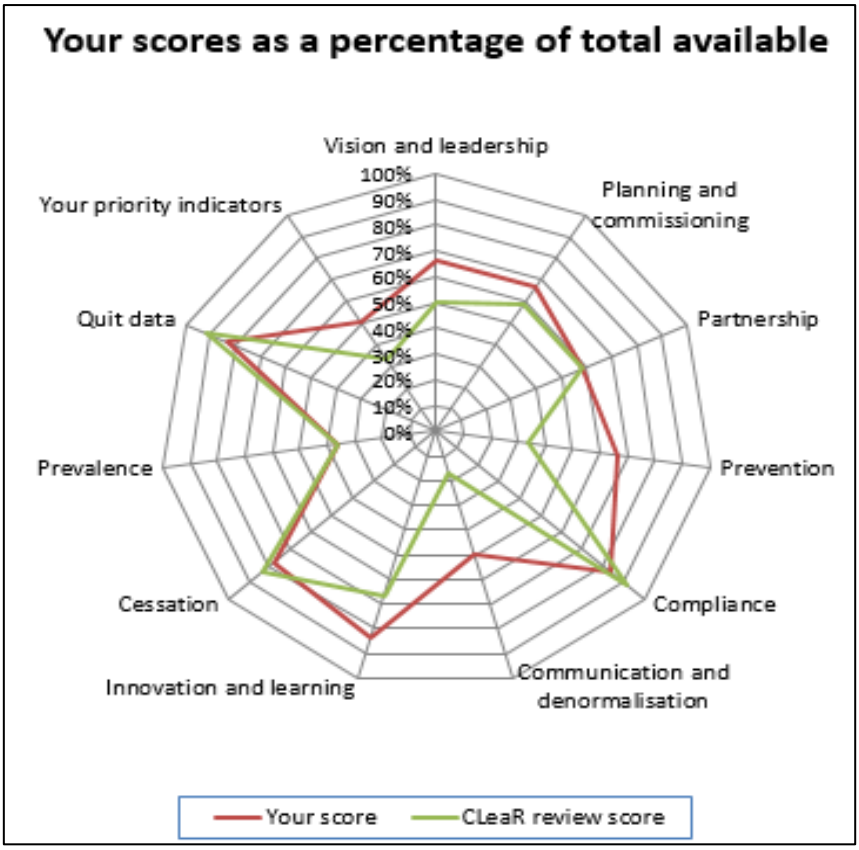
- There are examples of working across boundaries. Doncaster could take a more active role in regional and sub-regional groups and by doing so share good practice.

- Investigation into how young smokers are identified and worked with by youth services could result in greater opportunities for them to quit.

- Consideration should be given to how, in the light of tight budgets, to fund the changes needed to achieve your ambitions.

3. CLeaR results

The chart below shows (in red) Doncaster’s original self-assessment scoring, as a % of available marks in each section and (in green) the CLeaR team’s peer-assessment results. The scores of the peer assessment were frequently similar but lower and higher in some areas to those of the self-assessment. Detailed comments below show where the assessments differ. Both assessment scores highlight areas where improvements can be made.



3.1 Detailed comments on your peer-assessment

Note: Scoring by the peer assessment team was based on the current position rather than any potential or planned activities (e.g. proposed new Tobacco Control Plan) that were described. If implemented successfully your plans will have a positive effect on future scores.

Clear Theme	Your score	Our score	Max	Comments
Leadership				
Vision and leadership (including WHO FCTC)	8	6	12	The Health and Wellbeing Board receives information on tobacco, but it is only as a part of an annual Health Protection Assurance report. Whilst it is important to show the connectivity and interdependence of topics there may be a value in tobacco-specific reporting. Although we did not see all of the clinical champions identified in the self-assessment, there was some evidence of clinical champions being established but it was acknowledged that more work was needed to develop champions in all areas. There was a lack of clinical champions in primary care; this may improve with the

