Author/Lead Officer of Report: (Sarah Hepworth, Health Improvement Principal*)*

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Report of:	*Greg Fell, Director of Public Health*
Report to:	Co-operative Executive
Date of Decision:	*20 April 2022*
Subject:	*Sheffield Tobacco Control Strategy report 2022-2027*

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

Which Cabinet Member Portfolio does this relate to? PLACE
Which Scrutiny and Policy Development Committee does this relate to?
The Overview and Scrutiny Management Committee

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

If YES, what EIA reference number has it been given? *(1171)*

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

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

Purpose of Report:

The purpose of this report is to agree the proposed new strategy for the Sheffield Tobacco Control Programme for the next 5 years (2022-2027) and proposed changes to the future commissioning model to support delivery of the strategy.

The proposal is to maintain annual investment at the current level of £977k for 5 years (~£1.67m in total with Clinical Commissioning Group investment of £90k).

The vision of the proposed new Tobacco Control Strategy is that Sheffield people live longer and healthier lives, smokefree. The vision is also that Sheffield children grow up in a city where smoking is unusual; and that Sheffield is a smokefree city in which to live, work and play. Our ambition to make smoking obsolete by 2030 or to get to 5%

prevalence in adults.

This strategy seeks to maintain efforts to reduce the harm caused by tobacco on the residents of Sheffield. As well as the health inequalities, death and disability caused by tobacco use and second-hand smoke, in addition it seeks to address the impact of tobacco on the Sheffield City Council's resources and the burden on adult social care costs from avoidable disability. And to positively impact the local economy as well as local NHS system through productivity gains for businesses and boost to the local economy as ex-smokers spending habits shift from tobacco to other consumer products. This strategy will therefore significantly contribute to reductions in costs of treating smoking related illness both in social care and the NHS.

This strategy will build on the excellent work and achievements of the current 2017-2022 multiagency strategy that ends Oct 2022. Sheffield is one of the most proactive and highest preforming Local Authorities in the country in relation to the delivery of comprehensive tobacco control and driving down smoking prevalence.

Recommendations:
It is recommended that:

1. The content of this report is noted and approval is given to the Tobacco Control Strategy 2022-2027 and the Tobacco Control future commissioning model;

2. The Director of Culture and Environment be authorised to end contracts relevant to the delivery of the Tobacco Control Strategy in accordance with terms and conditions of those contracts as they come to the end of their natural terms;

3. In accordance with the commissioning strategy and this report, authority be delegated to the Director of Financial and Commercial Services to:

    a) in consultation with the Director of Culture and Environment, and Director of Public Health, approve the procurement strategy for the services outlined in this report;
    b) in consultation with the Director of Culture and Environment, Director of Public Health and Director of Legal and Governance to award, vary or extend contracts for the provision of services outlined in this report.

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

Background Papers:
- Tobacco Control Health Needs Assessment 2021
- Local Tobacco Control Profiles for England
- Tobacco literature review 2021
- Covid Health Impact Assessment on Tobacco 2021
- Tobacco Strategy Summary presentation 2022--2027
- Stop Smoking Service Mini Specification 2022
- Equalities Impact Assessment 2022
- Media Briefing on tobacco control 2022
- Tobacco Control Service Evaluations 2021
- Smoking in Pregnancy Incentives Business Case

- Trading Standards Enforcement Action Business Case for increased investment

Lead Officer to complete:-		
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.	Finance: *Anna Beeby/Janinne Scarborough* and Andrew Turpin
		Legal: *Richard Marik*
		Equalities: *Adele Robinson*
	Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.	
2	**EMT member who approved submission:**	*Greg Fell Director of Public Health*
3	**Cabinet Member consulted:**	*Cllr Alison Teal*
4	I confirm that all necessary approvals have been sought in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report for submission to the Decision Maker by the EMT member indicated at 2. In addition, any additional forms have been completed and final sign off at 1 from Commercial Services, Legal and Finance.	
	Lead Officer Name: *Sarah Hepworth*	**Job Title:** *Health Improvement Principal*
	Date: 20th *April 2022*	

1. PROPOSAL

1.1 This proposal is for a new Tobacco Control Strategy for Sheffield with a future commissioning model to support the strategy. The proposal is to maintain annual investment at the current level of £977k for 5 years (~£1.67m in total with Clinical Commissioning Group investment of £90k).

1.2 However, it is proposed that money is redistributed from the Smokefree Children's Service (£100k) and the Smokefree sites funding (£28k) further upstream to deliver more prevention and early interventions. Specifically, this will involve incentives to support pregnant women to quit smoking (£60k) and increased investment in SCC Trading Standards enforcement action (£40k) to address the availability and accessibility of cheap and illicit tobacco to prevent children from starting to smoke. Increased investment in stop smoking services by £20k to ensure the service can deal with increasing demand arising from the QUIT programme - treatment of tobacco dependency in secondary care. A small allocation (£8k) to the internal Public Health staffing budget is also recommended to support delivery of the overall tobacco control programme.

1.3 We currently commission a range of tobacco control interventions to prevent children from starting to smoke and support smokers to quit. These include

stop smoking services; communication and marketing campaigns; prevention programme in secondary schools; enforcement action on cheap and illicit tobacco and age of sale of tobacco and e-cigarettes; smokefree sites and homes; harm reduction nicotine replacement therapy; e-cigarettes; and Specialist Midwifery Stop Smoking in Pregnancy Service (funded by Sheffield CCG).

