Lancashire County Council

Lancashire Health and Wellbeing Board

Wednesday, 16th July, 2014 at 2.00 pm in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Supplementary Agenda

We are now able to enclose, for consideration at the next meeting of the Lancashire Health and Wellbeing Board to be held on Wednesday, 16th July, 2014, the following report(s).

Part 1 (Open to Press and Public)

No.	**Item**	
13.	**The Tobacco Control Strategy for Lancashire 2014-2016**	(Pages 1 - 50)

Ian Fisher
County Secretary and Solicitor

County Hall
Preston

Lancashire County Council

Health and Wellbeing Board
Meeting to be held on 16 July 2014

Electoral Division affected:
All

The Tobacco Control Strategy for Lancashire 2014-2016
(Appendices A, B, C and D refer)

Contact for further information:
Jo McCullagh, 07876844160, Adult Services, Health and Wellbeing Directorate,
Joanne.McCullagh@lancashire.gov.uk

Executive Summary

Tobacco smoking is the single largest preventable cause of ill health, premature death and health inequalities in Lancashire, killing 1,673 adults aged 35 years and over each year. Smoking rates remain higher in Lancashire than England as a whole in adults (21.2% vs 20%), pregnant women (16.8% vs 12.0%) and young people (16% vs 11%). The total cost of smoking to society in Lancashire, including lost productivity, sick days, illness and death, house fires and dealing with tobacco litter is estimated to be £316.6 million each year.

Further to this, the Tobacco Free Lancashire Alliance has been formed to work collaboratively across the County to reduce the harm caused by tobacco and has developed a 'Tobacco Control Strategy for Lancashire 2014-2016'. This is in line with the government's national tobacco plan and the 'Local Government Declaration on Tobacco Control', which was adopted by Lancashire County Council in December 2013.

Reducing smoking in pregnancy is one of the key priority areas of the Tobacco Control Strategy for Lancashire 2014-2016 and Lancashire County Council's Strategy for Health and Wellbeing. A scoping of the smoking in pregnancy pathways currently operating across Lancashire has highlighted significant variances in programme delivery and gaps in current provision in line with the inherited legacy of the three Primary Care Trusts (PCTs). Therefore, in line with NICE guidance, a comprehensive Lancashire programme needs to be undertaken to systemise and embed organisational change to ensure all pregnant smokers are offered effective support in order to reduce the rates of smoking.

Further to this, a pan-Lancashire 'Tackling Smoking in Pregnancy' multi-disciplinary project group has been formulated as a sub-group of the Tobacco Free Lancashire Alliance, which has collectively developed a two-year 'Tackling Smoking in Pregnancy Action Plan. The plan will be jointly implemented by Public Health Teams, Maternity Services within Hospital NHS Trusts, Clinical Commissioning Groups (CCGs), Stop Smoking Services and the Community and Voluntary Sector from Lancashire County, Blackburn with Darwen and Blackpool.

The proposed plan will facilitate implementation of a standardised opt-out pathway, comprehensive training for frontline staff, development of information for pregnant smokers and accurate data collection to reduce smoking rates during pregnancy and ensure every child in Lancashire has the best start in life.

This proposal to endorse and implement the Tobacco Control Strategy for Lancashire 2014-16 and the associated Tackling Smoking in Pregnancy Action Plan will assist in reducing health inequalities resulting from smoking and protecting successive generations of young people from the harm done by tobacco in Lancashire.

Recommendation

That the Board endorse the Tobacco Control Strategy for Lancashire 2014-2016 and associated Tackling Smoking in Pregnancy Action Plan and implement within commissioning plans where appropriate.

Background and Advice

1. Impact of Smoking in Lancashire

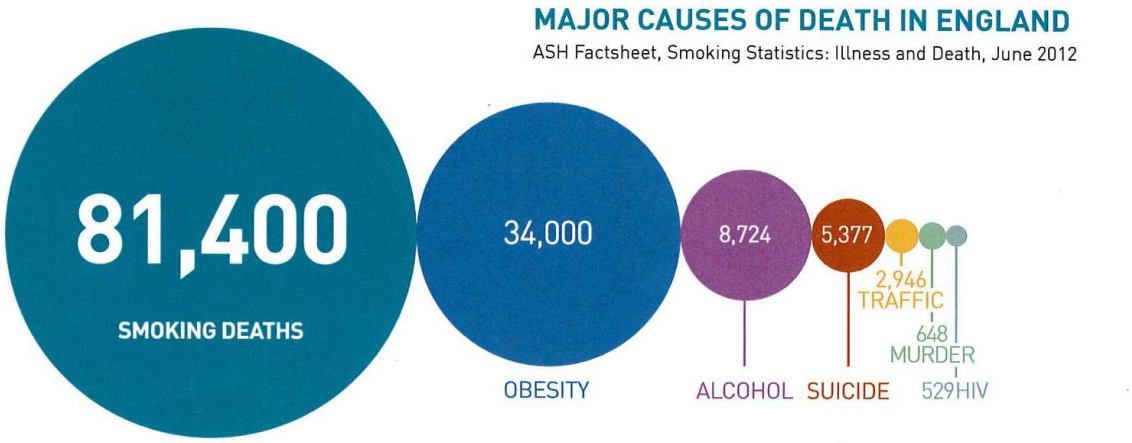
Tobacco smoking is the single largest preventable cause of ill health, premature death and inequalities in the communities we serve. One in two long-term smokers die prematurely as a result of smoking, half of these in middle age. On average, each smoker loses 16 years of life and experiences many more years of ill-health than a non-smoker.

Smoking kills around 80,000 people each year in England and 1,673 adults aged 35 years and over in Lancashire alone. This is greater than the total number of deaths from alcohol, obesity, illegal drugs, murder, suicide, road traffic accidents and HIV infection combined (see figure 1).

Smoking disproportionately affects those disadvantaged by poverty and is a major contributor to health inequalities, accounting for half of the difference in life expectancy between social classes I and V. Nationally, adults in routine and manual occupations are twice as likely to smoke as those in managerial and professional occupations (30% vs 13.8% respectively). In Lancashire County, over a third of routine and manual workers currently smoke (35.3%).

Tobacco negatively impacts on the whole economy – not just the NHS. The cost of smoking to society in Lancashire, including lost productivity, sick days, illness and death, house fires and dealing with tobacco litter is estimated to be £316.6 million each year. Even if all of the tax revenue from local tobacco sales were to come directly into Lancashire, estimated at £273.4 million, this would leave an annual shortfall of £43.2 million.

Figure 1



Smoking rates remain higher in Lancashire than England as a whole in adults (21.2% vs 20%), pregnant women[4] (16.8% vs 12.0%) and young people (16% vs 11%). However, two-thirds of smokers (63%) want to quit and welcome support to do so.

Reducing health inequalities resulting from smoking and protecting successive generations of young people from the harm done by tobacco therefore remains a public health priority in Lancashire.