				introduction of tobacco control indicators in the Primary Care Evaluation Matrix. The QUIT programme has advanced the agenda in secondary care where there has also been high level supported demonstrated. The LGA declaration on tobacco control has been signed by both the local authority and the CCG. The elected members interviewed showed a commitment to local community involvement and a desire to achieve improvements in health. There appeared to be a desire to help Doncaster become truly smokefree and work towards a smokefree generation but the concept of what this might look like in reality and the steps needed to achieve it were not well defined. It was acknowledged that the adopted targets are unrealistic. Discussions were held on how this should be managed. Your aim to reduce nicotine dependence is at odds with your 'ditch or switch' message, and with NICE guidance on tobacco harm reduction. It was not clear that the wider impact of tobacco would be known by elected members in general. It was recognised by some that tobacco control could contribute to wider determinates such as the economy, poverty etc, but It was difficult to identify how the tobacco control agenda was being systematically included in other work streams. To this end, tobacco control could be promoted wider within the Borough Council e.g. economic development. You recognise that your current tobacco control plan is out of date. It also does not capture your work to promote a smokefree Doncaster. It is acknowledged that a more comprehensive review will take place including action following the CLeaR peer assessment. The tobacco control strategy appears to be essentially an introduction to the action plan. Public Health are seen as leaders of the topic but the need to ensure other

				organisations play their appropriate part was recognised. The Director of Public Health has shown strong leadership around this topic and a willingness to raise the issue specifically (as opposed to part of broader reports) as a way of gaining support for the ambitious targets.
Planning and commissioning	8	7	12	Whilst your service specifications generally reflect NICE guidance there are some gaps in implementation. It is acknowledged that in-patients are specifically excluded from the adult stop smoking service. The commissioning of stop smoking services has been consistent and led to a relatively stable market. (see later comments) Work has been undertaken in maternity services to embed smoking cessation. The provision of smoking cessation via the Health Visiting Service has both advantages (ability for long term follow up and family involvement) and disadvantages (not the responsibility of maternity services). Until recently there have been improvements in SATOD data. There is a stated desire to work towards a smokefree NHS in part through the use of QUIT and CQUIN programmes. Some of this work has been undertaken on a sub-regional basis and by sticking to the model Doncaster may be ahead of others. It is important to embed what 'Smokefree NHS' means (i.e. not simply environmental) in the acute sector. Progress to help staff quit; train security staff and others and have a flexible approach to the use of electronic cigarettes are all helpful. There appears to be a reluctance to engage in harm reduction (i.e. temporary abstinence). This may have an impact on the effectiveness of smokefree NHS policies and reduce the opportunities for some smokers to experience abstinence. The Health and Well Being Board, by not receiving reports on tobacco control as a single issue, may not be as well sighted on this topic as others.

				The connections between key documents could be better. We heard the corporate plan does not lend itself to topic specific issues, but tobacco control is currently being lost in the whole system approach. There is a tension between having specific targets and actions for tobacco and showing how tobacco contributes to many other issues e.g. tackling inequalities. Although there are some SMART targets in the tobacco control plan it was acknowledged that interim targets were needed that could be made more specific regarding timescales and/or quantifiable outcomes.
Partnership, cross-agency and supra-local working.	7	7	12	You have a tobacco control alliance with regular meetings and reporting. Although membership is quite extensive attendance is limited. You acknowledge that the Alliance could be more active. You have stated your future aims such as embedding smokefree NHS and moving onto social norms work. The peer assessment team acknowledged the intention of revitalising the alliance and that the CLeaR process was one way of generating interest and commitment in new partners. There are other groups that could act as a proxy for the alliance for some topics (e.g. the ICS group) We were able to have discussions with a wide range of people from several different agencies many of whom recognised their role in the wider partnership, but many did not seem to be aware of the ambitious local targets. The work of the public heath team in the organising of the alliance and developing plans was recognised but there is a risk that others, in the light of reduced resources, will use this as a reason to be less involved. You are considering the involvement of elected members in the alliance, which the assessment team recognise could be a positive step in engaging partners from outside of public health organisations. There are conflicting views on whether there is an identified lead for tobacco control and the alliance.

