BLACKBURN with DARWEN BOROUGH COUNCIL

Equality Analysis and Impact Assessment Tool

[Tobacco Free Lancashire

Tobacco Control Strategy 2014 -2016

Guidance

Please refer to the *Impact Assessment and Human Rights Screening Guidance v1.51* which is available on the Intranet via the following link:

http://cms.intra.blackburn.gov.uk/server.php?show=nav.3306

If you require further assistance please contact your department's Corporate Equality & Diversity group representative. This information is available from the Corporate Policy Department.

Section 1: Initial Assessment Please provide as much information as possible	
Name of activity:	Tobacco Free Pan Lancashire : Tobacco Control Strategy 2014-16
Manager or Sponsoring Directors Name:	Dominic Harrison
Department/Directorate:	Public Health
Service:	Tobacco Control
Assessment Lead:	Donald Read
Telephone:	01254 585348
E-mail:	donald.read@blackburn.gov.uk
Who else will be involved in undertaking the equality analysis and impact assessment:	Lancashire County Council Blackpool Council Tobacco free Lancashire Alliance
Who are you consulting with and how? **Please insert any information around surveys and consultations undertaken:**	1) The Tobacco Control strategy is built upon the ambitions contained within the national Tobacco Control plan and the White Paper 'Healthy Lives Healthy People' and on guidance produced by the National Institute for Health & Care Excellence. Both of these national strategies and relevant guidance have been subject to national consultation process and assessed for their equality impacts. 2)Tobacco Free Lancashire is a partnership of over 40 organisations from across Lancashire including upper tier local authorities, police, fire and rescue, health trusts and other public sector bodies, all of the district councils and voluntary and 3rd sector organisations (see full list Appendix 1) 3) All organisations in the TFL alliance have worked collaboratively to develop the TFL Tobacco control strategy. Partner organisations have been responsible for engaging with and consulting with their membership / key stakeholders as appropriate. 4) In addition a further consultation is being carried out during September 2014 with the draft strategy being published on a publicly accessible Cumbria & Lancashire Public Health Collaborative website and organisations and community groups (particularly those representing protected equality groups) will be contacted and made aware of the strategy and asked to comment via a short survey. Once the consultation is closed the TFL alliance will respond to the consultation, publish its response on the Public Health Collaborative website and make adjustments to the strategy accordingly. 5) In developing the action plans which are created to implement the strategy, relevant stakeholders are brought together. For

	example in developing the Smoking in Pregnancy action plan which sits under the TFL strategy, more than 50 people were brought together at a stakeholder conference, representing a wide range of organisations including voluntary sector, Healthwatch and patient groups. These stakeholder groups then form a working group to develop the plans and are engaged with throughout development and implementation. 6) In addition to consultation and engagement on the development and implementation of strategy and action plans as described above; tobacco control strategy and policy is informed by continuous insight work, engagement and research with specific groups on specific tobacco control topics. For example TFL and its partners have recently commissioned insight work with young people on emerging trends in tobacco such as shisha, e cigarettes etc. 7) TFL – through its tobacco control leads, also commission Tobacco Free Futures a North West based community enterprise which carries out a wide range of consultation and engagement on tobacco issues in the NW all of which have also been incorporated in the development of the strategy. 8) TFL believes that the activities described above demonstrate our belief that consultation and engagement is a dynamic and ongoing process which needs to be co-created using a wide range of sources and methods and be carried out as such throughout the development and life of the strategy as it is implemented and reviewed.
References *Please identify additional sources of information you have accessed to complete the EIA for example, websites; journals; reports etc.*	- Department of Health (2011). *Healthy Lives, Healthy People: A Tobacco Control Plan for England.* www.dh.gov.uk/publications - London Health Observatory (2011). *Local Tobacco Control Profiles for England – Public Health Observatories in England Nov 2011.* http://www.lho.org.uk/Download/Public/17712/1/Tartan%20Rug_FINAL_Nov2011%20v2.pdf - The Information Centre for Health and Social Care (2012). *Statistics on Smoking: England, 2012 and Census 2011 all population aged 35 and over.* - A full directory of niche tobacco products is available at: http://www.ntpd.org.uk - Office for National Statistics (2012) General Lifestyle Survey Overview. A Report on the 2010 General Lifestyle Survey. www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2010 - NHS Information Centre for Health and Social Care (2013). *Statistics on women's smoking status at time of delivery: England.* http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking - The Information Centre for Health and Social Care (2012) *Smoking, drinking and drug use among young people in England in 2011.* - Trading Standards (2013). *Young Persons Alcohol and Tobacco Survey 2013, North West Results.* TSNW, June