2. Tobacco Free Lancashire Strategy

The Tobacco Free Lancashire Alliance is a partnership made up of representatives from Local Authorities, the County Council, NHS Trusts and Clinical Commissioning Groups, Lancashire Constabulary, Lancashire Fire and Rescue and other partner organisations across Lancashire, Blackburn with Darwen and Blackpool. It is chaired by the elected Cabinet Members for Health and Wellbeing of Lancashire County Council, Blackpool Council and Blackburn with Darwen Council to ensure direct alignment and effective communication with the respective Health and Wellbeing Boards.

The Alliance works collaboratively across a multitude of organisations throughout the county to reduce the harm caused by tobacco. Further to this a Three-Year Tobacco Control Strategy for Lancashire 2014-2016 has been produced (see Appendix A), which outlines the areas of activity that Tobacco Free Lancashire and its collaborating partners will undertake to reduce smoking rates in Lancashire. Tobacco Free Lancashire's three-year strategy mirrors the government's national tobacco plan, in addition to local priorities. It supports one of the key objectives of the Local Government Declaration on Tobacco Control, which was adopted by Lancashire County Council in December 2013, to *'develop plans with our partners and local communities to address the causes and impacts of tobacco use.'*

The strategy will be supported by a detailed delivery plan for the County Council, which will be updated on a yearly basis to reflect progress.

3. Smoking in Pregnancy

Maternal smoking during pregnancy remains the greatest cause of foetal ill health and death. Tobacco smoke brings over 4,000 chemicals into the body, including 200 known poisons and 69 carcinogens. Every cigarette smoked during pregnancy introduces carbon monoxide into the maternal bloodstream and disrupts the foetal oxygen supply for 15 seconds, which in turn, reduces oxygen flow to the baby for 15 minutes.

Exposure to tobacco increases the risk of:

- Ectopic pregnancy
- Miscarriage
- Placental abnormalities and premature rupture of the foetal membranes
- Still-birth
- Preterm delivery
- Low birth weight (under 2,500 grams)
- Perinatal mortality
- Sudden infant death syndrome

Research studies have confirmed the correlation between maternal smoking and lower birth weight. Babies born to women who smoke during their pregnancy are an average 175-200g lighter than those born to non-smoking mothers. This is significant given that low birth weight is the single most important risk factor in perinatal and infant mortality.

Overall, smoking during pregnancy increases the risk of infant mortality by around 40% and causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths in the UK every year. It has been estimated that a 10% reduction in infant and foetal deaths could be achieved if all pregnant women stopped smoking.

Antenatal exposure to maternal smoking also has other damaging effects on child health, increasing the risk of:

- Cleft lip and cleft palate
- Attention deficit and hyperactivity disorder (ADHD)
- Impaired lung function and cardio-vascular damage
- Acute respiratory conditions such as asthma
- Learning difficulties
- Problems of the ear, nose and throat
- Obesity
- Diabetes
- Meningitis

Mothers who smoke are also less likely to breastfeed their babies than non-smokers and those who do produce a smaller amount of milk and breastfeed for a shorter time.

In addition to the societal and familial costs of smoking in pregnancy, the financial impact is also significant. Nationally it is estimated to cost the NHS between £20 million and £87.5 million each year to treat smoking-related complications in mothers and babies (0-12 months). This equates to approximately £10,000 per baby. Economic analysis has shown that supporting pregnant smokers to quit is 3-6 times more cost-effective than treating smoking-related health issues in new born infants.

In view of this, the UK Government has set a national ambition to reduce smoking at time of delivery (SATOD) rates to 11% or less by the end of 2015. Currently, around one in eight pregnant women in England (12.0%) are recorded as smoking at the time of delivery. However, smoking rates vary by age, social group and region. Teenage women are six times more likely to smoke throughout pregnancy than older mothers aged 35 years and over (35% vs. 6%). Similarly pregnant women from routine and manual occupations are five times more likely to smoke than those in professional and managerial roles (20% vs. 4%).

As table 1 highlights, smoking at time of delivery rates also remain higher in Lancashire than England as a whole (16.8% vs. 12.0%), with one in six pregnant women continuing to smoke. This means that it is highly unlikely that Lancashire will achieve the national SATOD ambition.

Table 1: Smoking Status at Time of Delivery (SATOD), April 2013 – March 2014

Clinical Commissioning Group	Number of Maternities	Number SATOD	% SATOD
Chorley and South Ribble	1,850	308	16.6%
East Lancashire	4,418	797	18.0%
Fylde and Wyre	1,247	189	15.2%
Greater Preston	2,429	412	17.0%
Lancashire North	1,588	257	16.2%
West Lancashire	989	142	14.4%
Lancashire County	**12,521**	**2,105**	**16.8%**
North West	**84,069**	**12,870**	**15.3%**
England	**632,956**	**75,913**	**12.0%**

The higher proportion of smoking during pregnancy in Lancashire is also reflected in greater rates of Lower Birth Weight (LBW) prevalence (see Table 2). In 2012, there were 1,119 LBW births across the County, representing a prevalence rate of 8.2% compared to 7.3% nationally.

It is estimated that around one in five (20-25%) of babies that are admitted to a Neonatal Unit are there primarily as a result of smoking during pregnancy, which equates to 224 LBW babies in Lancashire each year. The cost of delivering a complicated birth, the care of a LBW baby or the care of a premature baby is estimated as an average £12,500 per child compared to £1,000 for a normal vaginal birth[30-32]. Therefore, the overall health care cost of smoking related neonatal complications in Lancashire is an estimated £2.8million each year. Stopping smoking during pregnancy could therefore potentially save £11.5k per baby and £2.58million across the County annually.

Table 2: Low Birth Weight (LBW) Births, 2012

Area	Number of LBW Births	Percentage of LBW Births
Burnley	108	8.8
Chorley	115	9.3
Fylde	43	6.4
Hyndburn	110	9.8
Lancaster	110	6.9
Pendle	128	9.8
Preston	180	9.7
Ribble Valley	30	6.3
Rossendale	69	8.2
South Ribble	83	6.7
West Lancashire	88	7.5
Wyre	55	5.8
Lancashire County Council	**1,119**	**8.2**
North West	**6,417**	**7.2**
England	**50,516**	**7.3**

Infants born to smokers are also at greater risk of exposure to second-hand smoke (SHS) in the home and car. The World Health Organisation (WHO) has listed SHS as a human carcinogen to which there is no safe level of exposure. Babies and children are especially vulnerable to the effects of second-hand smoke because they have smaller vessels and their organs are still developing. Therefore 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) and sudden infant death syndrome (cot death). A report by the Royal College of Physicians estimates that second-hand smoke annually causes:

- 20,500 new cases of lower respiratory tract infection in children aged two years and under
- 121,400 new cases of middle ear infections in children of all ages
- 22,600 new cases of wheeze and asthma in children
- At least 200 new cases of bacterial meningitis

Based on these national figures, it is estimated that there are 3,057 additional incidents of childhood diseases each year within Lancashire, directly attributable to SHS:

- 360 new cases of lower respiratory tract infection in children under three years old
- 2,267 new cases of middle ear infections in children of all ages
- 419 new cases of wheeze and asthma in children
- At least 11 new cases of bacterial meningitis

Locally, it is estimated that exposure of adults and children to SHS in Lancashire, costs the NHS £15.67 million to treat every year.