				The overall time devoted to tobacco control has reduced in recent years due to competing priorities and additional duties. We acknowledge that a new action plan is to be developed. The new plan should identify the actions that each partner organisation will be accountable for, the role of the partnership and mechanisms for monitoring progress along with the scrutiny and escalation processes if not delivered. Interviewees demonstrated a good understanding of the need to protect local plans from the vested interests of the tobacco industry and this is embedded in some contracts. We heard strong statements on pensions and the desire to disinvest from tobacco in the medium to long term. Consideration was given to further action to inform all elected members and guard against tobacco industry influence. Sub-regional networking arrangements are strong and Doncaster benefits from working in partnership with others although this arrangement seemed passive rather than active and it was not clear how this might progress going forward. Doncaster is the host for the 'fakes cause fires' website. It was difficult to quantify the level of understanding of the importance of tobacco control (as opposed to smoking cessation) by frontline workers. There has been some good partnership working and joint commissioning with respect to the secondary care sector.
Challenging Your Services				
Prevention	4	2	6	Evidence of training about secondhand smoke and associated brief interventions by the stop smoking service was offered but as this has not been in operation long the results are not yet available. Limited evidence of a smokefree homes scheme was offered. We heard that there is an ambition to designate some town centre areas as smokefree, but this has yet not been developed or expressed as a coherent plan.

				We heard that you have emerging plans to address the issue of smoking in young people. Serious concern was expressed over the apparent misconceptions among young people of the prevalence of smoking and the numbers of young people smoking outside a local college. The healthy schools re-launch does not have smoking as one of its priorities. There has been some work around smokefree playgrounds and local authority-controlled schools. You have an ambition to follow up with smokefree events, but plans are under developed. We heard about how Project 3 receives referrals from the school nursing service, but in low numbers. We also heard that smokers were identified by RDASH working with under 19s, but few interventions followed.
Compliance	10	11	12	Trading Standards work on tobacco has been substantially funded by public health for around four years during which significant progress has been made. This is demonstrated by level of seizures and action on specific premises. Breaches of tobacco laws have been linked to the alcohol licensing process. There is involvement in the Trading Standards Regional Network including the tobacco and alcohol group. Intelligence on illicit tobacco is dealt with well through the use of the Consumer Advice Hotline and national intelligence systems. There has been some coordinated (and funded) work on test purchasing, nicotine inhaling products and surveillance. Across South Yorkshire the 'fakes cause fires' joint campaign with the fire service has been jointly funded and in part administered by Doncaster. There are few shisha premises in Doncaster and little evidence of the use of other niche products. However, regulatory officers are

				maintaining vigilance and working collaboratively. Enforcement by both environmental health and trading standards was intelligence led and described as balanced between proactive and reactive. There were few reported complaints regarding smokefree places and compliance is thought to be high. Cooperation from HMRC was cited as poor in spite of continued attempts to engage. There has been some activity regarding compliance with product legislation. This has been combined with work on fake chargers for electronic cigarettes. There were strong policies and procedures described about protecting work from the influence of the tobacco industry. Robust procedures were in place regarding any necessary contacts needed for enforcement purposes. However, this could be promoted wider than regulatory officers.
Communications and denormalisation	3	1	6	Whilst Yorkshire Smoke Free has a comprehensive communications plan there is no Alliance Plan and an acknowledged lack of coordination between local partners. Although the self-assessment suggested a number of national campaigns had been supported and amplified the communications team could only demonstrate ad hoc superficial press release and social media activity. Local media coverage was described as 'limited'. It was difficult to attribute local activity as the reason for any significant uplift in referrals to the stop smoking service during campaign periods such as Stoptober. We did not hear of any plans for new locally driven campaigns to support the vision of a smokefree Doncaster.
Innovation and learning	5	4	6	The Tobacco Control Alliance has a regular reporting mechanism for monitoring data and it is a standing item on the alliance agenda. This data is not shared as widely as it could be and could form part of a broader