	2013. - Tobacco Free Futures (2012) *Locality Tobacco Briefings September 2012: Lancashire*. TFF 2012. - Office for National Statistics (2009). *Smoking and Drinking Amongst Adults.* Office for National Statistics - Robinson S & Bugler C (2010). *Smoking and drinking among adults, 2008.* General Lifestyle Survey 2008. ONS, 2010. - Wanless D. (2004) *Securing good health for the whole population.* London: TSO - Marmot M et al (2010) *Fair Society, Healthy Lives: strategic review of health inequalities in England post 2010.* Marmot Review Secretariat London. - McAndrew F et al (2012). *Infant Feeding Survey – 2010. A survey conducted on behalf of the Information Centre for Health and Social Care.* Leeds: The Information Centre for Health and Social Care. - Singleton N et al (1998) *Psychiatric morbidity among prisoners in England and Wales: the report of a survey carried out in 1997 by Social Survey Division of the Office of National Statistics on behalf of the Department of Health.* London: The Stationary Office - McManus S, Meltzer H & Campion J (2010) *Cigarette Smoking and Mental Health in England: Data from the Adult Psychiatric Morbidity Survey 2007.* National Centre for Social Research. www.natcen.ac.uk/study/cigarette-smoking--mental-health - Jochelson K & Majrowski W. (2006) *Clearing the Air: Debating Smoke-Free Policies in Psychiatric Units.* London: King's Fund. - World Health Organisation (2005). *WHO Framework Convention on Tobacco Control* http://www.who.int/fctc/text_download/en/index.html - Scientific Committee on Tobacco and Health Great Britain (SCOTH) (1998) *Report of the Scientific Committee on Tobacco and Health*. London: TSO 1998. - Scientific Committee on Tobacco and Health Great Britain (SCOTH) (2004) *Secondhand smoke: Review of evidence since 1998.* Scientific Committee on Tobacco and Health (SCOTH), November 2004 - Royal College of Physicians (2010). Passive smoking and children. A report by the Tobacco Advisory Group. London: RCP, 2010. - The Information Centre for Health and Social Care (2012). *Statistics on Smoking: England, 2012.* http://www.ic.nhs.uk/news-and-events/news/about-1260-hospital-admissions-a-day-due-to-smoking-new-figures-show - Health Economics Research Group, Brunel University; Queen's Medical Centre, University of Nottingham & London Health Observatory (2012) *Building the economic case for tobacco control: A toolkit to estimate economic impact of tobacco.* http://www.brunel.ac.uk/herg/research-programme/building-the-economic-case-for-tobacco-control - Department of Health (2011). *Healthy Lives, Healthy People: A Tobacco Control Plan for England.*