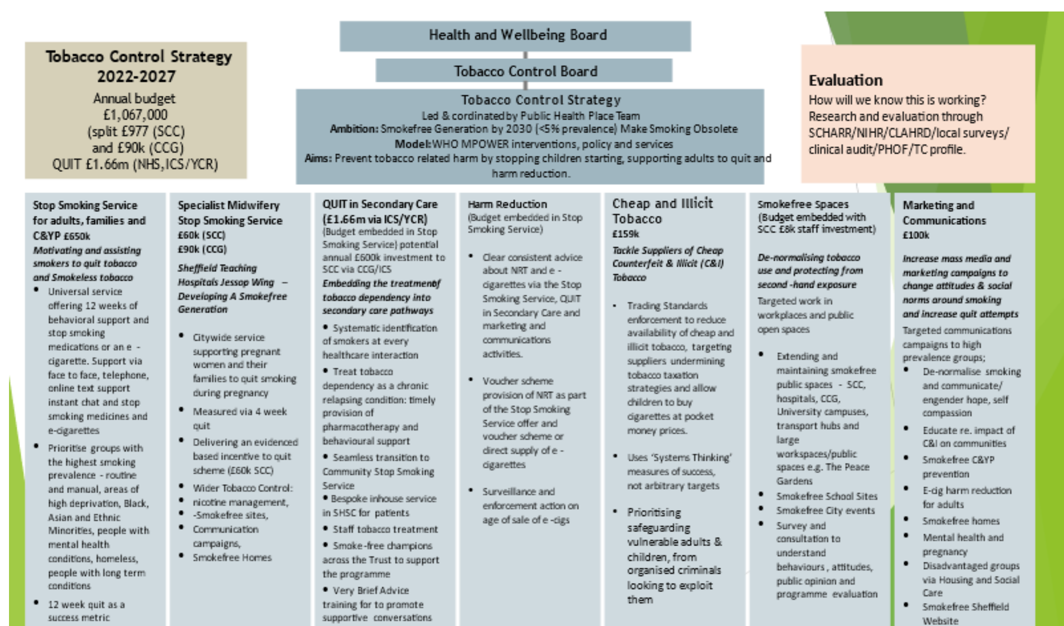
1.4 QUIT (treatment of tobacco dependency in secondary care) was developed 3 years ago and is funded by Yorkshire Cancer research and the Integrated Care Partnership. Delivery of QUIT has been limited due to the Covid Pandemic.

1.5 The current strategy and commissioned services are due to end October 2022 and this provides an opportunity to review and refresh the approach in Sheffield.

1.6 The Smokefree Children's Service overall has not impacted significantly on our current rates of uptake and smoking prevalence amongst children and young people and all our major public institutions in the city have now introduced Smokefree site policies. Therefore, we are recommending the end of funding for these two elements of the programme (see Appendix A for more details on the rationale).

1.7 An even more assertive local Tobacco Control Strategy is needed if Sheffield is to see a step change in reducing smoking prevalence and continuing to accelerate the trend in reductions across all social groups and especially amongst children; pregnant women; routine and manual workers; people with mental health conditions; and smokers living in disadvantaged communities and those living in poverty. This is in order to achieve the government ambition of being Smokefree 2030 and increasing the number of children who never smoke.

1.8 **The services that will be funded are shown on the *Tobacco Control Models Diagrams 2022-2027,* a description is provided below for each service/ intervention**



1.9 ***Increasing the number of children who never smoke***
One of the most effective ways to reduce the number of young people smoking is to reduce the number of adults who smoke. We know that children are heavily influenced by adult role models who smoke: Children are 90% more likely to smoke if they live in a household where a parent or sibling smokes. Continuing to encourage adult smokers to quit must therefore remain an important part of reducing prevalence amongst the young and achieving a smokefree generation.

1.10 ***Stop Smoking Services for adults and children (high prevalence groups)***
Stop smoking services remain the largest component of the tobacco control commissioning model, receiving £650k annual SCC investment (60%) and an overall total investment of £3,250,000m over the 5 years of the strategy lifetime. We are recommending an increase of £20k annual investment to support the new children's quit element and inflation.

1.11 The Community Stop Smoking Service will offer intensive stop smoking interventions targeting high prevalence groups, providing behavioural support and prescribed stop smoking medicines or e-cigarettes (vapes) in order to achieve a 12-week carbon monoxide verified quit in adults age18 +, and 40 x 4 weeks carbon monoxide- verified quits in children with support of NRT for those children 12-17 years of age and above, in line with the evidence base. E-cigarettes are an age restricted product for adults only.

1.12 The service will prioritise action amongst high prevalence groups which include:

- Routine and Manual Workers (R&M)
- Those in living in the top 40% most deprived areas of Sheffield
- Black Asian and Minority Ethnic (BAME) communities
- Mental Health (SMI) severe and enduring mental illness, those on GP mental illness registers, those on enhanced Care Programme Approach or receiving secondary care interventions
- Mental health, depression and anxiety
- Those smokers who are living in social housing
- Those who are homeless
- Substance misusers
- Lesbian, Gay, Bisexual, Transgender and Queer/Questioning
- Those who have a learning disability
- Any household with children under 19 (Parents and Carers)
- People with smoking related conditions (e.g. Cancer, Coronary Heart Disease, Respiratory disease and Diabetes)
- Smokers screened for tobacco addiction in hospital and referred via the South Yorkshire ICS QUIT programme
- Children aged 11-17 years old.
- Immediate households of pregnant women (partners, siblings, older children, parents), although not a high prevalence group, will also be seen by the Service as the *priority* is to protect the unborn child or neonate from harm. Pregnant Women will receive their support through specialist midwifery-based service

1.13 ***Very Brief Advice***
The vision is that it will become standard in some settings such as social care, housing, citizens advice, food banks, voluntary and community and faith sector and substance misuse services as it is in health settings (primary and secondary care, including GP's dentists, pharmacists and hospital pre-op, midwifery, doctors and nurses, health visitors) to be offered Very Brief Advice (VBA) on smoking status and identifying people who use smokeless tobacco using the National Centre for Smoking Cessation and Training (NCSCT) "Ask, Advise, Act" model. Individuals will be asked if they smoke (Ask), advised of the health harms of smoking and the financial costs to them as an individual (Advise) and undertake an immediate referral to the appropriate stop smoking support for them (Act). Providing Very Brief Advice in a range of settings will maximise the opportunity to reach smokers, of whom surveys show 2/3 want to quit (ASH, 2021). The service will deliver Very Brief Advice (VBA) smoking cessation and secondhand smoke training including how to make are referral to the service to relevant partners.

1.14 The service will support clients who are unable to abruptly quit to develop a cut down to quit plan. The service will consult with local voluntary and community organisations that work with, or alongside, South Asian communities to understand their specific issues and needs in relation to smokeless tobacco and ensure service provision is culturally appropriate and accessible.

1.15 ***QUIT – treatment of tobacco dependency in secondary care***
£50k per year of the annual £650k investment within the CSSS is allocated by SCC to support the delivery of the QUIT programme. QUIT – is the South Yorkshire and Bassetlaw Integrated Care System's programme for treatment of tobacco dependency in secondary care. Where patients are screened and treated for tobacco dependency when they have contact with any of the NHS Trusts in South Yorkshire and Bassetlaw with an onward referral for community stop smoking support. It is estimated that the CSSS will receive around 820 onward referrals in year one (22/23).