				information sharing process of reports and updates. The current level of challenge has been around the self-assessment. This may form the basis of challenge going forward and there appears to be a desire to achieve this through constructive comment. We heard that a 'positive approaches' course had been accredited as part of the safe and well referral partnerships initiative. Innovative campaigns have been developed around misuse of electronic cigarettes.
Cessation	14	15	18	The adult cessation service is well established with a relatively stable workforce. It has been maintained as a discrete service but within the broader MECC agenda. The service specifications are linked to the priority populations. Although gaps were identified in acute in-house provision an overall level of service would need to be increased if Doncaster's ambitions were to be realised. The service website is comprehensive and tailored to local users. Although because it is part of a wider network of services the local data is limited and, at the time of accessing, out of date. Along with other promotions and the development of pathways with various stakeholders the service would appear to be generating sufficient referrals from target audiences. The peer assessment team heard a lot about training of staff through various schemes (MECC, VBA, QUIT and SCIP) in some areas this had resulted in increased referrals in others this was yet to develop. The CQUIN is in place but there is more to do to realise its full potential including the establishment of an efficient electronic referral. The peer assessment team heard that electronic cigarettes had been adopted in some premises for in patient use. In addition, the use of e-cigs as a way of quitting is encouraged with the 'Ditch or Switch' message well known

				The issuing of medication through different means is a little complicated and you are considering changes. There are some limitations imposed on the supply of nicotine replacement products through the triage process. We heard that budget shortfalls were being mitigated by underspends in some areas. The adult service exceeds the minimum standard for CO validation of quits. However, concern was expressed over the difficulty of getting good data for smoking at the time of delivery. The general stop smoking service has a robust system for engaging with lapsed quitters. Activity to reduce smoking in pregnancy is included in a larger contract and may be subject to proportional reductions in budget of 2.5% pa for three years. This may seriously impact on the ability to deliver on the ambitious targets. Work with offenders has shifted from in prison to working with those leaving detention.
Results				
Prevalence	5	5	14	Smoking prevalence of adults in general and routine and manual workers in Doncaster, although still relatively high, has been reducing but the last monitoring period showed a possible flattening in the trendline. This has prompted a review of the approach and a determination to ensure progress continues. Smoking at the time of delivery had been improving with the gap between local and national levels narrowing but latest data shows a slight increase. A task and finish group is implementing the results of a recent 'deep dive' into secondary care at Doncaster and Bassetlaw Hospital. Other CLeaR 'deep dive' tools have not yet been used.

Quit data	10	11	12	YSF perform well with higher than average quits per 100,000 population with an improving trend. Service also has impressively low levels of lost to follow up rates (10%). Data is submitted to NHS Digital. Referrals from the CQUIN route have been slow to develop in the general acute sector (mental health have been referring more consistently over time) The deep dive action plan will help to address this. The service has contributed to reductions in health inequalities in general and reducing smoking in routine and manual groups has been enhanced by including a quality premium in the specification. Locations for service delivery are now in areas of greatest need and have included community fire stations
Local Priorities	3	2	6	It is acknowledged that progress on reducing prevalence has recently stalled. Priority 1 – Young People. No trend information is available Priority 2 – Adult Prevalence. Acknowledged not reducing quickly enough to meet targets. Priority 3 – Reducing Inequalities – new service provision in place since data collected so may show improvement. All of the above priorities should be articulated as part of the new tobacco control plan for Doncaster. It would be helpful to have appropriate metrics to measure progress for each of these priorities.

The key challenges the peer assessment team identified for Doncaster are:

1. Making the new tobacco control ambitions for Doncaster explicit ensuring all organisations are aware of how they can contribute to the wider agenda and local priorities.
2. Ensuring that the flattening of the trends to reduce smoking prevalence does not continue or worsen with consequent significant

effects on health and wellbeing tobacco among certain populations in the Borough.

3. Broadening the involvement of partners in developing and monitoring of progress in implementing a new tobacco control action plan as part of a revitalised alliance.
4. Delivering a fully implemented Smokefree NHS including both a positive environment and integrated support for people to quit.
5. Ensuring stop smoking services can fully engage with vulnerable groups and have a positive impact on health inequalities.
6. Developing a partnership tobacco control communications plan.
7. Ensure compliance work continues to be supported to a level that enables both reactive and proactive work to be undertaken.