Additionally, children of smokers are far more likely to become smokers themselves, which perpetuates cycles of health inequalities and deprivation. The Public Health Outcomes Framework has emphasised the continued commitment to reducing health inequalities and increasing healthy life expectancy. In order to achieve this, giving every child the best start in life must be made a priority and this must include protecting babies from the damage of tobacco smoke, both before and after birth.

In view of this, decreasing smoking rates during pregnancy remains a public health priority in Lancashire[9] and the earlier a mother can quit her habit the greater the health benefit for both herself and her baby.

4. Pan-Lancashire Smoking in Pregnancy Programme

In line with the NICE guidance on smoking in pregnancy, a comprehensive Pan-Lancashire programme needs to be undertaken to systemise and embed organisational change to ensure all pregnant smokers are offered effective support in order to reduce the rates of smoking.

In response, a Pan-Lancashire 'Tackling Smoking in Pregnancy' multi-disciplinary project group has been formulated as a sub-group of the Tobacco Free Lancashire Alliance. To date, this group contains representatives from Midwifery and Health Visiting Teams in Community and Hospital NHS Trusts, CCG's, Public Health Teams, Stop Smoking Services, the Community and Voluntary Sector (CVS) from Lancashire County, Blackburn with Darwen and Blackpool.

It has collectively developed a two-year 'Tackling Smoking in Pregnancy Action Plan (see Appendix C), which has four areas of action:

1. Implementation of a standardised opt-out pathway
2. Comprehensive training for frontline staff
3. Development of information and support for pregnant smokers
4. Accurate data collection and performance monitoring

Given the shared commissioning responsibilities of the smoking in pregnancy pathway across Lancashire County, the six Clinical Commissioning Groups (CCG's), five Maternity Services within Hospital NHS Trusts, Public Health within Lancashire County Council, four Stop Smoking Services and the Community and Voluntary Sector will need to collectively work together and invest in this programme to reduce smoking rates during pregnancy and ensure every child in Lancashire has the best start in life. Further to this, Public Health has secured funding to deliver the Lancashire County Council elements of the programme between 2014 and 2016.

Consultations

The Tobacco Control Strategy for Lancashire 2014-2016 (Appendix A), has been collectively developed and adopted by members of the Tobacco Free Lancashire (TFL) Alliance and a two-week consultation was held with the following stakeholders to facilitate collaborative contribution:

Blackburn with Darwen Clinical Commissioning Group
Blackburn with Darwen Council
Blackpool Clinical Commissioning Group
Blackpool Council
Blackpool Teaching Hospitals NHS Foundation Trust
Burnley Borough Council
Cumbria and Lancashire Public Health Collaborative
Chorley Borough Council
Chorley & South Ribble Clinical Commissioning Group
East Lancashire Clinical Commissioning Group
East Lancashire Hospitals NHS Trust
Fylde Borough Council
Fylde and Wyre Clinical Commissioning Group
Greater Preston Clinical Commissioning Group
Hyndburn Borough Council
Lancashire Association of Councils for Voluntary Service
Lancashire Care NHS Foundation Trust
Lancashire Constabulary
Lancashire County Council
Lancashire Fire & Rescue
Lancashire North Clinical Commissioning Group
Lancashire Teaching Hospitals NHS Foundation Trust
Lancaster City Council
Pendle Borough Council
Preston City Council
Pennine Care NHS Foundation Trust
Ribble Valley Borough Council
Rossendale Borough Council
South Ribble Borough Council
Southport and Ormskirk Hospital NHS Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
West Lancashire Borough Council
West Lancashire Clinical Commissioning Group
Wyre Borough Council

The TFL Alliance builds a strategic partnership within Lancashire to support Tobacco Control programmes and action to reduce smoking prevalence and niche tobacco use, protect adults and children from exposure to second-hand smoke and help all residents to live tobacco free lives.

A multidisciplinary, pan-Lancashire Smoking in Pregnancy workshop was held in November 2013 with 53 representatives from Midwifery and Health Visiting Teams in Community and Hospital NHS Trusts, CCG's, Public Health Teams, Stop Smoking Services and the Community and Voluntary Sector from Lancashire, Blackburn with Darwen and Blackpool to review the current service provision and collectively develop a two-year action plan. Further to this, a Pan-Lancashire 'Tackling Smoking in Pregnancy' multi-disciplinary project group was formulated as a sub-group of the Tobacco Free Lancashire Alliance and has collectively developed the 'Tackling Smoking in Pregnancy Action Plan (Appendix C). Two meetings and a four-week

consultation were held with all stakeholders to facilitate collaborative contribution to the plan. The group will meet bi-monthly to implement the plan and report progress to the TFL Alliance on a quarterly basis.

Implications:

This item has the following implications, as indicated:

Financial

Implementation of the 'Tobacco Control Strategy for Lancashire' between 2014 and 2016 will require funding from the Public Health grant.

Funding has been secured from the Public Health grant to implement the Public Health components of the 'Tackling the Smoking in Pregnancy' programme. The financial allocation is £150,000 in 2014/15 and £105,000 in 2015/16. The programme will be evaluated after the two-year period to inform the need for recurrent annual investment. Additional capacity and resource investment to support the smoking in pregnancy pathway to the £255,000 contribution from Public Health will also be required from the six CCGs operating within Lancashire County as commissioners of maternity services

Legal
None identified. The Tobacco Control Strategy for Lancashire is in line with the government's national tobacco plan and the 'Local Government Declaration on Tobacco Control', which was adopted by Lancashire County Council in December 2013.

Personnel
Programme management of the 'Tobacco Control Strategy' for Lancashire County Council will be undertaken by Public Health. However, the strategy will be collectively implemented by members of the Tobacco Free Lancashire (TFL) Alliance (please see above).

Programme management of the 'Tackling Smoking in Pregnancy' programme for Lancashire County Council will be undertaken by Public Health. However, this will be collectively implemented by the wider pan-Lancashire 'Tackling Smoking in Pregnancy' multi-disciplinary project group, which includes Public Health Teams, Maternity Services within Hospital NHS Trusts, Health Visiting teams in Community NHS Trusts, CCG's, Stop Smoking Services and the Community and Voluntary Sector from Lancashire County, Blackburn with Darwen and Blackpool. This is a task-finish sub-group of the Tobacco Free Lancashire Alliance and as such will submit progress updates on a quarterly basis.

Equality and Diversity
The 'Tobacco Control Strategy for Lancashire' 2014-16 is all embracing and as such, is not considered to have an adverse impact on any groups of individuals sharing protected characteristics. The strategy and programmes are designed to decrease smoking rates among all residents across the County to ensure they live smokefree

healthy lives. An Equality Analysis has been completed and is attached at Appendix 'B'.

Equally, the Tackling Smoking in Pregnancy Action Plan is all embracing and as such, is not considered to have an adverse impact on any groups of individuals sharing protected characteristics. It is designed to have a positive impact on both pregnant women and protecting babies from the damage of tobacco smoke, both before and after birth. An Equality Analysis has been completed and is attached at Appendix 'D'.

