NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE quality standards

Equality impact assessment

Tobacco: treating dependence

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

### 1. TOPIC ENGAGEMENT STAGE

### 1.1 Have any potential equality issues been identified during this stage of the development process?

Smoking has higher prevalence amongst certain population groups, including:

* people experiencing socioeconomic disadvantage
* people who identify as LGBT+
* people with a mental health condition
* people in contact with the criminal justice system
* looked after children
* people experiencing homelessness.

The [ASH briefing on health inequalities and smoking](https://ash.org.uk/information-and-resources/ash-briefings/) from 2019 shows:

* socioeconomic disadvantage is associated with higher prevalence of smoking
* cumulative disadvantage increases the likelihood of smoking
* children who grow up around people who smoke are more likely to smoke
* links between socioeconomic status and smoking and regional and local variations in smoking prevalence and health outcomes.

Some groups may not be well-served by existing stop-smoking provision, such as people experiencing socioeconomic disadvantage, those with a mental health condition, people who identify as LGBT+. Although these groups may be motivated to stop smoking, they may experience additional challenges to successfully stop. The [ASH briefing on health inequalities and smoking from 2019](https://ash.org.uk/information-and-resources/ash-briefings/) gives examples of factors that may influence whether people experiencing socioeconomic disadvantage successfully stop smoking, such as dependence on nicotine, lack of social support and stress.

People with mental health conditions have a higher prevalence of smoking and are less likely to access standard smoking cessation services and have lower quit rates. People with severe mental illness may have a life expectancy 20 years lower than the general population, part of which is attributable to smoking. Although smoking rates have substantially decreased in the general population, for those with mental health conditions rates have remained. The [Department of Health’s Towards a Smoke free Generation: a tobacco control plan for England](https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england) references studies that show 40.5% of adults with serious mental health conditions smoke. The report notes that some health professionals can be reluctant to offer people with mental health conditions support to quit smoking. This is because of beliefs that the medicines might lead to adverse outcomes in this group, or that the mental health condition should be addressed before attempting smoking cessation.

Specific consideration should be given to pregnant women because of the impact of smoking on the health of the baby and the woman. Some stop-smoking interventions such as varenicline and bupropion are not suitable for young people or pregnant or breastfeeding women.

People from South Asian communities are the predominant users of smokeless tobacco products in England.

### 1.2 Have any population groups, treatments or settings been excluded from coverage by the quality standard at this stage in the process. Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

No population groups, treatments or settings have been excluded from the quality standard at this stage.

Completed by lead technical analyst: Charlotte Fairclough.

Date:10 / 02 / 2022

Approved by NICE quality assurance lead: Mark Minchin

Date: 28 / 02 / 2022

### 2. PRE-CONSULTATION STAGE

### 2.1 Have any potential equality issues been identified during the development of the quality standard (including those identified during the topic engagement process)? How have they been addressed?

The QSAC advised that people who use smokeless tobacco should also be included in statements on identifying people who smoke. People from a South Asian background are the predominant users of smokeless tobacco. Draft quality statements 1 and 2 include this population and reference specific recommendations on the use of smokeless tobacco in [NICE’s guideline on tobacco](https://www.nice.org.uk/guidance/ng209).

The QSAC commented that the cost of some stop-smoking interventions such as nicotine replacement therapy, could be a barrier to their use for people experiencing socio-economic disadvantage. Draft quality statements 3, 4 and 5 reference recommendations on access to treatments in [NICE’s guideline on tobacco](https://www.nice.org.uk/guidance/ng209) and aim to increase access to all stop-smoking interventions.

The QSAC discussed that some stop-smoking services may be aimed at groups of people dependent on age. Draft quality statement 3 on access to stop-smoking support and interventions does not restrict by age and aims to increase access for all people.

The QSAC recognised the considerable health inequalities in this area including for people from black and minority ethnic groups, people in contact with mental health services and manual workers. The draft statements do not exclude any population groups and aim to reduce health inequalities in these areas. A consideration has been added to draft quality statement 5 on stop-smoking support for people with a severe mental health condition.

Specific considerations for stop smoking treatment in pregnancy have been included in draft quality statements 3 and 5 as some stop-smoking interventions are not suitable in pregnancy or during breastfeeding.

Specific considerations for stop smoking treatment in children and young people have been included in draft quality statements 3 and 5 as some stop-smoking interventions are not suitable for this population.

### 2.2 Have any changes to the scope of the quality standard been made as a result of topic engagement to highlight potential equality issues?

No changes have been made to the scope of the quality standard at this stage.

### 2.3 Do the draft quality statements make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

No draft quality statements make it more difficult in practice for a specific group to access services compared with other groups.

### 2.4 Is there potential for the draft quality statements to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

There is no potential for the draft quality statements to have an adverse impact on people with disabilities.

### 2.5 Are there any recommendations or explanations that the committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 2.1, 2.2 or 2.3, or otherwise fulfil NICE’s obligation to advance equality?

There is no additional recommendations or explanations to be made at this stage.

Completed by lead technical analyst: Charlotte Fairclough

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