NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality impact assessment

Tobacco suite: prevention, cessation and harm reduction (update)

The impact on equality has been assessed during guidance development according to the principles of the NICE equality policy.

1.0 Checking for updates and scope: before scope consultation (to be completed by the Developer and submitted with the draft scope for consultation)

1.1 Have any potential equality issues been identified during the check for an update or during development of the draft scope, and, if so, what are they? (Please specify if the issue has been highlighted by a stakeholder)
Age The prevalence of smoking in Great Britain is higher among younger adults. Around 20% of 16-34 year olds smoke, whereas less than 11% of adults aged 60 and over smoke. However, younger adults smoke less cigarettes a day, with those aged 16-24 smoking on average around 8 cigarettes a day, compared to around 13 per day at most among those aged 50-59 (House of Commons Library Briefing paper: Statistics on smoking 2017). Success at quitting smoking increases with age, with data for England from NHS Stop Smoking Services (April to Dec 2016) showing that 41% of those aged under 18 succesfully quit compared to 56% of those aged 60 and over. ***Children and young people*** Most smokers begin smoking in their teens, with two- thirds beginning before the age of 18. In 2015 there were 90,000 regular smokers aged 11-15 (Health matters: smoking and quitting in England 2015) and currently 8% of 15 year olds regularly smoke. (Department of Health Tobacco Control Plan for England (2017). In 2014 over 80% of young people who regularly smoked, said they had family members who also smoked, and children who have parents who smoke, are more likely to become smokers themselves (Department of Health Tobacco Control Plan for England

(2017).

Stakeholders attending a scoping workshop for this guidance highlighted that young people who are not in education or employment, are particularly vulnerable to taking up smoking.

Sex

In Great Britain, men are more likely to smoke than women, with an estimated 18% of men and 15% of women being smokers. In 2016, 56% men and 63% of women had never smoked. Among smokers in England, more women set a quit date than men in almost all age groups, however men self-report a higher successful quit rate than women (House of Commons Library Briefing paper: Statistics on smoking 2017).

Data from 2014 - 2015 suggest that in Great Britain, men are more likely than women to be electronic cigarette users (6.3% of all men aged 16 and over compared to 4.9% of all women aged 16 and over), but there is considerable variation by age group with the most likely age for men to use electronic cigarettes being 16-24 years. Among women this was the least likely age group, with the most common age group for them being 50-59 years Office for National Statistics - Adult smoking habits in the UK 2017).

Disability

40% of adults with serious mental health conditions smoke (Department of Health Tobacco Control Plan for England 2017) as do 64% people in mental health settings (Health matters: smoking and quitting in England 2015). Smokers with mental health disorders are more likely to be heavily addicted to smoking than smokers in general (Royal College of Physicians and Royal College Psychiatrists Smoking and mental health 2013). However the Tobacco control plan for England, notes that some health professionals can be reluctant to offer people with mental health conditions support to quit smoking, even though the proportion of people with a mental health condition who would like to quit, is similar to the proportion among smokers generally (Department of Health Tobacco Control Plan for England 2017). While the number of smokers in general has fallen by around 30% over the last 2 years, there has been little change in smoking prevalence among people with mental health problems (Health matters: smoking and quitting in England 2015).

Regarding learning disabilities, no national data has been identified, but it was noted that one study has reported that smoking prevalence among adolescents with mild learning disabilities is higher than among their peer group (reported in Tobacco use: inequalities by protected characteristics and socioeconomic factors 2015).

Race

There is some variation in smoking rates by ethnicity with higher smoking prevalence among Bangladeshi, Pakistani and Irish men and among Caribbean and Irish women (Health matters: smoking and quitting in England 2015). Smokeless tobacco is used predominantly by some South Asian communities in the UK and is more likely

to be used by people of Bangladeshi heritage, and by women, older people and those from lower socio-economic groups within these communities (NICE guideline PH39 Smokeless tobacco: South Asian communities 2010).

Religion or belief

Smoking prevalence varies by religion. Data from 2016, shows the highest prevalence among those identifying as having 'no religion' (19.6%). Similar smoking prevalence rates are reported by those identifying as Christian (13.9%) Buddhist (13.4%) and Muslim (12.9%). Those identifying as Jewish report a prevalence of 9.9%. The lowest rates were reported by those identifying as Hindu (6.5%) or Sikh (5.5%) (Public Health England Local Tobacco Control Profiles).

Pregnancy and maternity

Over 10% of pregnant women currently smoke, but there is considerable variation in prevalence when factors such as age, income, and geographical area are taken into consideration. Smoking prevalence among pregnant women is higher among those aged under 20 than among older women. Pregnant women from manual occupation groups are five times more likely to smoke than women from managerial and professional occupations (Department of Health Tobacco Control Plan for England 2017). In 2014-2015, the prevalence of women who were smokers at the time of delivery ranged from 2% in central London to 27% in Blackpool NHS Digital Statistics on Smoking, England - 2016.