1.16 The CCG have committed to funding £75k in year 1 to support recruitment of additional stop smoking advisors and up to £500k per year for stop smoking medicines associated with the delivery of QUIT. It is envisaged that the number of referrals to CSSS will increase as Trust's clinicians' awareness of tobacco addiction and local services increases over the lifetime of the contract and the level of investment from the CCG will need to be negotiated based on demand and baseline data. To manage financial risk quits will be capped in line with the budget envelope and KPI requirements of this contract.

1.17 ***QUIT in Secondary Care (£1.66m via ICS/YCR)***
South Yorkshire and Bassetlaw Integrated Care Partnership and the Yorkshire Cancer Research have committed to an annual investment of £1.66m in secondary care for screening of tobacco addiction (£8.3m over the 5 year term of this strategy). This covers Sheffield Teaching Hospitals, Sheffield Health and Social Care and also Sheffield Children's Hospital and is a core element of the National NHS Long Term Plan. Sheffield is an early adopter site. A Memorandum of Understanding is in place and has been developed with SCC legal Services.

1.18 ***Cheap and illicit tobacco***

There will continue to be a focus on eradicating cheap and illicit tobacco and from Sheffield neighbourhoods. Trading Standards will deliver enforcement of existing regulations i.e., illegal, and underage sales, proxy purchasing, smoking in cars and point of sale display for both tobacco and e-cigarettes. The investment in this service will increase by £40k per year. This means the annual investment into SCC Trading Standards cheap and illicit enforcement action is £159k per year and a total of £795k over the 5-year term of the strategy.

1.19 Research shows that 38% of pupils aged 11 to 15 who were current (regular and occasional) smokers bought their cigarettes in shops, despite the law which prohibits the sale of cigarettes to those under the age of 18. Breaking age of sale laws puts young people at risk. (ONS statistics on smoking 2019). CCTV footage from an inner-city shop in Sheffield suspected of selling illegal cigarettes showed children in school uniform being sold single cigarettes for 80p each.

1.20 Sadly, this is not a one-off incident with illegal sellers often preying on children. Smokefree Sheffield was told by children at a local secondary school about shopkeepers selling them single cigarettes and packs at pocket money prices (£3). Cheap and illicit tobacco makes smoking affordable, can be the means of introducing young people into a lifelong addiction, and keeping adult smokers in addiction.

1.21 Furthermore, vulnerable people in Sheffield are being exploited to make and sell illegal tobacco, criminal gangs are operating across Sheffield, hiding behind vulnerable individuals who are set up to take the blame. An investigation into a ‘fag house’ in Parson Cross found a person with physical and learning disabilities being taken advantage of to sell illegal cigarettes and tobacco from his home. In another case, a sweatshop was operating in the city centre with three illegal Chinese immigrants being used as slaves to produce 100,000s of fake branded cigarette pouches.

1.22 It is estimated that smoking prevalence would drop by 10% if all cheap and illicit tobacco were eradicated. Cheap and illicit tobacco introduces serious organised crime into Sheffield neighbourhoods and occupies retail space and housing which would otherwise enable neighbourhood growth and prosperity. Most unfairly, it is the already deprived neighbourhoods where cheap and illicit tobacco thrives, widening the health and social inequalities in Sheffield.

1.23 The Sheffield Trading Standards Team have an excellent track record in taking illicit tobacco off our streets. During the last few years, they have closed 10 premises by revoking alcohol licenses and legal prosecutions. During 2021/22 alone they removed 804,000 cigarettes and 259kg of loose tobacco from the streets of Sheffield.

1.24 The increased investment is needed for more technical and sophisticated surveillance operations. Traders have changed tactics from large stocks on site to smaller supplies, the exploitation of vulnerable adults and stronger links with organised crime. This requires longer surveillance operations to secure sufficient information to ensure robust prosecutions are invoked and alcohol

license revocations where the public health licensing objectives are breached. Our key goal, and measure of success, is to push the street price of illegal tobacco as close to the true retail price (current average £10.80 a packet of 20 cigarettes) to ensure the efforts to support smokers to quit is not undermined and to target and shut down those highest risk tobacco operations exploiting vulnerable adults & getting children hooked on cigarettes.

1.25 ***Marketing and Communications***
It is recommended to continue the annual investment of £100k to deliver communications and marketing for tobacco control a total of £500k over the lifetime of the strategy.

1.26 The focus of media campaigns will be on those populations where the Tobacco Health Needs Assessment has identified the greatest challenges e.g. smoking in pregnancy, routine and manual occupations, people with mental health conditions, smokers living in deprived communities, smokers living in poverty and children. Communications and Marketing campaigns are a critical component of comprehensive tobacco control programmers as they influence population level quits outside of the stop smoking service, this is important to drive down prevalence and meet the needs of the whole smoking population not just those who attend CSSS, as only around 5% of smokers do each year. It is also important to deliver campaigns at a local level due to lack of national campaigns.

1.27 Research has shown that media campaigns are highly effective and cost-effective in motivating quit attempts, discouraging uptake of smoking and are responsible for a significant proportion of the reduction in smoking prevalence. During the last 5 years Smokefree Sheffield have delivered a range of campaigns targeting high prevalence smokers, these have been effective and certainly contributed to our success in reducing smoking prevalence at a faster rate in adults than other areas across the country. Campaigns focus on attitude shifting, educating on the harms of tobacco, set the agenda for discussion, changing beliefs, communicating hope, educating smokers about what support is available locally, increasing quit intentions and nudging towards and generating quits. Campaigns aim for high reach and consistent exposure over time with mix of positive and negative approaches.

1.28 An example of our campaign work is the Smokefree Sheffield QuitforCovid campaign which was delivered from March to July 2020. The campaign focused on the importance of quitting to be as healthy as possible right at a time when we were all worried about our health at the height of the Covid19 pandemic. We developed social media messaging, direct e-mails to SCC staff, news updates, press releases, blogs, text messages via GP practices, radio adverts (Hallam FM) and TV adverts (ITV on demand) as well as QuitforCovid stickers and leaflets being developed to be placed on food parcels distributed via foodbanks as part of the city response.

1.29 The campaign reached over 480,000 people and had over 3,000 engagements, 4,403 people visited the Smokefree Sheffield website between April – June 2020 (641%⬆ on the previous year), 2,703 visited the Quit for Covid page and 1,941 visited the support page (2,356%⬆ on the same time the previous year). The Community Stop Smoking Service saw an increase of 53% more smokers accessing the service during March and April of 2020 for quit support than the previous year.

