Equality Impact Assessment

Introductory Information

Budget/Project name

Tobacco Control Strategy and Model 2022 – 2027

EIA number 1171

Proposal type

- ● Budget
- ● Project

Decision Type

- ● Cabinet
- ○ Cabinet Committee (e.g. Cabinet Highways Committee)
- ○ Leader
- ○ Individual Cabinet Member
- ○ Executive Director/Director
- ○ Officer Decisions (Non-Key)
- ○ Council (e.g. Budget and Housing Revenue Account)
- ○ Regulatory Committees (e.g. Licensing Committee)

Lead Cabinet Member Alison Teal

Entered on Q Tier

○ Yes ● No

Year(s)

○ 14/15	○ 15/16	○ 16/17	○ 17/18	○ 18/19	○ 19/20	○ 20/21	● 21/22

EIA date March 2022

EIA Lead

Person filling in this EIA form

Amanda Pickard and Jack Dale

Lead officer

Sarah Hepworth

Lead Corporate Plan priority

○ An In-Touch Organisation	● Strong Economy	● Thriving Neighbourhoods and Communities	● Better Health and Wellbeing	● Tackling Inequalities

Portfolio, Service and Team

Cross-Portfolio
● Yes ○ No

Portfolio
PLACE

Is the EIA joint with another organisation (eg NHS)?
○ Yes ● No

Brief aim(s) of the proposal and the outcome(s) you want to achieve

Proposal is for a comprehensive evidence-led Tobacco Control Strategy and Services. The outcomes are to prevent tobacco related harm by stopping children starting, supporting adults to quit and harm reduction, with the aim of achieving the ambition of a smoke free generation by 2030 (<5% prevalence).

Impact

Under the Public Sector Equality Duty we have to pay due regard to the need to:
- eliminate discrimination, harassment and victimisation
- advance equality of opportunity
- foster good relations

More information is available on the Council website including the Community Knowledge Profiles.

Note the EIA should describe impact before any action/mitigation. If there are both negatives and positives, please outline these – positives will be part of any mitigation. The action plan should detail any mitigation.

Overview

Briefly describe how the proposal helps to meet the Public Sector Duty outlined above

Despite the success of the Sheffield Tobacco Control Multiagency strategy 2017-2022 in driving down smoking prevalence by 7.3% (from 17.6% (2017) to 10.3% (2022)) smoking continues to cause immense harm to individuals, families, and communities in Sheffield with around 61,000 adults continuing to smoke with a quarter of people in routine and manual occupations smoking. The current strategy is due to end in October 2022.
The new 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 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 significantly contribute to reductions in costs of treating smoking related illness both in the NHS and social care.

Tobacco is the leading cause of death and is a key driver of health inequalities in the UK and Sheffield. A person's likelihood of smoking increases in line with the level of deprivation in their neighbourhood (ONS) and people who live in the most deprived areas are three times more likely to smoke than people from the least deprived areas.

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 you are to be able to afford it.

Each year in Sheffield, when income and smoking costs are considered, 14,189 households are driven into poverty. The residents of these households include: 23,759 adults below pension age, 4130 pension age adults and around 11,240 dependent children. Poorer smokers proportionately spend five times as much of their weekly household budget on smoking than richer smokers. Smoking is a significant contributor to child poverty. People with mental health problems are also more likely to smoke and have more difficulty in giving it up leading to a greater burden of tobacco related disease.

The new Tobacco Strategy has a direct positive impact on improving health inequalities as those in more deprived groups bear the heaviest burden of death and disease related to tobacco.

By helping individuals quit tobacco or switch to a safer alternative (harm-reduction), the new Tobacco Control Strategy will help lift households out of poverty and improve the health and wellbeing by reducing the tobacco related burden of disease.

The new Tobacco Control Strategy targets the following priority groups with the highest smoking prevalence or at highest risk of harm from tobacco via 7 key approaches in order to improve health inequalities: the 40% most deprived, those with mental health difficulties, BAME population, routine and manual workers, LGBTQ population, pregnant women, households with children under 19, offenders, those with disabilities and the homeless.

The model follows the best evidence in line with the WHO MPOWER model of tobacco control, which is a whole systems approach to reducing tobacco use. The Sheffield Tobacco Control Strategy will focus on the following 7 approaches:

1) Providing a Stop Smoking Service which targets the above priority groups, offering behavioural approaches alongside NRT and harm-reduction techniques.