4. CLeaR opportunities

This section highlights the effects of tobacco consumption in Doncaster

With an estimated 18+ population of **239,030** and a median salary of **£19,940** Doncaster falls within the middle deprivation quintile among boroughs in South Yorkshire (Met County)

Doncaster's over 18s smoking prevalence is estimated as **19.8% (2016)**. This equates to **47,705 adult smokers.**

If the wider impacts of tobacco-related harm are considered, it is estimated that each year smoking costs Doncaster **£78m** of which costs to the NHS contribute approximately **£14.7m**; lost productivity **£50.7m** and Social Care **£10.5m** (of which **£5.7m** is attributable to the local authority social care budget).

It is estimated that South Yorkshire Fire and Rescue Service will attend **11** smoking related house fires with a cost to the Borough of around **£2m**

Smokers in Doncaster consume around **533,490m** cigarettes each day resulting in approximately **79kg** of waste daily.

In addition, the local population in Doncaster spend **£99.5m** on tobacco related products. (Approximately £2,050 per smoker) As smoking is closely associated with economic deprivation this money will be disproportionately drawn from Doncaster's poorest citizens and communities. If this money was spent on other things instead of smoking the effect would be to create jobs in the local economy.

With an estimated 18+ smoking prevalence of 19.8% (2016), Doncaster has a population of about

47,705 adult smokers

Each year we estimate that smoking in Doncaster costs society a total of approx £78m

This cost is accrued across a range of social domains:

Healthcare

Smoking both causes and exacerbates long term health conditions and is the leading cause of preventable death and disease in England

The total annual cost of smoking to the NHS across Doncaster is about **£14.7m**

£4.3m is due to approx 3,462 hospital admissions for smoking-related conditions

£10.4m is due to treating smoking-related illness via primary and ambulatory care services

(that's as a result of around 145,348 GP consultations, 42,751 practice nurse consultations, 80,690 GP prescriptions, and 25,985 outpatient visits)

Productivity

Smokers take more sick-leave from work than non-smokers and smoking increases the risk of disability and premature death

£50.7m of potential wealth is lost from the local economy in Doncaster each year as a result of lost productivity due to smoking

675 early deaths due to smoking result in 821 years of lost economic activity, costing businesses about £18.9m

Each year absenteeism due to smoking-related illness results in about 113,998 days of lost productivty, costing a further £10.1m

Additionally, it is estimated that smoking breaks cost businesses in Doncaster £21.8m

Social Care

Many current / former smokers require care in later life as a result of smoking-related illnesses.

Each year this costs society in Doncaster an additional £10.5m

£5.7m is funded from the local authority social care budget

£4.8m is paid by individuals or families who self-fund private care

House Fires

Smoking materials are a major contributor to accidental fires in England, with around 7% being smoking-related.
Fatalities are disporportionately high in smoking-related fires, representing 49% of all house fire deaths

It is estimated that South Yorkshire Fire and Rescue Service will attend about 11 smoking-related house fires each year in Doncaster

£2m is lost annually in the Borough as a result

Smoking-related fires are expected to be responsible for approx 1 fatality every 2 years, resulting in average annual societal losses of £1.1m

In addition to deaths, smoking-related fires are expected to result in 3 non-fatal injuries each year, further increasing the societal cost by £374,930

Smoking-attributable fires will also result in property damage at an average annual cost of £531,820

and the annual cost to South Yorkshire Fire and Rescue Service for responding to these fires is £36,210

Littering

62% of people drop litter and smoking materials constitute 35% of all street litter.
The majority of cigarette filters are non-biodegradable and must be collected and disposed of in landfill sites.

Smokers in Doncaster consume about 533,490 cigarettes every day.
Of these, roughly 466,860 are filtered, resulting in around

79kg
of waste daily

This represents 29 tonnes of waste annually, of which 12 tonnes is discarded as street litter that must be collected by the Local Government

That's enough cigarette butts being discarded on the street to fill 525 standard wheelie bins every year (and that's not counting cigarette packaging and other smoking-related litter!)