1.30 Further examples of campaigns ***the "Closer Each Time" Campaign and the "We Care" Campaign are in Appendix A.*** Outcomes of the campaigns in terms of percentage of people reporting cutting down or attempting to quit following these campaigns are below:

Respondents who had 'cut down' following seeing the campaign
Closer Each Time - 41.6%
Quit for Covid - 20%
We Care - 10%

Respondents who had 'tried to quit' following seeing the campaign
Closer Each Time - 16.7%
Quit for Covid - 6.67%
We Care - 6.67%

1.31 Since the inception of the Smokefree Sheffield website in 2018 we have had 23,708 people visiting the site and 44,327 unique page views, with the support page being the most visited. This demonstrates audiences searching for our website showing a raised awareness of brand and desire to access information.

1.32 We are one of few councils in the country to have maintained a communications budget. Sheffield's work is recognised nationally by Action on Smoking and Health UK and by the Office of Health Improvement and Disparities and we are often asked to present at conferences to share our leaning and best practice. Recent examples include meeting with Javed Khan to influence and shape the next government Tobacco Control Strategy for England, ASH UK, End of Smoking Conference, National QuitforCovid Webinar 2020 and Smoking in Pregnancy Conference hosted by Manchester in March 2022.

1.33 ***Incentive scheme for pregnant women in Sheffield***
Giving babies and children best start in life
Smoking in pregnancy is associated with low-birthweight, miscarriage, stillbirth, and postnatal deaths. These adverse outcomes mean it is essential to support women to quit during pregnancy, to increase their chances of remaining smokefree and reduce relapse to smoking after birth. As well as improving health outcomes for mother and baby targeting smoking in pregnancy is also an opportunity to prevent future uptake in children by increasing number of smokefree homes for children.

1.34 The CCG will continue to fund the Specialist Midwifery Stop Smoking Service which will provide behavioral support and deliver direct supply of nicotine replacement therapy for pregnant women at £90k per year a total of £450k over the 5-year strategy period. It is proposed that SCC will fund an additional investment of £60k per year for incentives in pregnancy at total of £300k over the 5-year strategy.

1.35 The increased investment will allow the purchase of 58% more quits during pregnancy. Thus, this will fund,180 x 4 week quits in pregnant women a year. which will mean a total of 311 x 4 week quits will be achieved each year,

compared to around 131 x 4 week quits which are currently delivered annually. This is estimated to reduce Sheffield's smoking at time of delivery rate down to 5.9% in line with the government ambition to achieve 6% smoking in pregnancy rate. The current smoking rate at time of delivery is 9.8% (527 women smoking in pregnancy). The investment in incentives is estimated to reduce the number of women who will be smoking each year to around 317 women.

1.36 There is a very strong evidence base for incentives in pregnancy. They are nationally recommended by Action on Smoking and Health UK (2021), Public Health England (2020) and NICE (2022). An evidenced based incentive scheme developed by Greater Manchester is recommended as part of NHS Long Term Plan. Incentives are recognised as being highly cost-effective and deemed as 'excellent value for money'. Research demonstrates that when incentive schemes are implemented quit rates doubled from 8.6% to 22.5%. In Greater Manchester incentives increased quitting from 30% to 70% and increased engagement by women into the service from 41% to 69%.

1.37 Incentives in pregnancy are so effective because smoking is concentrated in more deprived groups on low incomes. This is reflected in rates of women smoking during pregnancy with women from more deprived backgrounds more likely to smoke during, and throughout their pregnancy. The vouchers enable them to buy essentials they may need for the birth of their baby. Vouchers will not be able to be spent on tobacco or other undesirable items such as alcohol or gambling.

1.38 ***Projected impact of an incentive scheme for pregnant women in Sheffield***

* Promotes healthier start in life for new babies in the womb and when they are born
* Average 145g higher birthweight babies & reduced number of growth restricted babies (Tappin et al 2015)
* Reduced admission to neonatal unit, incidence of stillbirth and neonatal morbidity
* Increased number of smoke-free homes & increased number of quit attempts by partners (Smoke Free Action Briefing 2019)
* Impact will ripple through generations, elevating families out of poverty, reducing social disadvantage & impacting on wider community

1.39 A full evaluation report will be completed following implementation of the incentive scheme. The smoking in pregnancy incentives proposal will further enhance the excellent work undertaken to-date to support pregnant mums and partners across Sheffield.

1.40 ***Investment in PH staff in PLACE***

It is recommended that £8k per year (£40k over the 5-year strategy period) is committed to the internal PLACE PH budget to support delivery of the comprehensive Tobacco Control Programme which currently has 1,5wte resource to deliver the entirety of the programme. The development of the programme has led to increased workload which whilst positive has led to increased capacity demands.

1.41 ***Harm reduction – vaping and nicotine replacement therapy***
There is no funding attached to this element of the programme it will be embedded across the overall approach to reducing smoking prevalence. The Sheffield Tobacco Control Board in line with current evidence from PHE/OHID advise all smokers to stop completely and immediately and access support via the Yorkshire Smokefree Sheffield Service and utilise a combination of behavioural support and stop smoking medication such as Nicotine Replacement Therapy (NRT) or Champix. However, for individuals who are not currently willing or able to stop smoking they are encouraged to swap to vaping or use of nicotine replacement therapy as a harm reduction measure. Vaping is significantly less harmful than smoking, those who switch will reduce their chances of developing smoking related illness as e-cigarettes do not contain the 4000 harmful chemicals that cigarettes do.

1.42 We recommend that smokers who wish to use e-cigarettes to quit or switch should purchase their products from a retailer that is committed to selling products that are registered with Medicines and Healthcare Products Regulatory Agency (MHRA) under the Tobacco Products Directive 2016 and are compliant with the requirements of the TPD. The Sheffield e-cigarette policy position statement outlines the evidence base and our commitments.

1.43 We are committed to supporting adults to maximise the opportunity of use of e-cigarettes and will continue to monitor the trends in electronic cigarette use amongst young people through local and national surveys. These are an age restricted product and children should not be accessing them.

1.44 We are committed to protecting children from access to e-cigarettes via continuing to enforce existing laws, via Trading Standards enforcement work which protects them by preventing retailers from selling e-cigarettes or e-liquids to someone under 18 and preventing adults from buying or attempting to buy on behalf of a child.