Risk management

Endorsement of the Tobacco Control Strategy for Lancashire
Tobacco smoking is the single largest preventable cause of ill health, premature death and inequalities in Lancashire, killing 1,673 adults aged 35 years each year. Smoking rates remain higher in Lancashire than England as a whole in adults (21.2% vs 20%), pregnant women[4] (16.8% vs 12.0%) and young people (16% vs 11%). The total cost of smoking to society in Lancashire, including lost productivity, sick days, illness and death, house fires and dealing with tobacco litter is estimated to be £316.6 million each year.

If the request to adopt the Three-Year Tobacco Control Strategy for Lancashire 2014-16 is declined, inequalities and gaps in health policy will continue, exposure to smoking behaviour will not decrease and rates of smoking will not reduce.

As a consequence, Lancashire County Council will not achieve the smoking-related Public Health Outcome targets and the economic, societal and financial burden of smoking-related illness, death and health inequalities will continue.

Endorsement of the Tackling Smoking in Pregnancy Action Plan

Maternal smoking during pregnancy remains the greatest cause of foetal ill health and death. Babies born to women who smoke during their pregnancy are lighter than those born to non-smoking mothers and low birth weight is the most significant risk factor in perinatal and infant mortality. Rates of smoking during pregnancy remain higher in Lancashire than England as a whole (16.8% vs. 12.0%) and this is reflected in the greater rates of Lower Birth Weight (LBW) prevalence across the County (8.2% compared to 7.3% nationally). Consequently, reducing smoking in pregnancy is one of the key priority areas of the Tobacco Control Strategy for Lancashire 2014-16 and Lancashire County Council's Strategy for Health and Wellbeing.

A scoping of the smoking in pregnancy pathways currently operating across Lancashire has highlighted significant variances in programme delivery and gaps in current provision. If the request to endorse the Lancashire-wide 'Tackling Smoking in Pregnancy' action plan is declined, inequalities and gaps in service delivery will continue and as a result, pregnant smokers will not receive effective support to quit their habit. Inaccuracies in SATOD data collection will also continue. In turn, rates of smoking during pregnancy, exposure to second-hand smoke and levels of perinatal and infant mortality in Lancashire will not reduce.

As a consequence, within Lancashire: the emotional turmoil experienced by families as a result of infant smoking-related illness and death will continue; financial savings from smoking-related health care (estimated £18.25million) will not be made; Public Health Outcome targets will not be achieved; and levels of health inequalities will continue.

Therefore, this strategy and associated action plan should be prioritised to ensure every child in Lancashire is given the maximum opportunity to live a smokefree healthy life.

Local Government (Access to Information) Act 1985
List of Background Papers

NA

Reason for inclusion in Part II, if appropriate

N/A

Tobacco FREE Lancashire

A Three-Year Tobacco Control Strategy for Lancashire 2014-2016

'Making tobacco less desirable, acceptable and accessible in Lancashire'

Foreword

As Lancashire Portfolio Leaders for Health, we are pleased to endorse this tobacco control strategy which has been developed in partnership with a wide range of stakeholder organisations and agencies interested in working together to reduce the devastating impact that tobacco has in Lancashire.

Tobacco smoking is the single largest preventable cause of ill health, premature death and health inequalities in the communities we serve. One in two long-term smokers die prematurely as a result of smoking, half of these in middle age. On average, each smoker loses 16 years of life and experiences many more years of ill-health than a non-smoker[1].

Smoking kills over 80,000 people each year in England and 2,212 adults aged 35 years and over in Lancashire alone[2,3]. This is greater than the total number of deaths from alcohol, obesity, illegal drugs, murder, suicide, road traffic accidents and HIV infection combined[3].

Reducing health inequalities resulting from smoking and protecting successive generations of young people from the harm done by tobacco therefore remains a public health priority in Lancashire. We are committed to this strategy and look forward to working with all partners to help in its delivery.

Chair of Tobacco Free Lancashire Alliance, Lancashire County Council

Chair of Tobacco Free Lancashire Alliance, Blackburn with Darwen Council

Chair of Tobacco Free Lancashire Alliance, Blackpool Council

Tobacco Free Lancashire Membership

This Tobacco Control Strategy has been collectively developed and adopted by the following organisations:

Blackburn with Darwen Clinical Commissioning Group
Blackburn with Darwen Council
Blackpool Clinical Commissioning Group
Blackpool Council
Blackpool Teaching Hospitals NHS Foundation Trust
Burnley Borough Council
Cumbria and Lancashire Public Health Collaborative
Chorley Borough Council
Chorley & South Ribble Clinical Commissioning Group
East Lancashire Clinical Commissioning Group
East Lancashire Hospitals NHS Trust
Fylde Borough Council
Fylde and Wyre Clinical Commissioning Group
Greater Preston Clinical Commissioning Group
Hyndburn Borough Council
Lancashire Care NHS Foundation Trust
Lancashire Constabulary
Lancashire County Council
Lancashire Fire & Rescue
Lancashire North Clinical Commissioning Group
Lancashire Teaching Hospitals NHS Foundation Trust
Lancaster City Council
Pendle Borough Council
Preston City Council
Pennine Care NHS Foundation Trust
Ribble Valley Borough Council
Rossendale Borough Council
South Ribble Borough Council
Southport and Ormskirk Hospital NHS Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
West Lancashire Borough Council
West Lancashire Clinical Commissioning Group
Wyre Borough Council

Together they build a strategic partnership within Lancashire to support Tobacco Control programmes and action to reduce smoking prevalence and niche tobacco use, protect adults and children from exposure to second-hand smoke and help all residents to live tobacco free lives.

1. Overview

Tobacco Free Lancashire

Tobacco Free Lancashire is a partnership made up of representatives from Local Authorities, the County Council, NHS Trusts and Clinical Commissioning Groups, Lancashire Constabulary, Lancashire Fire and Rescue and other partner organisations across Lancashire County, Blackburn with Darwen and Blackpool. It is chaired by elected members of Lancashire County Council, Blackpool Council and Blackburn with Darwen Council to ensure direct alignment and effective communication with the respective Health and Wellbeing Boards.

In Lancashire, we recognise that a variety of tobacco products are used by our population. The use of niche and smokeless tobacco products, such as shisha, pan, gutkha and nass amongst many others, remain a concern in communities such as Blackburn, Accrington, Burnley and Preston[4]. It is for this reason that we call ourselves 'Tobacco Free Lancashire', rather than 'Smokefree Lancashire'.

We work collaboratively across a multitude of organisations throughout the county to reduce the harm caused by tobacco.

Tobacco Use in Lancashire

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 (20.0%) still smoke[5]. However as table 1 illustrates, smoking rates remain higher in Lancashire than England as a whole in adults[5], pregnant women[6] and young people[7,8]. There are around 268,308 current adult smokers in Lancashire[9]. However, two-thirds of smokers (63%) want to quit and welcome support to do so[10].

Table 1: Smoking Prevalence Rates in Lancashire

	Blackburn with Darwen	Blackpool	Lancashire County	England
Adult Smoking Prevalence[5]	27.2%	25.9%	21.2%	20.0%
Smoking at time of Delivery[6]	15.5%	27.5%	16.8%	12.0%
Young People Smoking Prevalence[7,8]	21.0%	16%	16%	11%

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[11].