Tobacco Expenditure

Smokers in Doncaster spend roughly £99.5m on tobacco products each year

That's about £2,050 per smoker

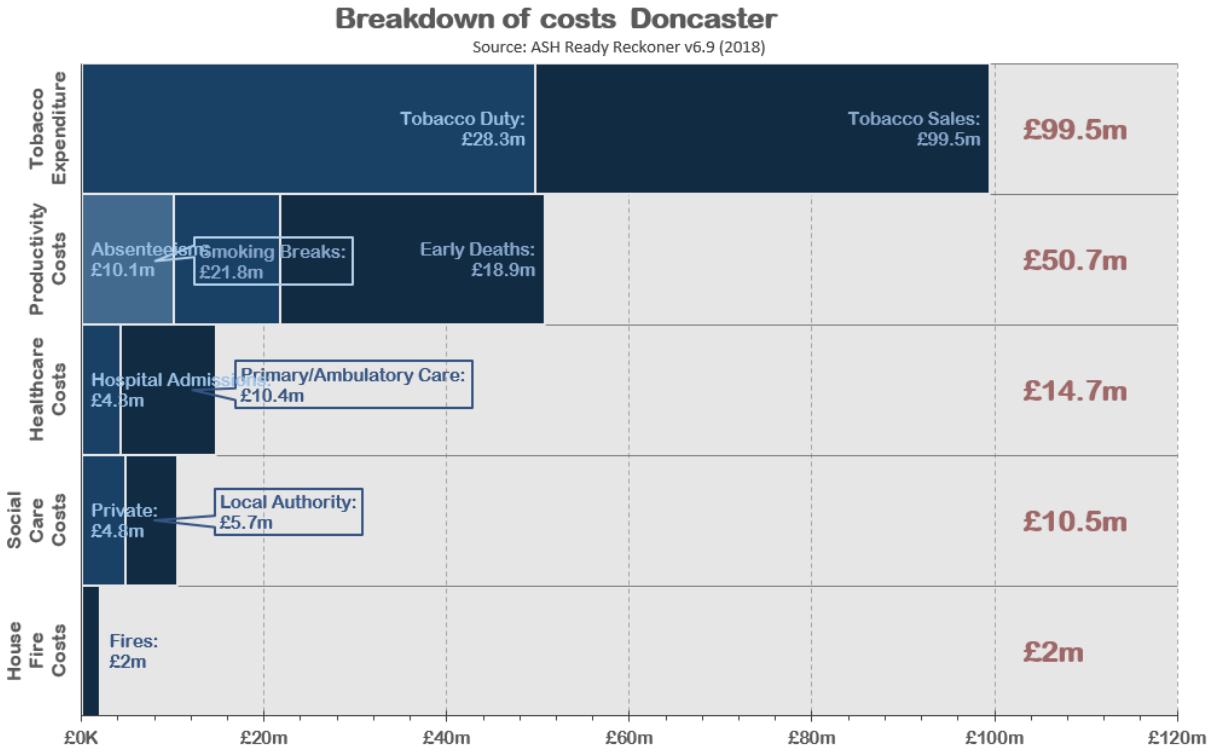
Of the total expenditure on smoking products, £49.6m is collected by the Exchequer as tobacco duty. Despite this extra revenue, tobacco still costs the community in Doncaster one and a half as much as the duty raised