2. HOW DOES THIS DECISION CONTRIBUTE?

2.1 This proposal will reduce inequalities and make Sheffield fairer. This proposal seeks to maintain efforts to reduce the harm caused by tobacco on the residents Sheffield. As well as the health inequalities, death and disability caused by tobacco use and second-hand smoke, in addition it seeks to address the impact of tobacco on the Sheffield City Council's resources and the burden on adult social care costs from avoidable disability. And to positively impact the local economy as well as local NHS system through productivity gains for businesses and boost to the local economy as ex-smokers spending habits shift from tobacco to other consumer products. and this strategy will significantly contribute to reductions in costs of treating smoking related illness both in social care and the NHS.

2.2 Those in more deprived areas of the city who may be least able to afford an addiction to tobacco, tend to be most addicted and least able to quit as they are surrounded by other people who smoke heavily. The most deprived areas of the city are targeted by those selling cheap and illicit tobacco which brings serious organised crime into neighbourhoods and drives out legitimate businesses and hinders neighbourhoods' ability to thrive.

2.3 This proposal will also focus on interventions that prevents smoking in pregnancy and prevents young people from starting to smoke, this means that babies and young people avoid the devasting effects of smoking on their health and wellbeing and life chances.

2.4 The Tobacco Control Programme will be delivered at the heart of communities utilising the partnerships and skills of the Voluntary Community and Faith sector in engagement of residents via the LAC's and other forums. Services will be embedded and delivered from the heart of the VCF buildings across the city.

2.5 Reductions in smoking prevalence positively impact on climate change due to the reduction in deforestation and waste from cigarette litter.

3. HAS THERE BEEN ANY CONSULTATION?

3.1 There is no statutory requirement to consult on this proposal. Discussions have taken place with a range of stakeholders during the development of the strategy and have informed the proposals. These include Tobacco Control Board partners and other key partners:

- Sheffield Stop Smoking Service
- Sheffield Teaching Hospitals QUIT/Maternity
- Sheffield City Council C&YP Service
- SCC CYP Public Health Lead
- Sheffield CCG
- Sheffield Smokefree C&YP Service
- Marketing and Communications Service
- Sheffield Health and Social Care Trust
- Sheffield Commissioning and Inclusion Team
- COPD nursing Team at STH
  CCG Mental Health Team
- Sheffield 0-19 Partnership (HV, CYP PH, SCC Early Years Prevention& Family Centres)
- Sheffield Children's Hospital
- SCC Head of Youth Services
- SCC Director of Education
- SCC Trading Standards
- South Yorkshire Fire and Rescue Service
- Sheffield Universities
- Charles Clifford Dental Health STH
- SCC Housing
- SCC Social Care
- Local Medical Council
- Local Pharmaceutical Committee
- Voluntary Community and Faith sector
- Individual GPs, Primary Care Networks and Managers
- Pre-op Consultants
- SCC Poverty Lead
- Consultant in Dental Public Health
- Deputy Director of Meds Management CCG
- Action on Smoking and Health UK
- Office for Health Disparities England (Y&H)

- Colleagues in other areas of England – Leeds, Manchester

3.2 Market testing has taken place to inform the commissioning of the Community Stop Smoking Service for Adults and Children and feedback has been incorporated into our suggested approach.

3.3 We have previously consulted with the public on the travel of direction in terms of moving to deliver more upstream interventions and wider tobacco control as well as stop smoking services. This approach was supported by the majority of the public who responded. The sample size of the survey was representative of the Sheffield population and smokers. Therefore, as the recommendation for this strategy is continuing to deliver comprehensive tobacco control, it is not deemed necessary to deliver public consultation on this. However further consultation will take place as the commissioning model is developed with key partners. Service users will be engaged in the development of services/interventions and evaluations.

3.4 We are also conducting some local insight work with smokers to inform the local strategy and service/intervention development in collaboration with Sheffield Hallam University.

4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

4.1 Equality of Opportunity Implications to be approved by Adele

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

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

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

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

4.1.4 The increased investment in the CSSS, enforcement action on age of sales and illicit tobacco and incentives in pregnancy will all positively impact on the rates of children smoking as well as the continued work on smokefree policies and communications and marketing campaigns.

4.1.5 The future commissioning model for mass media and marketing will focus on those areas where the Tobacco Health Needs Assessment has identified highest need building on our track record of successful delivery.

4.2 Financial and Commercial Implications

4.2.1 The changes proposed require no additional investment but require a commitment to maintain investment in Tobacco Control at the current levels (£977,000) for 5 years, total of £4,885 000. This demonstrates a strong commitment to control tobacco as the biggest killer and greatest threat to Public Health in Sheffield. However, in doing so, the proposed future commissioning model shifts investment in wider tobacco control, further upstream and furthermore focusses investment to areas of greatest need in line with the Tobacco Health Needs Assessment and a stronger approach to prevent uptake of children smoking in line with the evidence base.

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

4.3 Legal Implications

4.3.1 Section 2B of the National Health Service Act 2006 requires each local authority to take such steps as it considers appropriate for improving the health of the people in its area.

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

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

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

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

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

4.4 Other Implications

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

4.4.2 ***ASH Roadmap 2030 and Government Independent Review***
Action on Smoking and Health UK have outlined 8 key recommendations that the government must commit too in order to achieve the Smokefree 2030 vision and take a giant step towards eradicating health inequalities. Realising the government ambition to be Smokefree by 2030 or 5% prevalence – making smoking obsolete will be "extremely challenging", particularly in areas of deprivation and among people living with mental health conditions and will require bold action. This will mean 30,500 fewer smokers for Sheffield by 2030.

4.4.3 The government is currently undertaking an Independent Review of Tobacco Control and will make recommendations about what policies and local targets should be put in place to achieve the government's Smokefree 2030 ambition, particularly to address the stark health disparities associated with smoking. The Sheffield Director of Public Health and Health Improvement Principial Tobacco Control Lead in Sheffield have both fed into this review in the last month speaking directly to Javed Khan who is leading the review for the government. There is some risk that these recommendations could be NHS focused and miss the required efforts in reaching smokers via wider determinant routes such as housing, poverty, and social care.

4.4.4 The government via NHS England have also launched a national Pharmacy Stop Smoking Service contract due to be published which could complicate the local offer and develop a parallel stop smoking service that is not as well-established causing confusion and duplication. This is being put in place to fill the gap in areas across the country that no longer have stop smoking services due to funding cuts. The detail of this is not yet finalised and local sign up from pharmacies is unclear in terms of want/will as pharmacists rather than their staff must currently be in place to lead the programme, which is not deemed by them to be a workable model.