2) Specialist Midwifery Service to assist pregnant mothers in quitting tobacco. This has positive impacts on improving birth and life-course health outcomes in babies and as well as mothers and reduces the likelihood of children growing up in smoking households, which has been shown to increase by 3 times the likelihood of children starting smoking.

3) Tackling the availability of cheap and illicit tobacco which disproportionately harms the health of children and adults from lower income backgrounds.

4) Harm reduction which encourages those unable to quit tobacco to switch to safer alternatives, thus reducing the impact of tobacco health harms.

5) Tackling smoking in secondary care by instigating quit attempts on admission to hospital.

6) Developing smokefree sites which helps those who are quitting stay smokefree and de-normalises the use of tobacco in society.

7) Marketing and communications which targets the priority groups in greatest need.

Changes from the previous model have been proposed inline with the best available evidence and knowledge acquired from the previous strategy delivery. This includes removing the Children and Young Peoples service (whole school approach and children's quit service delivered within this contract) which allows £100k to be invested across other elements of the new Tobacco Control Strategy in order to maximise benefits to Children and Young People. This is based on a lack of evidence for effectiveness of the programme,

difficulties in recruitment, and stronger evidence for benefits for Children and Young People being gained from investing an additional £40k in tackling cheap and illicit Tobacco availability and investing in staff to work on Smokefree Sites and Smokefree Homes. Learning and assets from the previous 5 years of the delivery of the school's service will be preserved and built upon by creating a legacy toolkit for distribution to schools in order to maximise exiting sustainably from this work and avoiding loss of the positive work to date. Provision for those aged 12+ requiring support to quit smoking will be factored into the adult Stop Smoking Service for 2022-2027. The new strategy also sees an increase in funding for the Specialist Midwifery Service that sees introduction of an evidence based incentives scheme, benefitting mothers to be and their children and reducing harm in pregnancy from tobacco.

A general whole systems approach has been in place since 2017 and has been shown to be effective by the reduction in prevalence in the last 5 years in adults by 7.3% (20,000 fewer smokers) and smoking has reduced across all social groups. Improvements have been seen in almost every measure of tobacco control over that time. However, much more needs to be done if we want to achieve National Government's target of a Smokefree Generation by 2030 and tackle the health inequalities being driven by tobacco and the new strategy and its changes uses best available local, national and international evidence in order to keep this positive momentum.

It has been very positive to undertake this EIA as this has highlighted areas where we need to focus to ensure we continue to improve to support groups as effectively as possible with EDI protected characteristics.

Impacts

Proposal has an impact on

● Health	● Transgender
● Age	● Carers
● Disability	● Voluntary/Community & Faith Sectors
● Pregnancy/Maternity	● Cohesion
● Race	● Partners
● Religion/Belief	● Poverty & Financial Inclusion
● Sex	● Armed Forces
● Sexual Orientation	○ Other

Give details in sections below.

Health

Does the Proposal have a significant impact on health and well-being (including effects on the wider determinants of health)?

● Yes ○ No *if Yes, complete section below*

Staff
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ○ Low ○ Medium ● High

Details of impact

The proposal has a direct positive impact on health and wellbeing for staff. The tobacco control strategy continues in providing a city-wide stop smoking service that is accessible by all staff and targeted at those in the priority groups. In 2018 Sheffield City Council went smokefree on its Council premises, assisting SCC smokers in quitting tobacco by providing a trigger-free environment, promoting the stop smoking service, reducing the impact of second-hand smoke on the wider workforce and de-normalising tobacco use. The new strategy continues and builds upon this work by continuing the Stop Smoking Service and continuing to monitor and develop its smokefree sites both within the Council and in wider city sites such as University Campuses and public transport interchanges.

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ○ Low ○ Medium ● High

Details of impact

Health is the primary positive impact of the proposal. The new five-year Tobacco Control Strategy will positively impact the health of our customers/population by tackling the leading cause of death and a key driver of health inequalities. 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 (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 Covid-19 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 this accounts for 8% of local authority spending on adult social care. Therefore by taking a whole system approach to tackling tobacco we will continue to reduce smoking rates in the city and positively impact the health of the Sheffield population.