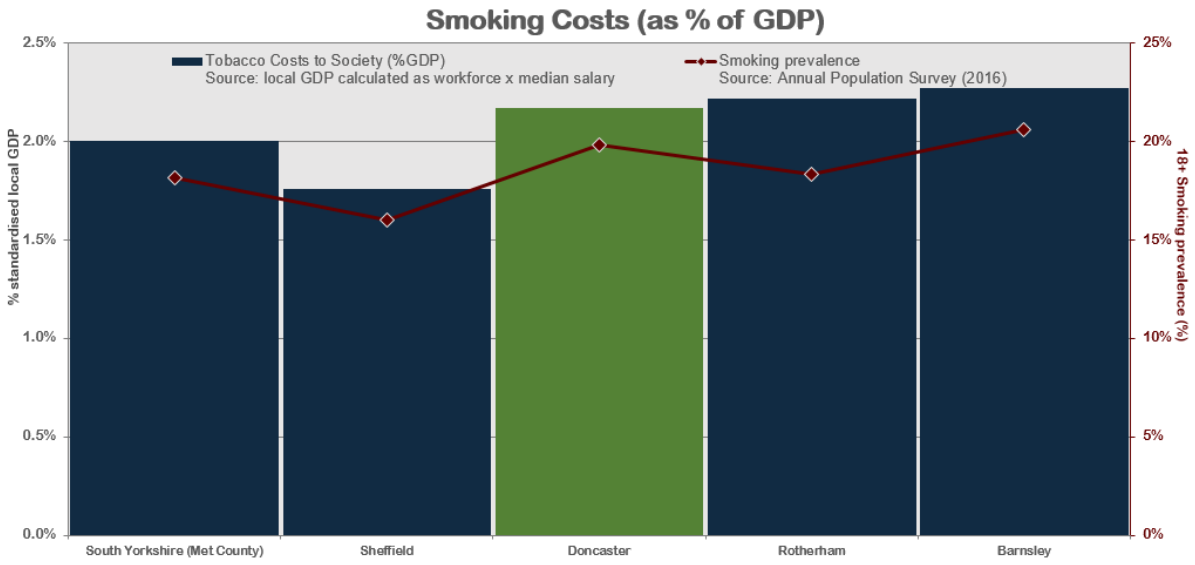
This represents a net annual cost to society of

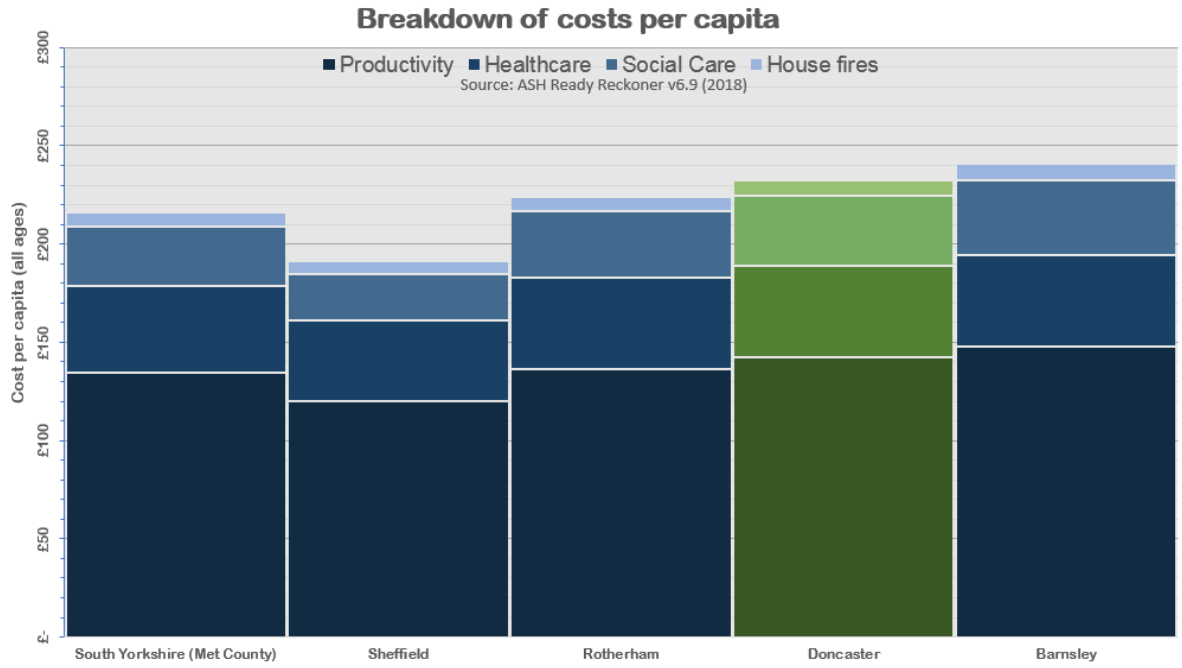
£28.3m

Breakdown of costs and expenditure in Doncaster

Source: ASH Ready Reckoner v6.9 (2018) Accessed 30/03/19







See http://ash.lelan.co.uk/ for more details

5. CLeaR resources

Tobacco Control Plan Delivery Plan 2018
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/714365/tobacco-control-delivery-plan-2017-to-2022.pdf