	www.dh.gov.uk/publications - Ghouri N et al. Influence of Islam on Smoking among Muslims, *British Medical Journal [Online].* 2006; 332: pp.291-294. Available from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360407/, accessed 12th June 2014 - 'A smokefree future' A comprehensive Tobacco Control Strategy for England 2010-2020 – Equality Impact Assessment, Department of Health, 2009, Available from http://webarchive.bromleypct.nhs.uk/www.bromley.nhs.uk/EasySiteWeb/getresource9a27.pdf?AssetID=1261, accessed 12th June 2014	
Implementation date:	**October 2014**	
Type of activity:	Budget changes	☐
	Change to existing policy	☐
	Commissioning	☐
	Decommissioning	☐
	New policy	☒
How was the need for the activity identified?	Sets out the need for localities to develop their own tobacco control strategies The TFL strategy also builds upon needs identified by the Lancashire Joint Strategic Needs Assessment for Tobacco as well as Local Tobacco profiles produced by Public Health England which highlight that tobacco use remains one of the most significant public health challenges. While rates of smoking have continued to decline over the past decades, nationally one in five adults (20.2%) still smoke. However, smoking rates remain higher in Lancashire than England as a whole in adults, pregnant women and young people. The strategy enables the efforts of the TFL Alliance to be coordinated and effective in tackling smoking related harms.	
What is the activity looking to achieve?	A key aim of the strategy is to reduce the damaging impact of tobacco so that smoking is history for the children of Lancashire.	
What are the aims and objectives?	Mission Statement: To make smoking less desirable, acceptable and accessible in Lancashire to ensure all residents live tobacco free lives. In line with the World Health Organisation's Framework Convention on Tobacco Control (FCTC) and the national Tobacco Control Plan, Tobacco Free Lancashire adopts the five internationally recognised strands of comprehensive tobacco control measures as their core aims, which are to: Aim 1) Stop the promotion of tobacco Aim 2) Make tobacco less affordable Aim 3) Effectively regulate tobacco products Aim 4) Help tobacco users to quit Aim 5) Stop exposure to second-hand smoke	

	The strategy has the following objectives: Ambition 1) Reduce adult (aged 18 or over) smoking prevalence to 18.5% or less by the end of 2015 Ambition 2) Reduce rates of regular smoking among 15 year olds to 12% or less by the end of 2015 Ambition 3) Reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015
Services currently provided:	Public Protection Services Stop Smoking Services (includes smoking in pregnancy)
Recommendations following change in service: *Please outline recommendations that have been identified for implementation following a review of the activity.*	This is a new overarching 3 year strategy.
Who does the policy or decision being made impact upon?*	Carers or family ☒ Yes ☐ No ☐ Indirectly General Public ☒ Yes ☐ No ☐ Indirectly Partner organisations ☒ Yes ☐ No ☐ Indirectly Service Users ☒ Yes ☐ No ☐ Indirectly Staff ☒ Yes ☐ No ☐ Indirectly
Signature:	**Date:**

*If no impact is identified on any of the groups a full EIA may not be required. Please contact your departmental Corporate Equality & Diversity representative for further information.

Section 2: Equality Analysis and Impact Assessment

Does the activity have the **potential** to:

- Have a **positive** impact (benefit) on any of the groups?
- Have a **negative** impact / exclude / discriminate against any person or group?

Explain how this was identified? Evidence / Consultation?

Please refer to the notes in the full guidance document – page 13
NB: Requires (existing or new) consultation with 'relevant' people who are from these groups or who have knowledge insight into these groups.
NB. Marriage & CP is only protected in terms of work-related activities NOT service provision

Group	Positive (Y/N)	Negative (Y/N)	Don't know	Reasons for positive / negative impact (Please include all evidence you have considered as part of your analysis)	Action No.
Age	Y	N		Tobacco and smoking disproportionately impacts on children and young people. Effectively reducing the prevalence of smoking can positively improve the health of children and young people. The vast majority of people who smoke become addicted as children before they are legally old enough to buy cigarettes; with two thirds initiating under the age of 18, the legal age of sale, and almost two-fifths under 16 years. The prevalence of smoking amongst young people is higher in Blackburn with Darwen (BwD) and Lancashire (including Blackpool) than England (BwD 21%; England 11%). Children are adversely affected by breathing second hand smoke as they breathe faster and breathe in more toxic chemicals than adults. Children exposed to second-hand smoke are at increased risk of bronchitis, asthma symptoms, middle ear infections (glue ear), meningitis and sudden infant death syndrome (cot death).	