Age

Staff
○ Yes ● No

Impact
○ Positive ● Neutral ○ Negative

Level
● None ○ Low ○ Medium ○ High

Details of impact

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ○ Low ● Medium ● High

Details of impact

Those whose parents or siblings smoke are around three times more likely to smoke than children living in non-smoking households. Children who start smoking at the youngest ages are more likely to smoke heavily and find it harder to give up. These smokers are at the greatest risk of developing smoking related diseases. Evidence and research have show that the majority of smokers and particularly long-term smokers start as teenagers and young adults, with 6% of Year 10 (14 - 15 year old) children in Sheffield reporting to regularly using tobacco. Although this figure is significantly lower than previous years, this is still too high and equates to roughly 314 young people using a highly addictive product and will negatively impact Sheffield's ability to achieve smoke free status by 2030. ASH UK estimate that ASH UK also estimate around 930 children start smoking each year in Sheffield.

The new proposal as with the previous Tobacco Control Strategy positively impacts across the whole life course from the unborn through to adults, with some elements having a particular focus on children and young people.

The community Stop Smoking Service is a universal service open to all adults age 18+ and specialist provision will also be made for children and young people aged 11-17 also using NRT support in line with the evidence base.

Tackling cheap and illicit tobacco directly impacts children and young people by reducing availability of pocket money priced tobacco such as cheap packs and singles that leads to early addiction and lifelong habits.

The specialist pregnancy and midwifery service also takes a life course approach directly impacting babies and children as well as the health of mothers. This service helps tackle tobacco related harm to unborn and new-borns such as low birthweight, miscarriage, and pre-term birth.

Children are 90% less likely to smoke if parents don't smoke and they live in a smoke free home – therefore supporting parents to quit is a priority along with promoting and supporting smoke free homes, workplaces, and public spaces.

A decision was taken to not include the Children and Young Peoples Service for the 2022-27 Strategy (stop smoking support delivered by Zest and whole school approach to tobacco control). This is due to ongoing difficulties in recruitment to the stop smoking service via this contract and a lack of evidence for return on investment. Current evidence suggests that health gains for children and young people are best sought via helping parents quit and households go smokefree as well as tackling the availability of cheap tobacco for children. Some provision for Children and Young People in schools will continue however via a Secondary School toolkit with a wider focus on health and wellbeing and which distils and builds on resources and learning from the previous 5 years Children and Young Peoples Contract. Provision for 11-17 year olds requiring stop smoking support will be encompassed within the new overall adult contract for the Stop Smoking Service.

Since the COVID-19 pandemic national evidence suggests that the 18-35 age cohort smoked more and as such the 2022-2027 Tobacco Control Strategy makes this a key priority group for delivery of comms and marketing.

Furthermore we will work with schools, head teachers and also align with the Sheffield Youth Strategy to develop an education Health Wellbeing Offer for schools which will incorporate smoking and ensure children most likely to take up risky behaviours are offered tailored support and advice. This will include information on drugs and alcohol and onward referrals as appropriate smoking can be a gateway into these drugs. The approach will be developed with Children and Young People and relevant partners.

We will increase our enforcement work on age of sale to prevent children from getting hold of e-cigarettes as well as cigarettes. Vaping is a route out of tobacco for adults. Children should not be vaping these are an age restricted product.

Disability

Staff
○ Yes ● No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ● Low ● Medium ○ High

Details of impact

The Stop Smoking Service offer is open and promoted to staff and will target all high prevalence groups which are identifies as those with disability such as learning difficulty mental health conditions.

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ● Low ○ Medium ○ High

Details of impact

19% of Sheffield residents have a long-term health condition or disability and a large proportion live in areas of financial deprivation. The Tobacco Needs Assessment identifies those with learning disabilities and those with mental health conditions as at greater risk of tobacco related harm. Those living with mental health conditions are more likely to smoke and more likely to struggle in quitting. Tobacco is the single largest factor in the 10-20 year life expectancy difference suffered by those with mental health conditions. The new strategy proposals cover the whole of Sheffield and are inclusive to all residents however the proposals will focus heavily on support in those areas where there is a higher prevalence of those with disability as the strategy considers those with learning disabilities and mental health conditions to be priority target groups.

The Stop Smoking Service will also, as part of their screening of referrals, refer people on to other services to look at a more holistic approach to health and wellbeing.

The specification for the Stop Smoking Service also emphasises those with learning disability and mental health conditions as being priority groups for the service and the specification sets out reasonable adjustments to cater for those with a range of physical, mental and psychological disability such as serious mental health conditions and autism etc.