Smoking disproportionally affects those disadvantaged by poverty and is a major contributor to health inequalities, accounting for half of the difference in life expectancy between social classes I and V[12,13]. Adults in routine and manual

occupations are around twice as likely to smoke as those in managerial and professional occupations (27% vs 13% respectively)[5].

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[5]. Similarly, women who smoke in pregnancy are also more likely to be younger, single, of lower educational achievement and in unskilled occupations[14]. Smokers from routine and manual groups comprise 44% of the overall smoking population and reducing smoking in this group is critical to reducing inequalities.

Smoking rates are also higher among Bangladeshi and Irish males[15] (40% and 30% respectively), prisoners[16] (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[17]. Even higher rates are experienced in inpatient settings, where up to 70% of patients smoke and around 50% are heavy, more dependent smokers[18]. Reducing health inequalities resulting from smoking therefore remains a public health priority in Lancashire.

In recent years, smoking rates have remained somewhat stagnant and we need to take new and braver action to drive smoking rates down further[1].

Impact of Second-hand Smoke

Tobacco smoke contains over 4,000 chemicals, 69 of which are carcinogenic. Tobacco smoke not only damages a smoker's health but also the health of the people around them. Breathing other people's smoke is called second-hand smoking (SHS).

The World Health Organisation (WHO) has listed SHS as a human carcinogen to which there is no safe level of exposure[19]. Thirty minutes exposure to SHS reduces blood flow to the heart in fit, healthy adults. Long term exposure increases a non-smoker's risk of developing heart disease and lung cancer by a quarter and stroke by three-quarters[20,21].

Children are especially at risk from the effects of second-hand smoke because they have smaller vessels and their organs are still developing.

Therefore they breathe faster and breathe in more toxic chemicals than adults[22]. 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) [22].

It is estimated that there are 3,902 additional incidents of childhood diseases each year within Lancashire, directly attributable to SHS [9,22]:

- 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

Financial Impact of Tobacco in Lancashire

Smoking is the primary cause of preventable ill health and premature death from respiratory diseases, circulatory disease and cancer (appendix 1) accounting for 2,212 deaths in adult aged 35 years and over each year in Lancashire alone[3]. One in 20 of hospital admissions are smoking related[23] and the estimated lifetime cost of treating a smoker with a smoking related disease in Lancashire is £15,121[24].

In Lancashire it costs the NHS a total of £53.77 million to treat smoking-related illnesses each year[24] (£29.51 million primary care and £24.26 million secondary care). A further £20.42 million is spent on treating the consequences of exposure to second-hand smoke[24] in children and adults.

The costs to the wider economy from sickness absenteeism, smoking breaks and reduced productivity are estimated at £19.61 million across Lancashire each year[24]. Every year 190,006 working days are lost through smoking related absence across the County.

Costs to the community are also significant. It is estimated that annual costs relating to smoking related house fires and clearing litter caused by smoking are £15.3 million and £9.3 million respectively[24].

A smoker of twenty cigarettes a day is estimated to spend around £2,800 a year on their habit. The more disadvantaged the smoker, the greater the burden high-cost tobacco imposes on their household income and the greater the impact smoking has on their family. Poorer smokers proportionately spend five times as much of their weekly household budget on smoking than do richer smokers. If poorer smokers quit they are more likely to spend the money they save in their local communities[25].

The scale of the tobacco epidemic needs to be clearly recognised in Lancashire if we are to significantly reduce smoking rates across the county.

Electronic Cigarettes

The use of electronic cigarettes is becoming more common, both locally in Lancashire and at a national level. However, these products are currently unregulated and unlicensed in the UK and therefore vary widely in their composition. They are currently undergoing thorough research by the UK's Medicines and Healthcare Regulatory Authority (MHRA) and will be licensed for public use in 2016.

Electronic cigarette use may retain some people smoking when they otherwise would have stopped. There is currently no medical evidence to support how they can be used to reduce or stop smoking and therefore should not be used as a cessation tool.

Electronic cigarette devices also replicate smoking. In addition to creating confusion and undermining compliance with smokefree policies, they also normalise smoking

behaviour for children and young people. A 2013 Trading Standards Survey with 18,000 young people aged 14-17 years highlighted that 13% had tried e-cigarettes[8]. This could potentially facilitate a lifelong addiction to nicotine and provide a route into smoking conventional cigarettes. In response, the Government decided to implement legislation to ban sales of e-cigarettes to young people aged less than 18 years in January 2014.

The Role of this Strategy

This strategy outlines the areas of activity which Tobacco Free Lancashire and its collaborating partners will undertake to reduce smoking rates in Lancashire. It is supported at a sub-national level by Tobacco Free Futures, a Community Interest Company that develops tobacco control activity best delivered on a North West footprint, and in turn is intended to complement and support local plans for tobacco control. Tobacco Free Lancashire's three-year strategy mirrors the government's national tobacco plan[1], as well as local priorities. It will be supported by a detailed delivery plan which will be updated on a yearly basis to reflect progress. The unitary authorities of Blackburn with Darwen, Blackpool and Lancashire County Council are included within this plan, so any reference to 'Lancashire' includes all three Councils, unless otherwise stated.

A key aim of the strategy is to reduce the damaging impact of tobacco so that smoking is history for the children of Lancashire. As table 1 highlights, smoking rates in Lancashire are higher than the English average and this strategy aims to change that.

Funding and Commissioning Tobacco Control

Lancashire County, Blackpool and Blackburn with Darwen Borough councils currently have responsibility for commissioning tobacco control and stop smoking services in the community. There are Stop Smoking Services in every area in Lancashire which are commissioned by the appropriate Authority. Clinical Commissioning Groups have responsibility for commissioning secondary care, including hospital, maternity and mental health, which includes smokefree programmes.

The national Tobacco Control Plan[1] identifies how the proposals in the White Paper Healthy Lives, Healthy People[26] place the responsibility for public health within upper tier local authorities. With ring-fenced funding this will enable tobacco control to be delivered locally to support national policy to reduce the prevalence of smoking. Local statutory Health and Wellbeing Boards play a vital role in steering the tobacco control strategy and in supporting tobacco control alliances. Tobacco Free Lancashire has therefore taken a lead in developing this strategy and subsequent annual action plan updates.

The national plan stresses that future ring-fenced funding should be used to support local comprehensive tobacco control activity, as well as other public health activities, according to local need. This strategy will therefore also help to identify those activities best delivered at a locality, Lancashire and sub-national basis.

2. Mission Statement, Aims and Ambitions

Mission Statement: To make smoking less desirable, acceptable and accessible in Lancashire to ensure all residents live tobacco free lives.

Aims

In line with the World Health Organisation's Framework Convention on Tobacco Control (FCTC)[27] and the national Tobacco Control Plan[1], Tobacco Free Lancashire adopts the six 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
Aim 6) Effectively communicate for tobacco control

Additionally, Tobacco Free Lancashire has also adopted the following aims:

Aim 7) To protect tobacco control policy from industry influence
Aim 8) To reduce health inequalities in Lancashire through reduced tobacco consumption
Aim 9) To ensure that tobacco control is prioritised in cross-cutting policies, guidance and funding

All of these aims relate to reducing tobacco consumption and exposure to second-hand smoke in both children and adults living in Lancashire.