5. ALTERNATIVE OPTIONS CONSIDERED

5.1 **Do nothing** – business as usual re-commissioning or extend current contracts. This option will not provide the greatest opportunity to respond to changing need as evidenced by the Tobacco Health Needs Assessment and will not provide the best opportunity to re-consider how to address and accelerate population prevalence especially amongst children and young people.

5.2 **Collaborative commissioning as a sub-region of South Yorkshire** - this option is not recommended as the timescales are not conducive to be able to do so, and the aims and ambitions of the different Local Authorities are sufficiently different that there is not a good match.

5.3 **Bring the communications and marketing strand in- house -**SCC Communications Team were consulted and did not feel in a position to deliver

the current contract requirements for Tobacco Control Communications and Marketing as the service needed to prioritise corporate issues, so declined the opportunity to bid for the communications and marketing element of the programme.

6. REASONS FOR RECOMMENDATIONS

6.1 The proposal set before the Co-Operative Executive is the preferred option because:

- It is based on detailed analysis of local need through a Tobacco Health Needs Assessment in line with commissioning good practice.
- It is evidence based, drawing on good practice and evidence of what works in a local, national, regional, and international context including the World Health Organisation MPOWER approach and is based on an excellent track record of delivery in driving down prevalence in adults during the last 5 years of the current Sheffield Tobacco Control Strategy.
- It has been developed over a 6 month period with the Sheffield Tobacco Control Board partners and is supported by the board, the Director Public Health and Public Health Co-Op Executive Member Cllr Alison Teal. Office of Health Disparities and Action on Smoking and Health UK.

APPENDIX 1 – Tobacco Strategy 2022-2027 -Background Information

Success of the current strategy 2017-2022

During the last 5 years the current Sheffield Tobacco Control Strategy has contributed to significant reductions in smoking prevalence in Sheffield with smoking rates now at around 10.3% (2021) compared to 17.6% in 2017 – smoking has declined across all social groups. This 7.3% reduction equates to around 20,000 smokers quitting during this time. This is a 1.4% reduction each year compared to a national average decline of 0.4%. Sheffield's smoking prevalence in adults is the second lowest in the Yorkshire and Humber region, the lowest in South Yorkshire and is lower than the England average of 12.1% (Local Tobacco Control Profiles OHID). This success demonstrates the level of work undertaken across the programme and by the multiagency partnership as we compete with many areas which are more affluent than Sheffield and will start from a baseline of fewer smokers.

Over this five-year period the number of smoking related deaths from heart disease, stroke, COPD and lung and oral cancer have also continued to fall. As has the prevalence of heart disease (Sheffield Tobacco Needs Assessment 2021). Furthermore, from those who have successfully quit, we estimate that £100m in savings is now back in the pocket of local families and available to be spent each year in the local economy on other goods (ASH 2022).

In shifting away from a focus solely on individual behaviour change and focusing on delivering more population level interventions, policy and prevention alongside traditional stop smoking service provision and marketing and communication campaigns we have significantly reduced prevalence at a faster rate than before. These interventions impact on a range of environmental, social, economic, and behavioural factors that influence smoking behaviour and make it easier for smokers to stop and harder for children to start smoking. A multicomponent approach to tackling tobacco is required to meet the needs of the whole smoking population, not just to those who attend community stop smoking service, as only around 5% do each year (this equates to 3000 smokers).

National Strategy and Indicators

In 2017 the government Tobacco Control Plan for England: Achieving a Smokefree generation, set out three tobacco control related ambitions to be achieved in their 5 year plan. Sheffield's performance is measured against these national indicators and RAG rated below. These are

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

* Reduce smoking prevalence amongst adults in England from 15.5% to 12% or less. *Current Sheffield prevalence is 10.3% was 17% in 2017 (green)*

* Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population. *Current prevalence in Sheffield 17% compared to 27.7% in 2017(green). However still x2 as likely to smoke as generation population (red)*

* Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less by the end of 2022. *Current Sheffield Smoking in pregnancy rate is 9.8% was*

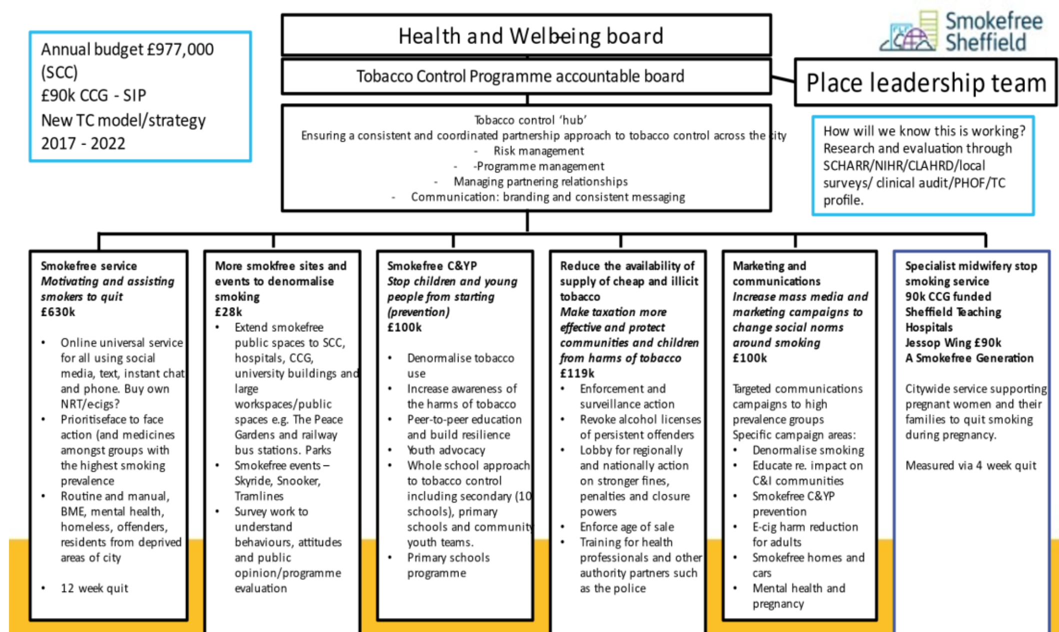
12.7% in 2017 (amber)

Smoking rates in the adult population and routine and manual workers have dramatically reduced in Sheffield in last 5 years. However routine and manual workers are twice as likely to smoke than the general population and there is work to do to reduce the inequality gap here. We have missed the national targets in children (15-year-olds), and pregnancy, although we have still seen good progress made in both these areas. For example, there are 373 fewer women smoking in pregnancy each year and rates of children smoking are at an all time low at an estimated 4.2%. Sheffield ranks second lowest smoking prevalence in pregnancy in Yorkshire and Humber and is now lower than the national average of 12.1%. However, the job is far from done despite good progress being made and we must continue in our efforts and accelerate declines in smoking prevalence across all groups.