Insight work will be undertaken with Sheffield Hallam University n to understand the barriers smokers with disabilities face in terms of accessing stop smoking services and how stigma related to smoking can impact on this.

We will also work with organisations whose core business is working with people with disabilities to ensure the service makes appropriate reasonable adjustments that make the service more accessible/welcoming for this group of smokers.

Pregnancy/Maternity

Staff
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ● Low ○ Medium ○ High

Details of impact

Staff made aware of support to QUIT via the Stop Smoking Specialist Midwifery service. Staff will be positively impacted in line with the general population outlined below.

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ○ Low ○ Medium ● High

Details of impact

The proposals include the continuation and expansion of the specialist midwifery service. This service based out of Jessop Wing is a citywide service supporting pregnant women and their families to quit smoking during pregnancy using behavioural support, specialist NRT and harm reduction support. It also includes delivering an evidenced based incentive to quit scheme. Tackling tobacco use in mothers and pregnant women has potential for long term life course impacts. Children of smoking parents are known to be almost 3 times as likely to smoke themselves as those with non-smoking parents. Smoking during pregnancy increases the risk of infant mortality by an estimated 40%. Sudden Infant Death Syndrome (cot death) is also significantly more common in infants and children who have one or two smoking parents who smoke in their home environment. The cost to the NHS is £20-90m per year based on treating mother and child (PH Research Consortium). Therefore, tackling tobacco use and supporting mothers and families to quit during pregnancy has the potential for large positive impacts.

Currently we average 517 mothers smoking at time of delivery (SATOD 20/21) which is around 9.8%. Under the new proposals we are on track to increase the SATOD quits from 131 to 311 which would reduce prevalence to approximately 6% SATOD.

Race

Staff
○ Yes ● No

Impact
○ Positive ● Neutral ○ Negative

Level
○ None ○ Low ○ Medium ○ High

Details of impact

As per the public impact

Customers

Impact

● Yes ○ No ● Positive ○ Neutral ○ Negative

Level
○ None ○ Low ● Medium ○ High

Details of impact

Tobacco use in different ethnic groups is a complex picture. Local data is not currently available and national data is based on ageing census data from 2011. National data suggests that smoking prevalence is highest amongst those of mixed ethnicity (19.5%), followed by "other" (15.6%), white (14.4%), then Black (9.7%), "Asian" (8.3%) and Chinese (6.7%). This however is masked by sex, as when figures are separated out by male/female we find that men have much higher rates than women in many BAME groups. Rates for women in black, 'other', Asian and Chinese are much lower than men. While Black and Asian ethnic groups may have lower smoking prevalence, most ethnic groups have particularly high rates of disease that can be associated with smoking. For example, Black people have increased risk of stroke and Black and South Asian people on average have strokes younger than White people do. Black Caribbean, Bangladeshi and Pakistani women and Pakistani, Bangladeshi and Indian men are at higher risk of diabetes and people with diabetes who have smoke have twice the risk of premature death than those who don't smoke.

As part of the new proposals, provision of Stop Smoking Services will be made in primary care networks (PCN'S) and community and faith settings and will follow the new ways of working post covid. This builds on positive work done during the pandemic to access under served groups in their settings. Work with Imans, Pastors, community faith leaders etc will assist in accessing these groups and religious and faith congregations via trusted members of these communities to encourage engagement with services. These improved relationships since COVID mean community organisations and 'trusted voices' are able to better help us to engage with BAME communities. Ways of working will include communications via community radio, faith publications, video and community WhatsApp groups and online broadcasts.

Service specifications also set out that staff and services are culturally appropriate and trained. Materials developed will be available in variety of languages with translation services where necessary . The stop smoking service will also aim to employ local BAME organisations to do translation where possible to foster trust and familiarity for local populations.

Insight work will be undertake with Sheffield Hallam University n to understand the barriers BAME communities face in terms of accessing stop smoking services and how stigma related to smoking can impact on this.

Also work will be undertaken to establish a prevalence in the South Asian community of use of chewing tobacco and also prevalence for Shisha in the city across all groups. We don't currently have baseline local data for this.

We will work with organisations who serve these communities to ensure the data collected is developed inclusively and effectively. This will then be used to shape how we deliver the local community stop smoking service.