Ambitions

Tobacco Free Lancashire will pursue the following ambitions, which will contribute to national targets within the Tobacco Control Plan[1] to:

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**

As table 1 outlines, for each local authority in Lancashire the challenge to achieve these ambitions will be different in scale as well as effort. These ambitions are therefore aspirational and should not be regarded as targets, which in many area of

the county would be unachievable within the timescale of this plan. Rather they represent an overall direction of travel.

The strategy will also contribute to other ambitions within the Public Health Outcomes Framework:

- Low birth weight of term babies (2.1)
- Infant mortality (4.1)
- Mortality from causes considered preventable (4.3)
- Mortality from all cardiovascular diseases (including heart disease and stroke) (4.4)
- Mortality from cancer (4.5)
- Mortality from respiratory diseases (4.7)
- Excess under 75 mortality in adults with serious mental illness (4.9)
- Sickness absence rate (1.9)

This strategy provides some high-level aims which will inform more detailed action planning at both the pan Lancashire and local levels to achieve these ambitions, in line with both national and sub-national tobacco control policies. The Joint Strategic Needs Assessment for Drugs, Alcohol and Tobacco[28] informs action planning for tobacco control at local levels by highlighting local priorities for each district.

Achieving our Aims and Ambitions

The main areas of activity required to achieve these aims and ambitions fall into the following broad categories, around which detailed action plans can be built:

- Communication
- Training
- Advocacy
- Performance management
- Specialist support
- Regulation and enforcement

Progress towards achieving our ambitions will be measured by Tobacco Free Lancashire in line with the Public Health Outcomes Framework, and reported to the three Health and Wellbeing Boards.

3. Strategy

Aim 1) Stop the promotion of tobacco

Tobacco Free Lancashire will:

- Support partners to develop effective smokefree policies covering all buildings (not already covered by legislation) and grounds. This may include council premises, hospitals grounds, prisons and other criminal justice settings, children's playgrounds and sports stadia;

- Support agencies which work with children and young people to ensure that tobacco products and accessories, including shisha and niche[1], are not promoted to young people in Lancashire, and advocate for the introduction of standardised tobacco packaging at a national level;
- Support retailers with information and training to implement the provisions of all tobacco control legislation which affects them.

Aim 2) Make Tobacco less affordable

Tobacco Free Lancashire will:

- Advocate for the maintenance of continued tax increases for tobacco products;
- Support sub-national and local action to reduce the illicit tobacco market in Lancashire, including sharing intelligence, analysis, enforcement information, public education, and engagement on illicit tobacco;
- Develop and promote local media campaigns and training packages on illicit tobacco with partners.

Aim 3) Effectively regulate tobacco products

Tobacco Free Lancashire will:

- Raise awareness of shisha and other niche tobacco products[2] and their impact through community education and training with partners, including retailers;
- 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.

Aim 4) Help tobacco users to quit

Tobacco Free Lancashire will:

- Continue to support the commissioning and development of specialist stop smoking services across Lancashire to assist adults and children to quit;
- Improve brief intervention training for all public, private and third sector frontline workers on tobacco control and smoking cessation;
- Promote the use of self-help materials for people who want to stop smoking without the support of the Stop Smoking Service, ensuring that these materials are appropriate and accessible to local populations;
- Increase awareness of the current unlicensed status of electronic cigarettes with both the public and partners and monitor updates to national policy;
- Support primary, community and secondary care to ensure that all opportunities within care pathways are taken to encourage and support

[1] Products, such as pan, gutkha and nass. Access full directory at http://www.ntpd.org.uk
[2] Products, such as pan, gutkha and nass. Access full directory at http://www.ntpd.org.uk

patients to quit, particularly in the case of pregnant women, mental health service users and pre-operative patients.

Aim 5) Reduce exposure to second-hand smoke

Tobacco Free Lancashire will:

- Ensure compliance with the existing smokefree legislation in workplaces and public places[29,30] is enforced;
- Support measures to stop second-hand smoke exposure for children (in playgrounds etc.), including the provision of smokefree homes and cars programmes;
- Support media campaigns on second-hand smoke;
- Support public, private and third sector frontline workers to deliver second-hand smoke brief interventions during routine contacts with clients through training;
- Advocate for strengthened legislation to ban smoking in cars when children under 18 years are present at national level.

Aim 6) Effectively communicate for tobacco control

Tobacco Free Lancashire will:

- Develop a communications plan for this strategy;
- Use social marketing principles to inform tobacco control communications and campaigns to ensure they are appropriately targeted;
- Use every opportunity to promote tobacco control at both pan-Lancashire and local level through all social media;
- Ensure that Stop Smoking Services are consistently and effectively advertised across Lancashire;
- Support and amplify national tobacco control campaigns.

Aim 7) Protect tobacco control policy from industry influence

Tobacco Free Lancashire will:

- Ensure all local authorities commit to the Local Government Declaration on Tobacco Control.

Aim 8) 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;
- Encourage partners to use their own policies and contacts with clients to maximise their potential to support tobacco control, taking particular account of the needs of hard -to-reach or under-represented population groups.

Aim 9) Ensure that tobacco is prioritised in cross-cutting policies, guidance and funding

Tobacco Free Lancashire will:

- Work to embed the actions in this strategy into appropriate local authority, Health and Wellbeing Boards and Clinical Commissioning Groups action plans to ensure this strategy is implemented;
- Ensure membership of Tobacco Free Lancashire includes appropriate elected members and representatives of the third sector and Clinical Commissioning Groups;
- Develop a performance and governance framework for this action plan with Health and Wellbeing Boards.

References

1. Department of Health (2011). *Healthy Lives, Healthy People: A Tobacco Control Plan for England.* www.dh.gov.uk/publications
2. 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
3. The Information Centre for Health and Social Care (2012). *Statistics on Smoking: England, 2012 and Census 2011 all population aged 35 and over.*
4. A full directory of niche tobacco products is available at: http://www.ntpd.org.uk
5. Office for National Statistics (2014) Integrated household survey, self-reported smoking prevalence, persons, aged 18+, 2011-12.
6. NHS Information Centre for Health and Social Care (2014). *Statistics on women's smoking status at time of delivery: England.* http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking
7. The Information Centre for Health and Social Care (2012) *Smoking, drinking and drug use among young people in England in 2011*.
8. Trading Standards (2013). *Young Persons Alcohol and Tobacco Survey 2013, North West Results*. TSNW, June 2013.
9. Tobacco Free Futures (2012) *Locality Tobacco Briefings September 2012: Lancashire*. TFF 2012.
10. Office for National Statistics (2009). *Smoking and Drinking Amongst Adults.* Office for National Statistics.
11. Robinson S & Bugler C (2010). *Smoking and drinking among adults, 2008*. General Lifestyle Survey 2008. ONS, 2010.
12. Wanless D. (2004) *Securing good health for the whole population.* London: TSO
13. Marmot M et al (2010) *Fair Society, Healthy Lives: strategic review of health inequalities in England post 2010.* Marmot Review Secretariat London.
14. 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.
15. HSE (2004) *The Health Survey for England*.
16. 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
17. 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
18. Jochelson K & Majrowski W. (2006) *Clearing the Air: Debating Smoke-Free Policies in Psychiatric Units.* London: King's Fund.
19. World Health Organisation (2005). *WHO Framework Convention on Tobacco Control* http://www.who.int/fctc/text_download/en/index.html
20. Scientific Committee on Tobacco and Health Great Britain (SCOTH) (1998) *Report of the Scientific Committee on Tobacco and Health.* London: TSO 1998.
21. 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.
22. Royal College of Physicians (2010). Passive smoking and children. A report by the Tobacco Advisory Group. London: RCP, 2010.
23. 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
24. 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
25. ASH (2013) *The Economics of Tobacco* http://www.ash.org.uk/files/documents/ASH_121.pdf
26. Department of Health (2010). *Healthy Lives, Healthy People: Our Strategy for Public Health in England.*