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

In 2019, local data held by Sheffield Health and Social Care, showed that 37.9% of service users on the SMI register were smokers compared to 40.1% of people in 2017 suggesting improvement over the last 5 years but stubborn rates that are significantly higher than the Sheffield average of 10.3%. Amongst service users on Acute Mental Health Wards, smoking prevalence is significantly higher at 55% (2022), which has reduced from 66% in 2016/17 (Insight work SHSC).

The Sheffield Strategy Model 2017-2022



Sheffield Tobacco Control Plan 2022-2027 development

Sheffield will continue to be bold in the absence of a new national tobacco plan. The future Sheffield tobacco control strategy builds on previous success and has been designed utilising a comprehensive needs assessment, service evaluation, behavioral science, national and international research, evidence reviews and guidance. It is developed in collaboration with the tobacco control board partners, a wide range of

city stakeholders, Action on Smoking and Health UK and the Office for Health Improvement and Disparities (previously Public Health England).

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

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

In addition, evidence from international exemplars has been considered, where a real reduction in population prevalence has occurred in countries and states that have implemented comprehensive tobacco control programmes i.e. the MPOWER model, have the lowest smoking prevalence in the world e.g. USA, specifically New York and California, New Zealand and Australia

Scale of the problem now

Despite the success of the Sheffield Tobacco Control Multiagency strategy 2017-2022 smoking continues to cause immense harm to individuals, families, and communities in Sheffield with around 61,000 (10.3%) adults continuing to smoke (Tobacco Profiles Dec 2022). Each year 6,000 people are admitted to hospital because of smoking and tobacco kills around 1000 people each year in the city. More than Covid19 per year to date. Long-term smokers die on average 10 years earlier, but before this many will spend years in poor health living with a serious smoking-related illness. Smokers need social care support ten years earlier than never smokers, accounting for 8% of local authority spending on adult social care (ASH 2022)

It is estimated that 939 11–15-year-olds start smoking in Sheffield annually, and that two thirds of adult smokers started before they reached 18 years old. Smoking is highly addictive, with two thirds of those who try smoking going on to become daily smokers. For every 3 young smokers, it's estimated that only 1 will quit, and 1 of those remaining smokers will die prematurely from smoking-related disease and disability. (ASH 2022)

Smoking impoverishes, and ratchets up inequalities

Smoking is a driver of inequalities in health and is responsible for half of the difference in life expectancy between the richest and poorest in UK and Sheffield. Smoking is linked to almost every indicator of disadvantage and there is a clear gradient, the more disadvantaged you are the more likely you are to smoke and least likely to be able to afford it (APG smoking and Health 2021)

People who live in the most deprived areas of the Sheffield (Manor, Gleadless Valley, Southey, Burngreave, Darnall) are three times more likely to smoke than people from the least deprived areas. A quarter of people working in routine and manual

occupations smoke. 1 in 9 pregnant women are smokers at the time their baby is born. People with mental health problems are more 3-4 times more likely to smoke and have more difficulty in giving it up (Sheffield Tobacco Needs Assessment 2021). People living in social housing are three times more likely to smoke (ASH 2022). Children who live with parents who smoke are 90% more likely to become smokers themselves.

Impact of Covid19 on smoking rates

Coronavirus (COVID-19) Rapid Health Impact Assessment Survey

A survey of 3,554 Sheffield residents about the impact of the Covid-19 pandemic, which ran between 21/7/2020 and 30/9/2020, asked respondents how their smoking habits had changed over the past 4 months (figure 34).
Of the 380 respondents who were smokers (10.7%):

* • 147 (38.7%) reported smoking more
* • 99 (26.1%) reported smoking about the same as usual
* • 47 (12.4%) reported smoking less
* • 39 (10.3%) reported quitting smoking and starting vaping
* • 48 (12.6%) reported quitting smoking completely.

Overall, 35.3% of study participants who were smokers showed some improvement in the amount they smoked. Unfortunately, this was fewer than the 38.7% who reported smoking more during the pandemic.

In Sheffield 35.5% of children (34,822 children) were in poverty *before* the pandemic this is up from 29.9% or 30,713 children five years ago. Demands on food banks increased four-fold during the initial part of the pandemic. The number of people who are on Universal Credit have doubled to 44,000. Rent arrears and other debts have increased substantially.

People living with social and economic hardship find stopping smoking far more difficult, but they are no less likely to try to quit. Smoking is more common in the communities they live in, they tend to have started younger and have higher levels of dependency on tobacco, all of which make it harder to quit successfully (ASH 2022)

Covid19 has shone a light on existing health inequalities and exacerbated them. Tackling smoking is part of the solution in lifting people out of poverty, levelling up and reducing health inequalities but also in helping to build resilience in health and social care systems and boost the local economy.

Poverty, worklessness and economic impact

The average smoker is spending between £2,000 to £5000 a year on tobacco costing Sheffield smokers £122m- £305m per year. Each year in Sheffield when income and smoking costs are taken into account 14,189 households are driven into poverty. The residents of these households include: 23,759 adults of working age, 4130 pension age adults and around 11,240 dependent children.

Smoker's employment chances and average earnings are also damaged by smoking. In Sheffield 4130 people are economically inactive due to smoking and smokers earn 6.8% less than non-smokers. The underemployment of smokers is likely due to higher levels of ill health which make it more difficult for them to maintain full employment to state pension age. When these costs, and the loss to society of people dying while still of working age are taken into account smoking in Sheffield is estimated to cost

£159 million in lost productivity. (ASH 2022). Overall, it is estimated that smoking costs Sheffield £193 million each year including costs of healthcare, social care, productivity, and fire costs.

Environmental impacts of smoking
It is not just its effects on health and local economy which make tobacco an unethical product: tobacco production, which occurs mostly in low- and middle-income countries, contributes to climate change and drives deforestation.

Commercial determinant of health
Tobacco is a commercial determinant of health that impacts negatively on people's lives for the profits of a few large tobacco companies and their shareholders. The big four tobacco transnationals are responsible for over 95% of UK tobacco sales and make around £1.5 billion a year in profits in the UK from selling a highly addictive and lethal product. ASH UK are calling on the government to make the industry pay for the damage it causes and fund the end of the smoking epidemic as they can afford it based on corporate huge profits and strapped local authorities need more funding to tackle this issue effectively (ASH Roadmap 2030).