				It is estimated that there are 3,902 additional incidents of childhood diseases each year within Lancashire, directly attributable to Second Hand Smoke: • 464 new cases of lower respiratory tract infection in children under two years old • 2,890 new cases of middle ear infections in children of all ages • 534 new cases of wheeze and asthma in children • At least 14 new cases of bacterial meningitis The strategy has the specific aim to: Reduce rates of regular smoking among 15 year olds to 12% or less by the end of 2015. This is a national ambition, no local data is currently available but this data will be included as an indicator in future local Tobacco profiles. Also the specific aim to: Reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015 which will improve the health of new-borns and babies The rate in Blackburn for 2013 was 17.2%. Also the specific aim to: reduce exposure to second-hand smoke (SHS), SHS has a disproportionate impact on children. Also the aim to: Advocate for strengthened legislation to ban smoking in cars when children under 18 years are present at national level. (NB: all data sources referenced within strategy) In terms of older people – support is given via the stop smoking service in Blackburn with Darwen and this is promoted with links between the service and the 50+ partnership. Data from the service shows that people in the 50+ age range make good use of the service and that the service is successful in helping them to quit. In 2012/13 over 500 smokers aged 45+ accessed the service, of whom 200 were 60+	

Disability	Y	N		• Smoking is the major preventable cause of ill health in the UK. Smoking can lead to the development of long term conditions and disability. • Action to reduce prevalence of smoking in the general population will reduce LTC and smoking related disability • Action to reduce smoking prevalence in general population will impact on people with disabilities. • More needs to be known about smoking and disability for example access to Stop Smoking services. • Disability organisations to be included in Strategy consultation	1
Marriage & Civil Partnership	N/A			N/A	
Pregnancy and maternity	Y	N		Rates of smoking at time of delivery (SATOD) are higher in Lancashire (including Blackburn with Darwen and Blackpool) are higher than in England as a whole. The rate for Blackburn with Darwen is 17.2. The England rate is 12.7 The strategy has the aim to: Reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015	
Race	Y	N		Smoking rates are higher in some BME groups for example: Smoking rates are higher among Bangladeshi and Irish males (40% and 30% respectively). In addition certain forms of tobacco use disproportionately affect BME communities in Blackburn, for example shisha and niche tobacco. [1] Data is collected through stop smoking services on the ethnicity of those accessing services. The data from 2012/13 shows that approximately 20% of clients accessing the service were from BME communities with the breakdown of ethnicities largely reflecting that of the population of the borough as a whole. The strategy has the specific aims regarding shisha and niche tobacco: • Raise awareness of shisha and other niche tobacco products and their impact through community education and training with partners, including retailers;	

[1] ASH Tobacco & Ethnic Minorities http://ash.org.uk/files/documents/ASH_131.pdf

				• Ensure that existing legislation in relation to shisha and other niche tobacco products is enforced; • Advocate for strengthened legislation at both national and local level to license both mainstream and niche tobacco products. Making smoking cessation services more accessible to ethnic minority groups will help to reduced health inequalities faced by these groups.	
Religion or belief	Y	N		There is some evidence to suggest religion can influence smoking behaviour. For example, smoking prevalence in high among Muslim communities globally (Ghouri et al, 2006). However, a number of other factors including culture, traditions, attitude, family environment and socioeconomic status are likely to be more important. The consultation on the strategy will ensure that Religious & Faith groups are consulted with. In July a meeting was held with 50 representatives from Mosques throughout Blackburn to discuss smoking and other key health issues. Representatives of the Stop smoking service were in attendance. Issues raised in this discussion will be taken into account in service planning and future such meetings are planned.	2
Sex	Y	N		In 1980, men were reported to smoke at a higher percentage at 42% than women at 36%. Today the statistics are still showing men at a higher rate though it has decreased considerably. Men are still more likely to smoke at 22% than women at 19%. This disparity in attitudes to smoking and quitting between men and women is due to a number of factors, with women being more likely to access specialist support to quit. Among children aged 11-15 years, girls are two and a half times more likely to be regular smokers but boys catch up with girls around ages 16-19 • Targeting pregnant women who smoke will have a positive effect on the health of the baby and the woman.	