The Tobacco Plan for England notes that although progress has been made in CO monitoring at antenatal appointments and referring pregnant women to stop smoking support, there is variation at local level in the extent to which all of NICE's recommendations to support women to quit smoking in pregnancy are implemented (Department of Health Tobacco Control Plan for England 2017).

Sexual orientation

Around 24% of adults who identify themselves as being lesbian, gay or bisexual are smokers, compared to just over 16% of those who identify themselves as being heterosexual (Public Health England Local Tobacco Control Profiles 2016). This may be partly explained by their younger age profile and because the prevalence of smoking is higher among younger people.

Lesbian, gay, bisexual and transgender people are less likely to have never smoked and less likely to have given up smoking than the general population (Public Health England Tobacco use: inequalities by protected characteristics and socioeconomic factors 2015). These groups often report limited access to health services (ASH Smoking and the LGBT community - Action on Smoking and Health 2016).

Gender reassignment

No national survey data have been identified on inequalities relating to tobacco use relating to people who have undergone or who are undergoing gender reassignment.

Socio-economic factors

Income level

The Department of Health 2017 tobacco control plan notes that since the previous plan was published in 2010, the prevalence of smoking among all adults has reduced significantly from around 20% to 15.5%. However significant inequalities remain, with smoking rates almost three times higher among those on the lowest incomes compared to those on the highest income.

Occupation

In Great Britain in 2016, 26% of those in routine and manual occupations were smokers compared to just over 11% of those in managerial and professional occupations (House of Commons Library Briefing paper: Statistics on smoking 2017).

In England, the largest absolute number of attempts to quit is among smokers from routine and manual occupations. However, the highest quit rates are among smokers who are retired or from managerial and professional groups. The lowest quit rates are among those who are long-term unemployed or who have never worked (NHS Digital Statistics on NHS Stop Smoking Services in England: April 2016 to March 2017).

Geographical area

Smoking prevalence varies significantly by geographical region with data from 2014 showing smoking prevalence to be 17% in London, the South East and South West compared to over 19% in the North East, North West and Yorkshire and The Humber (NHS Digital Statistics on Smoking, England - 2016). However in 2016, 60% of quitters in Yorkshire and Humber were successful, compared to 45% in the south west (NHS Digital Statistics on NHS Stop Smoking Services: England, April 2016 to December 2016).

People from deprived areas are more likely to smoke and less likely to quit. Smoking is increasingly concentrated in more deprived areas (Health matters: smoking and quitting in England 2015).

The tobacco control plan notes that the sale of illicit tobacco undermines public health policy by offering a cheaper alternative to those for whom price may otherwise be reason to stop smoking (Department of Health Tobacco Control Plan for England 2017). There are concerns that access to illicit tobacco is greatest in more deprived areas (NICE guideline PH14 Review decision 2014)

Specific groups

Prisoners

Around 80% of prisoners smoke compared to 20% of the general population. A 2015 report noted variation in access to services to support prisoners to quit. It noted that while there had been a marked improvement in some prisons, there were

concerns that transfer of responsibility for commissioning public health services for prisoners to NHS England in 2013, may have interrupted provision of these services (Public Health England. 'Reducing Smoking in Prisons. Management of tobacco use and nicotine withdrawal'. March 2015).

Prisons were excluded from 2007 legislation that made public places smoke-free. Smoking is prohibited in all indoor areas in adult prisons except cells occupied by smokers over 18 years of age and areas set aside in youth offender institutions for juveniles are smoke-free. Non-smokers must not be required to share a cell with a prisoner who is actively smoking, however, this has not been enforced uniformly (ASH Fact Sheet Smokefree Prisons. October 2015) The tobacco control plan 2017, commits to introducing smoke-free polices across all prisons in England.

Gypsies and travellers

Smoking prevalence is higher among gypsies and travellers than among the general population, with data from a 2009 survey reporting that 47% smoke (Public Health England Tobacco use: inequalities by protected characteristics and socioeconomic factors (2015). While no data have been identified on the uptake of services to support smokers from these communities to quit, it is noted that engagement with health services is often poor.

Looked after children and young people

It is noted that many looked after children are smokers when they arrive in the care system and others take up smoking during their time in care Tobacco use: inequalities by protected characteristics and socioeconomic factors (2015). Stakeholders attending a scoping workshop also noted that looked after children and young people are particularly vulnerable to taking up smoking.

1.2 What is the preliminary view on the extent to which these potential equality issues need addressing by the Committee? For example, if population groups, treatments or settings are excluded from the scope, are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

The issues identified above will be:

- noted in the review protocols and any evidence relevant to these groups will be extracted
- highlighted to and discussed by the committee during development of recommendations.

Completed by Developer: Sarah Willett

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Approved by NICE quality assurance lead: Simon Ellis

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