PHE guidance for a Smokefree NHS
https://campaignresources.phe.gov.uk/resources/campaigns/61-smokefree-nhs/resources

Royal College of Physicians report on the role of the NHS in treating tobacco dependency
https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs

Smoking in Pregnancy Challenge Group reports and resources
http://smokefreeaction.org.uk/smokefree-nhs/smoking-in-pregnancy-challenge-group/

Information for Directors of Public Health, local authority officers and members can be found at
http://ash.org.uk/category/information-and-resources/local-resources

Local information on the business case for tobacco can be found at
http://www.nice.org.uk/About/What-we-do/Into-practice/Return-on-investment-tools/Tobacco-return-on-investment-tool

Information on effectively engaging with priority smoking populations can be found in the Tobacco Control – commissioning support pack 2018/19
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/647221/Tobacco_commissioning_2018-19_principles_and_indicators.pdf

A briefing on investment and local authority pension funds (March 2018) is here http://ash.org.uk/files/documents/ASH_831.pdf

ASH and iPiP have created a toolkit for all those interested in protecting public policy from the influence of the tobacco industry. (FCTC Article 5.3) More information can be found and downloaded here
http://ash.org.uk/localtoolkit/toolkit-article-5-3-framework-convention-tobacco-control

Information on the Local Government Tobacco Control Declaration can be found here
http://smokefreeaction.org.uk/declarationsindex-html/

with additional councillor resources here
http://smokefreeaction.org.uk/smokefree-local-government/smokefree-councillor-network/

Information on the Smokefree NHS pledge here
http://smokefreeaction.org.uk/smokefree-nhs/nhs-smokefree-pledge/

Local Tobacco Control Profiles site has a range of latest data on smoking and the impact of smoking locally
https://fingertips.phe.org.uk/profile/tobacco-control
*Note this data may vary from the broader ASH Ready Reckoner Data included above. Please use whatever is most appropriate for your audience.

The NCSCT have a range of resources which may be of use for example:

NCSCT Training and Assessment Programme (free) - developed for experienced professionals working for NHS or NHS commissioned stop smoking services who want to update or improve their knowledge and skills - as well as newcomers to the profession, who can gain full NCSCT accreditation. http://www.ncsct.co.uk/pub_training.php

Very Brief Advice on Smoking – a short training module for GPs and other healthcare professionals to help increase the quality and frequency of Very Brief Advice given to patients who smoke.
http://www.ncsct.co.uk/VBA

Very Brief Advice on Smoking for Pregnant women
http://www.ncsct.co.uk/publication_briefing_for_midwifery_staff.php

Specialty module on mental health, aimed at anyone who works with smokers with mental health issues. An online training module and resource, it focuses on supporting clients with a diagnosed mental health condition, who may be treated in the community or a specialist setting.
http://www.ncsct.co.uk/publication_MH_specialty_module.php

Very Brief Advice on secondhand smoke – a short training module designed to assist anyone working with children and families to raise the issue of second-hand smoke and promote action to reduce exposure in the home and car.
http://www.ncsct.co.uk/publication_secondhand-smoke-training-module.php

6. CLeaR next steps

Thank you for using CLeaR. We invite you to:

- share the report with partners and stakeholders, and develop actions based on the recommendations;
- contact PHE if you'd like to discuss commissioning further support for tobacco control;
- allow local members of staff trained as peer assessors to participate in, and learn from, other assessments by acting as peer assessors;
- repeat your self-assessment in 12 months' time to track how your score changes; and
- consider commissioning a CLeaR peer re-assessment in 2022.

Contacts

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