				• Reducing smoking in young people should benefit girls more than boys as more girls smoke than boys	
Sexual orientation	Y	N		Evidence suggests LGBT groups have a higher rate of smoking and are underrepresented in data on smoking, the reasons behind this are not well known yet but there are suggestions that gay and lesbian social spaces (such as bars), violence, stress, and discrimination, as well as barriers to healthcare access and treatment services, contribute to higher rates of smoking (Department of Health, 2009). The strategy and its consultation will need to take account of this.	3
Gender reassignment	Y	N		See above	
Vulnerable Groups	Y			Smoking rates remain higher in several vulnerable groups including: prisoners (80%) and people living with a mental health condition. Nationally, a third (32%) of people with depression or an anxiety disorder and 40% for those with probable psychosis smoke. Even higher rates are experienced in inpatient settings, where up to 70% of patients smoke and around 50% are heavy, more dependent smokers. Reducing health inequalities resulting from smoking therefore remains a public health priority in Lancashire. The strategy has the aim to: Reduce health inequalities through reduced tobacco consumption Tobacco Free Lancashire will: • Use commissioning processes to ensure support is targeted to those who want to quit from all hard -to-reach or under-represented population groups in all settings, ensuring services are accessible and meet the diverse needs of these groups. • Use commissioning processes to develop and support the full implementation of smoke-free legislation in mental health and criminal justice settings;	
Deprived Communities	Y			People on low incomes start smoking at a younger age and are more heavily addicted, spending up to 15% of their total weekly income on tobacco. Similarly, women who smoke in pregnancy are also more likely to be younger, single, of	

				lower educational achievement and in unskilled occupations. Smokers from routine and manual groups comprise 44% of the overall smoking population and reducing smoking in this group is critical to reducing inequalities. The strategy has the aim to: Reduce health inequalities through reduced tobacco consumption. Tobacco Free Lancashire will: • Use commissioning processes to ensure support is targeted to those who want to quit from all hard -to-reach or under-represented population groups in all settings, ensuring services are accessible and meet the diverse needs of these groups. Aim 2 of the strategy: make tobacco less affordable, may in the short and medium term have an adverse impact However the fact that smoking-related death rates are 2-3 times higher in the most disadvantaged groups than among those that are better off (Marmot Review, 2011), highlights the need for action. Use of nicotine replacement therapies as a harm reduction approach is now in place in accordance with NICE guidance. This will be of benefit to those who find it more difficult to quit.	
Carers					
Other (please state)					
If no negative impacts have been identified, please explain why *A lack of negative impacts must be justified with evidence and clear reasons. Highlight how the policy negates any possible negative impacts.*	No negative impacts identified. Reducing levels of smoking benefits all in communities, reduces health and economic inequalities.				

Does the activity raise any issues for Community Cohesion?	None identified	**GUIDANCE (page 15)** *If the policy positively impacts some groups and negatively impacts or overlooks other sections of the community, what effect will this have on the relationship between these groups?* *How will you manage this relationship?* *If the policy will make a positive contribution to relations between sections of the community please outline them.*
Does the activity contribute positively to Community Cohesion?	None identified	
Does the activity raise any issues in relation to Human Rights as set out in the Human Rights Act 1998?	None Identified	**GUIDANCE (Page 10)** *It is important to note that if the decision removes or engages a person's absolute rights the policy/decision will need to be changed.* *Where it is a Limited or Qualified Right the decision needs to be proportional and legal.*
What is the overall cost of implementing the activity? **GUIDANCE** *Input cost e.g. Financial investment, HR, to realise and achieve benefits of the activity* *Source – e.g. specific funding stream, pooled budget or mainstream budget*	**Cost & Source(s) of funding** The implementation of the tobacco control strategy will have implications for TFL partners. These will be identified through the action planning stage and appropriate investment sought via business cases and commissioning within and across partner organisations. Other costs are met through existing organisational tobacco control budgets. Implementing the strategy will lead to cost savings for families, communities, healthcare etc.	
Does the activity support / aggravate existing departmental and corporate risk? **GUIDANCE** *Is the activity on the departmental risk register? If not, should it be?*	Not on departmental Risk Register. No risk envisaged	
Action following analysis: **GUIDANCE** *It is important that the correct option is chosen depending on the findings of the analysis.* *The action plan must be completed as required.*	No major change in policy	
	Adjust policy	YES – adopt Strategy as overarching Tobacco control strategy for BwD
	Continue policy	
	Stop and reconsider policy	