Religion/Belief

Staff
○ Yes ● No

Impact
○ Positive ● Neutral ○ Negative

Level
● None ○ Low ○ Medium ○ High

Details of impact

Customers
● Yes ○ No

Impact
● Positive ● Neutral ○ Negative

Level
○ None ● Low ● Medium ○ High

Details of impact

Data on prevalence within religious groups is not available locally. Much of the work around religion and faith work overlaps with the positive impact BAME work outlined above. Outreach work building on the positive relationships and improved engagement via the faith sector during the pandemic allows better engagement with leaders and trusted community voices in the faith sector. This allows better engagement with congregational groups. Voluntary and community faith leaders will also be invited to sit on the City-Wide Tobacco Control Board in 2022 to better engage with faith settings. We will collect data from all services on smokers and their religious belief. We aspire to undertake a prevalence survey to understand the levels of prevalence of smoking across religious groups.

Sex

Staff
○ Yes ● No

Impact
○ Positive ● Neutral ○ Negative

Level
○ None ○ Low ○ Medium ○ High

Details of impact

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ○ Low ○ Medium ○ High

Details of impact

Modelled data for Sheffield (2019) suggests smoking prevalence for men was around 16.6%, while for women it was lower at 11.1%. Services are generally representative and equal and not biased towards a particular sex. However, where appropriate comms and marketing campaigns are targeted towards specific sexes or tailored towards a specific group we are trying to reach. For example from past campaigns the ‘You Are Strong Enough’ and ‘Closer

Each Time' were neutral and not gender orientated, however the 'You Can Keep Your Patch On' video campaign targeted the male routine and manual population.

The Stop Smoking Service typically has higher uptake from women than men, hence carrying out some targeted male campaigns, and we propose to continue with an approach of tailoring campaigns according to the uptake we're seeing in the services and interventions.

The pregnancy and specialist maternity services do target women primarily, as the positive impacts of quitting smoking in pregnancy are great. As part of this service there is a focus on assisting partners and the wider family to quit smoking and create smokefree homes for children.

Sexual Orientation

Staff
○ Yes ● No

Impact
○ Positive ● Neutral ○ Negative

Level
● None ○ Low ○ Medium ○ High

Details of impact

As per the general population

Customers
● Yes ● No

Impact
● Positive ● Neutral ○ Negative

Level
○ None ○ Low ● Medium ○ High

Details of impact

LGBTQ people are disproportionately affected by wider social inequalities which can increase the risk of smoking initiation and tobacco addiction. For data collected in 2018, the latest available, the proportion of current smokers was significantly higher among people who identified as gay or lesbian (22.2%) than among heterosexual (straight) people (15.5%). In a Queer Voices Heard report published in March 2020, findings pointed to links between LGBT+ people being more vulnerable to mental health issues (also a priority group in the tobacco control strategy) and suggests that many use smoking as a coping mechanism.

As part of the proposals the Stop Smoking Service will work with services such as sexual health and relevant VCF LGBTQ organisations and the equalities partnership to ensure our services are reaching and meeting the needs of LGBTQ populations. Very Brief Advice training will also be made available to key staff so they have the skills and knowledge to be able to effectively engage and refer those in need into appropriate services.

We intend to monitor and review progress as further evidence and guidance arises.

Transgender

Staff
○ Yes ● No

Impact
○ Positive ● Neutral ○ Negative

Level
● None ○ Low ○ Medium ○ High

Details of impact

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ● Low ● Medium ○ High

Details of impact

No prevalence available however transgender is covered within the LGBQT data cited above.

Carers

Staff
○ Yes ● No

Impact
○ Positive ● Neutral ○ Negative

Level
● None ○ Low ○ Medium ○ High

Details of impact

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ● Low ○ Medium ○ High

Details of impact

The new strategy will ensure work with carers centres and Disability Sheffield in order to raise awareness of support services and ensure these groups needs are being met.

Consideration will be given to how best support carers who smoke to quit and how best to support those who are working with people with disabilities who smoke.

Where the carer is a non-smoker but they are looking after a client/relative who smokes advice will be given as appropriate to ensure the health of the carer is protected. This is both

in terms of paid and unpaid carers. We will work with the Carers centre and other agencies to shape our approach.

We do not have local prevalence data for this cohort but understand anecdotally that it may be a higher prevalence group. Very Brief Advice training will be made available to key staff so they have the skills and knowledge to be able to effectively engage and refer those in need into appropriate services.