The rationale to stop funding the Smokefree schools-based programme Sheffield has commissioned a peer-education programme in schools based on the evidence-based ASSIST model, costing £100k per year. We have delivered the programme in 26 secondary schools over 5 years, several times in some cases, targeting the most deprived schools with high smoking prevalence. The programme builds personal resilience, shifts attitudes in relation to uptake delivers a whole school approach includes development of school smokefree policy, training for teachers and peer educators, social norms campaigns, quit support in school settings. The Smokefree Children and Young People Service has been powerful for the time we are in the school, however whilst the programme has increased children's confidence in delivering key smokefree messages to their peers, the intention of pupils to avoid smoking is not translating into action. The programme overall has not impacted significantly on our current rates of uptake and smoking prevalence. We also have concerns about long term impact and sustainability of programme.

Due to the pandemic, it has become harder to engage with schools and access children. Schools have other competing priorities re: Catch up on education, covid recovery and are still dealing with ongoing Covid19 outbreaks. Since inception of the programme is has also been difficult to generate enough quality referrals for quit support despite targeted efforts to increase referrals. Once young people engage with a stop smoking advisor the outcomes are initially positive, however children do not continue to turn up to further appointments.

What will we do instead to prevent uptake and support children to quit?
We will embed quit support for C&YP into the main adult stop smoking service, build on the learning of direct supply of nicotine replacement therapy, deliver in CYP friendly settings, use automatic appointment reminders, and maximise use of social media platforms to promote the offer.

We will develop a historic legacy toolkit for schools with resources for resilience building, example smokefree policies including the school gates,, Information on nicotine management, information on quitting and referrals and host on the Sheffield Smokefree website. We will work with schools, the PH CYP team, SCC Director of

Education and SCC lead for the Sheffield Youth Strategy, building on the strong relationships established with headteachers through covid and take this opportunity to reshape/remodel the tobacco offer in the form of an overall Health and Wellbeing offer for schools, covering a range of public health topics. This will be based on addressing the needs of their pupils working in the context of recovery and their current demands. Which in turn will impact on their outcomes re keeping children in schools and in lessons reducing disruption to learning and educational outcomes.

We will deliver an annual CYP prevention communication campaign, developed and delivered with young people and partner organisations, schools, colleges, and youth groups/council.

Increasing Smokefree homes, sites and places – de-normalising smoking

We are recommending the end of the Smokefree policy funding as all our major public institutions in the city have now introduced Smokefree site policies which cover their external grounds for staff and service users. SCC introduced Smokefree playgrounds in 2017. Smokefree policies will be reviewed with partners and officer time will be allocated to continue this policy work and ensure policies remain in place and are enforced. Sheffield University will continue to be supported in implementing their policy as well as the Smokefree transport Interchanges. This work had been postponed due to the Covid pandemic.

Smokefree homes and outdoor policies help to change social norms around smoking by reducing the visibility, acceptability of smoking and discouraging young people from starting to smoke. Smokefree policies contribute to a reduction in the amount that people smoke, increase the number of people who quit and support relapse prevention. Smokefree policies protect heath. Cochrane reviews found consistent evidence of reduction in hospital admissions for cardiac events following the implementation of smokefree laws. There are also environmental advantages with reductions in cigarette litter.

The majority of the Sheffield public support outdoor smoke-free environments. A local survey identified strong public support for increasing outdoor smokefree policies, outside council and NHS settings and leisure centre grounds

Overall outcome results of support for extending Smokefree Spaces

Areas where children play	88% (n=1734)
Outside Council Buildings	70% (n=1366)
Outside NHS Buildings	81% (n=1589)
Inside open air sports stadiums	85% (n=1647)
Leisure Centre Grounds	82% (n=1590)

Organisations supported by SCC to implement comprehensive Smokefree policies which covers all external grounds.

- Sheffield Health and Social Care Trust May 2016
- Sheffield Teaching Hospitals (Jessop Wing, Charles Clifford and Weston Park Oct 17)
- STH Hallamshire and Northern General went Smokefree Oct 2018.

- Sheffield City Council Oct 2018.
- Smokefree Sheffield by the Sea event July/August 2018

2018/19

- Sheffield Children's Hospital (April 2019)
- Sheffield Hallam University (Sept 2019)
- Sheffield CCG (Oct 2019 no funding from SCC)

Outcomes that have been achieved:

- Fewer people observed in all settings smoking (Moorfoot, STH Hallamshire, Jessops, SHSC and Children's)
- Less complaints from the public
- Less tobacco litter (Jessops notably and the Children's hospital)
- Staff and patients quitting reducing their smoking as a result of SF policy being implemented on site
- Staff and patients switching to e-cigs
- 100's of staff trained in Very Brief Advice
- Increase in awareness of the Stop Smoking Offer in the city

Smokefree homes

Smokefree homes brief interventions will continue to be delivered across the 0-19 pathway in community, primary and secondary care settings and across SCC housing with a particular focus on under 5's and Roma Slovak Community where rates of smoking in the home are very high at around 60% in Sheffield. This will utilise these opportunities to talk with our residents about secondhand smoke and make every contact count.

It is estimated in England that around 62% of children are exposed to secondhand smoke in the home and car in England (Statistic in England 2019). Exposure rates are significantly higher among children and babies from poorer backgrounds. Awareness is low among deprived groups of the dangers of secondhand smoke in homes and cars. secondhand smoke (SHS) and health. In England there are 17,000 hospital admissions per year amongst children (under five years of age) with illnesses resulting from the effects of secondhand smoke exposure. Increasing the number of Smokefree homes is critical because children are more vulnerable to the dangers of secondhand smoke. They have small airways and breathe faster meaning their lungs take in more of 4,000 dangerous chemicals, putting them at risk of: asthma, pneumonia, bronchitis, colds, ear problems and chest infections.

We have recently run a communications and marketing campaign targeting deprived communities and children living in social housing. Children living in social housing are 3-4 times more likely to be exposed to tobacco smoke. Social media results showed it reached over 4,000 families and over 300 people accessed the website. Leaflets were distributed to parents and grandparents via Fir Vale Community Hub, Sheffield Teaching Hospitals Maternity Unit Jessop Wing, Sheffield Health Visiting Service and SCC Housing Team.

Examples of communications and marketing campaigns 2017-2022

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