Section 3: Action Plan

No.	What is the negative/adverse impact?	Actions required to reduce/eliminate the negative impact	Resources required* (see guidance note below)	Who will lead on action?	Target completion date (dd/mm/yyyy)
1	More needs to be known about smoking and disability for example access to Stop Smoking services.	Disability organisations to be included in the consultation exercise. Future service initiation documents to include the need for service providers to record disability status of people accessing the service.	None	DR	Ongoing
2	More needs to be known about smoking and religion or belief or lack of. We need to understand if this plays a part in encouraging or discouraging people from accessing smoking cessation services.	Meetings with faith groups carried out July 2014. Further meetings planned. Ongoing engagement with Mosques via work of One Voice	None	DR	Ongoing
3	More needs to be known about sexual orientation and smoking. Local information is scarce on this topic as services currently do not monitor this protected characteristic when providing services to residents.	This should be considered as part of wider LGBT engagement and health needs assessment work in the borough.	None	PH Team	

* 'Resources required' is asking for a summary of the costs that are needed to implement the changes to mitigate the negative impacts identified.

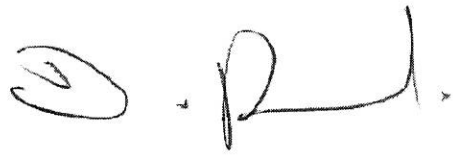
Section 4: Monitoring and Review

Monitoring guidance
The responsibility for establishing and maintaining the monitoring arrangements of the EIA action plan lies with the service completing the EIA. These arrangements should be built into the performance management framework.

Monitoring arrangements for the completion of Equality Impact Assessments will be undertaken by the Corporate Equality & Diversity Group and the oversight of the consequent action plans will be undertaken by the Management Accountability Framework.

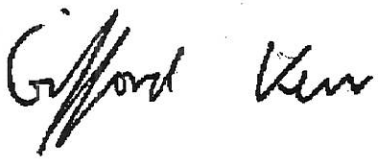
If applicable, where will the departmental action plan be monitored? **GUIDANCE** *For example, Service Management Team; Service Leadership Team; Programme Area Meeting.*	Through BwD PH Extended Senior leadership Team. Through Tobacco Free Lancashire Alliance meetings
Reviewing guidance The responsibility for establishing and maintaining the review arrangements of the Impact Assessment and the action plan lies with the service completing the Impact Assessment.	
Date of the next review of the Impact Assessment? *It should be reviewed at least every three years to meet legislative requirements*	August 2015
How often will the EIA action plan be reviewed? *E.g. Quarterly as part of MAF*	Quarterly
Who will carry out this review?	Donald Read & Local Authority Tobacco Control Leads

Signature of Equality Impact Assessment lead officer:



Date Completed: 15th August 2014

Signature of Head of Service / Directorate Lead:



Date Completed: 19th August 2014

This signature signifies the acceptance of the responsibility and ownership of the EIA and the resulting action plan (if applicable).

Signature of Cohesion & Equalities Manager, Blackburn with Darwen Borough Council:

Date received: 19th August 2014

This signature signifies the acceptance of the responsibility to publish the completed EIA as per the requirements of the Equality Act 2010.