Voluntary/Community & Faith Sectors

Staff
○ Yes ● No

Impact
○ Positive ● Neutral ○ Negative

Level
● None ○ Low ○ Medium ○ High

Details of impact

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ○ Low ● Medium ● High

Details of impact

The VCF sector will be important in the new proposals for a Tobacco Control Strategy in assisting services in engaging with underserved groups in deprived and BAME communities, both identified as priority groups. Much of this work overlaps with information given in the 'Race' section of this document. As part of the new proposals, provision of Stop Smoking Services will be made in Primary Care Networks (PCNs) and community and faith settings, and will follow the new ways of working post covid from delivery of the vaccination programme.

This provides better local access to services and builds on positive work done during the pandemic to access underserved groups in their settings. Work with trusted community organisations, community leaders, Iman's, Pastors, community and faith leaders will assist in accessing these groups and encourage greater community engagement with services. These improved relationships since COVID mean community organisations and 'trusted voices' are able to better help us engage with communities including BAME communities. Ways of working will include communications via community radio, faith publications, video and community WhatsApp groups and online broadcasts.

Cohesion

Staff
● Yes ○ No

Impact
○ Positive ○ Neutral ○ Negative

Level
○ None ● Low ○ Medium ○ High

Details of impact

The maintenance of the SCC Smokefree Sites work helps to address tensions in teams created by perceived inequities relating to 'smoking breaks' for those regularly going out to manage tobacco addiction. This was a frequently cited source of tension in teams as part of the consultation work initially carried out relating to smokefree sites. As part the proposed continued maintenance of this work, staff are made aware, encouraged, and actively supported to make use of the Stop Smoking Services provided, thus reducing prevalence of staff smoking and the need to take time out during working hours.

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ● Low ○ Medium ○ High

Details of impact

As tobacco is a key driver of health inequality, tackling tobacco and smoking prevalence in the population subsequently heavily impacts on social, economic, and environmental inequalities. Inequalities in society in turn lead to a friction and tension between socio-economic groups, fostering lack of trust and crime.

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. This strategy aims to increase investment in enforcement action which will positively reduce crime and increase community cohesion.

Partners

Staff
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ○ Low ● Medium ○ High

Details of impact

Delivery of the 2022-2027 Tobacco Strategy will include working positively with SCC partners. The Services include commissioning work and funding of staff in the SCC Trading Standards Team to carry out enforcement to reduce availability of cheap and illicit tobacco, gather and develop intelligence. This intelligence also supports and assists SY Police. Delivering and continuing Smokefree Sites work has and will foster better relationships between SCC Housing and Better Parks teams and allows us to provide staff with Very Brief Advice Training helping wider staff groups to quit tobacco. The new strategy also includes investment within the Public Health Team to assist in delivering on Smokefree sites and monitoring and evaluation work providing SCC job security.

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level

○ None ○ Low ○ Medium ● High

Details of impact

The 2022-2027 Tobacco Control Strategy builds on and expands on the partnership work achieved in 2017-2022.

The City-Wide Tobacco Control Board established as part of the 2017-2022 strategy will be continued as part of these proposals. This is a hugely successful partnership board that brings together key partners across the city to share learning, evidence and develop collaborative working, making savings by avoiding duplication and sharing resource.

The provision of the Services within the strategy helps partners support staff and clients achieve positive health and social outcomes.

The community dividends of a fully-fledged tobacco control strategy are hugely significant as the effects of smoking on communities from not only a health perspective, but also poverty and economic perspective are so great. Tackling smoking effectively will:

- Lift thousands of households out of poverty
- Increase local productivity (due to reduced loss of workforce) and boost economic prosperity with money spent on other items rather than tobacco
- Protect children from harm
- Reduce inequalities
- Improve quality of life in our communities
- Save potentially thousands of lives
- Save the NHS, SCC, the benefit system and social care huge amounts in spending
- Increase positive engagement and financial income to VCF organisations

- To achieve this, a multicomponent approach is required to meet the needs of the whole smoking population not just to those who attend Stop Smoking Services

Key partnership work includes:

- Continuation and development of the Tobacco Control Board
- Delivering stop smoking services from community VCF settings in collaboration with Primary Care Networks and the community and faith sectors.
- Potential to support/pay for room hire, or for organisations to deliver and to be paid to deliver quits on behalf of the service – subcontracting.
- Provide translations services via VCF partners

- VCF support us in developing bespoke targeted campaigns and promote the stop smoking campaigns via your social media networks and WhatsApp groups, faith networks etc and leaflets in community and faith buildings
- VCF reps on the tobacco control board
- Delivery of QUIT multiagency partnership across the ICS footprint for SYB and at a Sheffield place level
- 0-19 Smokefree partnership

Poverty & Financial Inclusion

Staff
○ Yes ● No

Impact
○ Positive ● Neutral ○ Negative

Level
● None ○ Low ○ Medium ○ High

Details of impact

Same impact for staff as general population

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ○ Low ○ Medium ● High

Details of impact

Smoking prevalence is correlated with poverty, with smoking rates increasing with in line with deprivation. Our most recent modelled data for Sheffield suggested that 33% of the 10% most deprived population currently smoke, versus 12% of the least deprived 10%.