www.dh.gov.uk/publications
27. World Health Organisation (WHO) (2011). *Framework Convention on Tobacco Control. Guidelines for implementation. 2011 edition*. http://www.who.int/gb/fctc/PDF/cop3/FCTC_COP3_DIV3-en.pdf
28. Intelligence for Healthy Lancashire (JSNA) (2012) *Alcohol, Drugs and Tobacco in Lancashire, Section 3:Tobacco.*
29. HM Government (2006) *The Health Act 2006 (c.28)* http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060028_en.pdf
30. HM Government (2007) *The Smokefree (Exemptions and Vehicles) Regulations 2007*. Statutory Instruments 2007 No.765 http://www.legislation.gov.uk/uksi/2007/765/pdfs/uksi_20070765_en.pdf

Appendix 1: Smoking related mortality: 2008-10

	England	Lancashire		Blackburn with Darwen		Blackpool	
	Rate	No.	Rate	No.	Rate	No.	Rate
Smoking attributable mortality	210.57	6,810	**242.54**	792	**320.65**	1,215	**352.56**
Smoking attributable deaths from heart disease	30.30	900	**35.48**	118	**50.99**	163	**53.52**
Smoking attributable deaths from stroke	9.79	306	**11.47**	41	**17.29**	55	**17.07**
Deaths from lung cancer	37.73	2,301	**42.60**	285	**59.09**	398	**59.60**
Deaths from chronic obstructive pulmonary disease	25.78	1,800	**29.18**	232	**43.19**	304	**40.94**

Significantly **higher** than the national average
Source: Local Tobacco Control Profiles for England, Public Health England

Appendix B

Section 4

Equality Analysis Toolkit

Proposal to Endorse the Tobacco Free Lancashire Strategy

For Decision Making Items

July 2014

What is the Purpose of the Equality Decision-Making Analysis?

The Analysis is designed to be used where a decision is being made at Cabinet Member or Overview and Scrutiny level or if a decision is being made primarily for budget reasons. The Analysis should be referred to on the decision making template (e.g. E6 form).

When fully followed this process will assist in ensuring that the decision- makers meet the requirement of section 149 of the Equality Act 2010 to have due regard to the need: to eliminate discrimination, harassment, victimisation or other unlawful conduct under the Act; to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and to foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having due regard means analysing, at each step of formulating, deciding upon and implementing policy, what the effect of that policy is or may be upon groups who share these protected characteristics defined by the Equality Act. The protected characteristic are: age, disability, gender reassignment, race, sex, religion or belief, sexual orientation or pregnancy and maternity – and in some circumstance marriage and civil partnership status.

It is important to bear in mind that "due regard" means the level of scrutiny and evaluation that is reasonable and proportionate in the particular context. That means that different proposals, and different stages of policy development, may require more or less intense analysis. Discretion and common sense are required in the use of this tool.

It is also important to remember that what the law requires is that the duty is fulfilled in substance – not that a particular form is completed in a particular way. It is important to use common sense and to pay attention to the context in using and adapting these tools.

This process should be completed with reference to the most recent, updated version of the Equality Analysis Step by Step Guidance (to be distributed) or EHRC guidance - EHRC - New public sector equality duty guidance

Document 2 "Equality Analysis and the Equality Duty: Guidance for Public Authorities" may also be used for reference as necessary.

This toolkit is designed to ensure that the section 149 analysis is properly carried out, and that there is a clear record to this effect. The Analysis should be completed in a timely, thorough way and should inform the whole of the decision-making process. It must be considered by the person making the final decision and must be made available with other documents relating to the decision.

The documents should also be retained following any decision as they may be requested as part of enquiries from the Equality and Human Rights Commission or Freedom of Information requests.

Support and training on the Equality Duty and its implications is available from the County Equality and Cohesion Team by contacting AskEquality@lancashire.gov.uk

Specific advice on completing the Equality Analysis is available from your Directorate contact in the Equality and Cohesion Team or from Jeanette Binns Jeanette.binns@lancashire.gov.uk

Name/Nature of the Decision

Proposal to Endorse the Tobacco Free Lancashire Strategy

What in summary is the proposal being considered?

Tobacco smoking is the single largest preventable cause of ill health, premature death and health inequalities in Lancashire, killing 1,673 adults aged 35 years each year[1,2]. Smoking rates remain higher in Lancashire than England as a whole in adults[3] (21.2% vs 20%), pregnant women[4] (16.9% vs 11.9%) and young people[5,6] (16% vs 11%). The total cost of smoking to society in Lancashire, including lost productivity, sick days, illness and death, house fires and dealing with tobacco litter is estimated to be £316.6 million each year[7]. Further to this, the Tobacco Free Lancashire Alliance has been formed to work collaboratively across the County to reduce the harm caused by tobacco and has developed a 'Three-Year Tobacco Control Strategy for Lancashire 2014-2016'. This is in line with the government's national tobacco plan[8] and the 'Local Government Declaration on Tobacco Control', which was adopted by Lancashire County Council in December 2013. This proposal to endorse the Tobacco Control Strategy for Lancashire 2014-16 will assist in reducing health inequalities resulting from smoking and protecting successive generations of young people from the harm done by tobacco in Lancashire.

Is the decision likely to affect people across the county in a similar way or are specific areas likely to be affected – e.g. are a set number of branches/sites to be affected? If so you will need to consider whether there are equality related issues associated with the locations selected – e.g. greater percentage of BME residents in a particular area where a closure is proposed as opposed to an area where a facility is remaining open.

Yes. The Tobacco Free Lancashire Alliance works collaboratively across a multitude of organisations throughout the county to reduce the harm caused by tobacco. Further to this a Three-Year Tobacco Control Strategy for Lancashire 2014-2016 has been produced, which outlines the areas of activity that Tobacco Free Lancashire and its collaborating partners will undertake to reduce smoking rates in Lancashire. Tobacco Free Lancashire's three-year strategy mirrors the government's national tobacco plan[8], in addition to local priorities. It supports one of the key objectives of the Local Government Declaration on Tobacco Control, which was adopted by Lancashire County Council in December 2013, to *'develop plans with our partners and local communities to address the causes and impacts of tobacco use.'* The strategy will be supported by a detailed delivery plan for Lancashire County Council, which will be updated on a yearly basis to reflect progress. This proposal to endorse the Tobacco Control Strategy for Lancashire 2014-16 will assist in reducing health inequalities resulting from smoking and protecting successive generations of young people from the harm done by tobacco in Lancashire.