The proportion of current smokers is also significantly higher among unemployed persons (26.8%) when compared with those who are employed (14.5%).

The average smoker is spending between £2,000 to £5,000 a year on tobacco costing Sheffield smokers between £122m and £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.

The average price of a pack of cigarettes in the UK is currently £10.80. This means if a person on universal credit smokes one pack a day the total cost per month is £304 (for a single person over 25 this equals 73% of total income, meaning a person addicted to tobacco would have to sacrifice paying bills or buying food in order to keep up with their tobacco habit). This will force more people to purchase cheap and illicit tobacco that can be more harmful to a person's health, supports criminal activity and makes cheap tobacco available to children.

Smokers' employment chances and average earnings are also damaged by smoking. In Sheffield 4,130 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.

Efforts to lower smoking prevalence will help ease the financial pressures managing an addiction to tobacco brings on those on more deprived groups and those living in poverty.

This year's budget includes a £40k increase of funding towards tackling counterfeit and illicit tobacco. This will negatively affect some people in this group financially in the very short-term as they will have to purchase premium taxed tobacco, however if tackled holistically alongside the wider components of the tobacco strategy, such as with access to stop smoking support, NRT, harm reduction and smokefree spaces etc services it has a positive health benefits. This will bring long term financial and health benefits.

Armed Forces

Staff
○ Yes ● No

Impact
○ Positive ● Neutral ○ Negative

Level
● None ○ Low ○ Medium ○ High

Details of impact

Customers
● Yes ○ No

Impact
● Positive ○ Neutral ○ Negative

Level
○ None ● Low ○ Medium ○ High

Details of impact

Smoking prevalence in the armed forces is higher than in the general population by around 5%. The percentage of woman in the forces who smoke is the same as in general population, whilst the percentage of men is around 4% higher. This is believed to be due to the amount of stress placed on active UK service personnel and the availability of duty free tobacco products within Ministry of Defence (MoD) sites, both here in the UK and UK MOD bases abroad. In a similar trend to general population, the smoking rates amongst military personnel has reduced year on year, however the military still has a proportionately higher prevalence of smokers. Stop Smoking Services are available to servicemen and women via the military, and veterans are able to access the service as per the general population.

Currently the only additional focus on veterans as part of these proposals are via the targeting homeless populations who we identify as a priority group. The Royal British Legions figures state that approximately 6% of homeless populations are veterans and ex-forces,

although anecdotally it is expected to be higher locally. We will continue to identify and prioritise these groups via engagement with housing and homeless services as well as drug, alcohol and substance misuse services.

Other

Staff
○ Yes ● No

Impact
○ Positive ○ Neutral ○ Negative

Level
○ None ○ Low ○ Medium ○ High

Details of impact

Customers
○ Yes ● No

Impact
○ Positive ○ Neutral ○ Negative

Level
○ None ○ Low ○ Medium ○ High

Details of impact

Cumulative Impact

Proposal has a cumulative impact

● Yes ○ No

● Year on Year	○ Across a Community of Identity/Interest
○ Geographical Area	○ Other

If yes, details of impact

The current strategy, soon to expire, which runs from 2017 until Oct 2022 to date has reduced smoking prevalence in adults by 7.3% (20,000 fewer smokers) and smoking has reduced across all social groups. We have achieved a 1.4% reduction each year (x3.6 national average which is 0.4%). Sheffield has been successful where others haven't because we have maintained our investment and deliver a mix of prevention, policy and treatment interventions at an individual and population level (previous model focused more on treatment – stop smoking services and individual behaviour change). We are the second best in Yorkshire and Humber – competing with more affluent areas. We are also best in South Yorkshire in terms of adult smoking prevalence.

The current strategy and commissioned services are due to end Oct 2022 and this new round for 2022-2027 provides an opportunity to review and refresh the approach in Sheffield to ensure we continue to accelerate a decline in smoking prevalence and uptake of smoking across all groups, especially those population groups where prevalence is highest and inequalities in health outcomes exist.

Smoking is still the biggest killer and driver of health inequalities therefore continuing to build on the previous successes from our comprehensive Tobacco Control approach allows us to maintain and accelerate the momentum gained to date.

Proposal has geographical impact across Sheffield

● Yes ○ No

If Yes, details of geographical impact across Sheffield

Yes – although the services are universal and city-wide, priority groups will mean that there is a greater on those wards and districts where we have a higher prevalence in smoking, namely those areas with the greatest deprivation and routine and manual populations.

Local Partnership Area(s) impacted

● All ○ Specific

If Specific, name of Local Partnership Area(s) impacted

City-wide but according to priority and need

Action Plan and Supporting Evidence

Action Plan

Approval of Tobacco Control Strategy		
Development and Approval of Procurement strategy		
Implementation of services and interventions and insight work		

Supporting Evidence (Please detail all your evidence used to support the EIA)

- 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
- 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

Consultation

Consultation required

○ Yes ● No

If consultation is not required please state why

We have previously consulted at length on the travel of direction and received favourable support on the whole systems, comprehensive evidence-based approach we are proposing to continue. We have and continue to involve service users and delivery partners/stakeholders in planning and development.

Are Staff who may be affected by these proposals aware of them

● Yes ○ No

Are Customers who may be affected by these proposals aware of them

● Yes ○ No

If you have said no to either please say why

Summary of overall impact

In line with best evidence from the WHO we deliver comprehensive tobacco control to reduce smoking prevalence and prevent uptake of smoking.

The current strategy, soon to expire, which runs from 2017 until Oct 2022 delivers 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, a prevention programme in school, smoking in pregnancy, QUIT – treatment of tobacco dependency in secondary care, enforcement action on cheap and illicit tobacco and age of sale of tobacco and e-cigarettes, Smokefree sites and homes, harm reduction NRT/E-cigarettes

- This model has been in place since 2017 and we have reduced smoking prevalence in adults by 7.3% (20,000 fewer smokers) and smoking has reduced across all social groups.
- 1.4% reduction each year x3.6 national average which is 0.4% Sheffield has been successful where others haven't because we have maintained our investment and deliver a mix of prevention, policy and treatment interventions at an individual and population level (previous model focused more on treatment – stop smoking services and individual behaviour change).
- We are the second best in Yorkshire and Humber – competing with more affluent areas
- Best in South Yorkshire in terms of prevalence

Despite the success of the Sheffield Tobacco Control Multiagency Strategy 2017-2022 in driving down smoking prevalence

- Smoking continues to cause immense harm to individuals, families, and communities in Sheffield with around 61,000 adults continuing to smoke.
- 1,000 deaths a year which is more than covid to date,
- 6,000 hospitalisations.
- Smokers die up to 10 years earlier than non-smokers and need social care 10 years earlier than non-smokers.

The current strategy and commissioned services are due to end Oct 2022 and this provides an opportunity to review and refresh the approach in Sheffield to ensure we continue to accelerate a decline in smoking prevalence and uptake of smoking across all groups, especially those population groups where prevalence is highest and inequalities in health outcomes exist.

If we deliver effective tobacco control we will:

- Lift thousands of households out of poverty
- Increase local productivity (due to reduced loss of workforce) and
- Boost economic prosperity with money spent on other items rather than tobacco
- Protect children from harm
- Reduce inequalities
- Improve quality of life in our communities
- Save potentially thousands of lives
- Save the NHS, SCC, the benefit system thousands

Smoking is still the biggest killer and driver of health inequalities therefore continuing to build on the previous successes from our comprehensive Tobacco Control approach allows us to maintain and accelerate the momentum gained to date.

Summary of evidence

The Sheffield Tobacco Control Needs Assessment 2020-2021

Local Tobacco Control profiles - OHID

Business Case

Changes made as a result of the EIA

As a result of completion of the EIA we will embed the actions re data collection and insight work This will be utilised to improve service provision for EDI groups via monitoring and review processes.

Escalation plan

Is there a high impact in any area?

○ Yes ● No

Overall risk rating after any mitigations have been put in place

○ High ○ Medium ○ Low ● None

Review Date	April 2027

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