Could the decision have a particular impact on any group of individuals sharing protected characteristics under the Equality Act 2010, namely:

- Age
- Disability including Deaf people

- Gender reassignment
- Pregnancy and maternity
- Race/ethnicity/nationality
- Religion or belief
- Sex/gender
- Sexual orientation
- Marriage or Civil Partnership Status

In considering this question you should identify and record any particular impact on people in a sub-group of any of the above – e.g. people with a particular disability or from a particular religious or ethnic group.

It is particularly important to consider whether any decision is likely to impact adversely on any group of people sharing protected characteristics to a disproportionate extent. Any such disproportionate impact will need to be objectively justified.

No, it is not considered that approval to endorse and implement this will have an adverse impact on any groups of individuals sharing protected characteristics.
The Tobacco Free Lancashire Alliance works collaboratively across a multitude of organisations throughout the county to reduce the harm caused by tobacco. Further to this a Three-Year Tobacco Control Strategy for Lancashire 2014-2016 has been produced, which outlines the areas of activity that Tobacco Free Lancashire and its collaborating partners will undertake to reduce smoking rates in Lancashire. Tobacco Free Lancashire's three-year strategy mirrors the government's national tobacco plan[8], in addition to local priorities. It supports one of the key objectives of the Local Government Declaration on Tobacco Control, which was adopted by Lancashire County Council in December 2013, to *'develop plans with our partners and local communities to address the causes and impacts of tobacco use.'*
Smoking disproportionately affects those disadvantaged by poverty and is a major contributor to health inequalities, accounting for half of the difference in life expectancy between social classes I and V[9,10]. Nationally, adults in routine and manual occupations are twice as likely to smoke as those in managerial and professional occupations (30% vs 13.8% respectively)[3]. In Lancashire County, over a third of routine and manual workers currently smoke (35.3%)[3].

Reducing health inequalities resulting from smoking and protecting successive generations of young people from the harm done by tobacco therefore remains a public health priority in Lancashire.
The strategy will be supported by a detailed delivery plan for Lancashire County Council, which will be updated on a yearly basis to reflect progress.

(NB: all data sources referenced within strategy)

If you have answered "Yes" to this question in relation to any of the above characteristics, – please go to Question 1.

N/A

If you have answered "No" in relation to all the protected characteristics, please briefly document your reasons below and attach this to the decision-making papers. (It goes without saying that if the lack of impact is obvious, it need only be very briefly noted.)

Approval of the proposal to endorse the Tobacco Control Strategy for Lancashire 2014-16, will de-normalise exposure to smoking and reduce use of tobacco to ensure all residents live smokefree healthy lives. It is not considered to have an adverse impact on any groups of individuals sharing protected characteristics.

Question 1 – Background Evidence
What information do you have about the different groups of people who may be affected by this decision – e.g. employees or service users (you could use monitoring data, survey data, etc to compile this). As indicated above, the relevant protected characteristics are:

- Age
- Disability including Deaf people
- Gender reassignment/gender identity
- Pregnancy and maternity
- Race/Ethnicity/Nationality
- Religion or belief
- Sex/gender
- Sexual orientation
- Marriage or Civil Partnership status (in respect of which the s. 149 requires only that due regard be paid to the need to eliminate discrimination, harassment or victimisation or other conduct which is prohibited by the Act).

  In considering this question you should again consider whether the decision under consideration could impact upon specific sub-groups e.g. people of a specific religion or people with a particular disability. You should also consider how the decision is likely to affect those who share two or more of the protected characteristics – for example, older women, disabled, elderly people, and so on.

N/A.

Question 2 – Engagement/Consultation
How have you tried to involve people/groups that are potentially affected by your decision? Please describe what engagement has taken place, with whom and when.
(Please ensure that you retain evidence of the consultation in case of any further enquiries. This includes the results of consultation or data gathering at any stage of the process)

N/A.

Question 3 – Analysing Impact

Could your proposal potentially disadvantage particular groups sharing any of the protected characteristics and if so which groups and in what way?

It is particularly important in considering this question to get to grips with the actual practical impact on those affected. The decision-makers need to know in clear and specific terms what the impact may be and how serious, or perhaps minor, it may be – will people need to walk a few metres further to catch a bus, or to attend school? Will they be cut off altogether from vital services? The answers to such questions must be fully and frankly documented, for better or for worse, so that they can be properly evaluated when the decision is made.

Could your proposal potentially impact on individuals sharing the protected characteristics in any of the following ways:

- Could it discriminate unlawfully against individuals sharing any of the protected characteristics, whether directly or indirectly; if so, it must be amended. Bear in mind that this may involve taking steps to meet the specific needs of disabled people arising from their disabilities

- Could it advance equality of opportunity for those who share a particular protected characteristic? If not could it be developed or modified in order to do so?

- Does it encourage persons who share a relevant protected characteristic to participate in public life or in any activity in which participation by such persons is disproportionately low? If not could it be developed or modified in order to do so?

- Will the proposal contribute to fostering good relations between those who share a relevant protected characteristic and those who do not, for example by tackling prejudice and promoting understanding? If not could it be developed or modified in order to do so? Please identify any findings and how they might be addressed.

N/A

Question 4 –Combined/Cumulative Effect

Could the effects of your decision combine with other factors or decisions taken at local or national level to exacerbate the impact on any groups?

For example - if the proposal is to impose charges for adult social care, its impact on disabled people might be increased by other decisions within the County Council (e.g. increases in the fares charged for Community Transport and reductions in respite care) and national proposals (e.g. the availability of some benefits) . Whilst LCC cannot control some of these decisions, they could increase the adverse effect of the proposal. The LCC has a legal duty to consider this aspect, and to evaluate the decision, including mitigation, accordingly.

If Yes – please identify these.

N/A

Question 5 – Identifying Initial Results of Your Analysis
As a result of your analysis have you changed/amended your original proposal? Please identify how –
For example:
Adjusted the original proposal – briefly outline the adjustments
Continuing with the Original Proposal – briefly explain why
Stopped the Proposal and Revised it - briefly explain

N/A

Question 6 - Mitigation
Please set out any steps you will take to mitigate/reduce any potential adverse effects of your decision on those sharing any particular protected characteristic. It is important here to do a genuine and realistic evaluation of the effectiveness of the mitigation contemplated. Over-optimistic and over-generalised assessments are likely to fall short of the "due regard" requirement.
Also consider if any mitigation might adversely affect any other groups and how this might be managed.

N/A

Question 7 – Balancing the Proposal/Countervailing Factors
At this point you need to weigh up the reasons for the proposal – e.g. need for budget savings; damaging effects of not taking forward the proposal at this time – against the findings of your analysis. Please describe this assessment. It is important here to ensure that the assessment of any negative effects upon those sharing protected characteristics is full and frank. The full extent of actual adverse impacts must be acknowledged and taken into account, or the assessment will be inadequate. What is required is an honest evaluation, and not a marketing exercise. Conversely, while adverse effects should be frankly acknowledged, they need not be overstated or exaggerated. Where effects are not serious, this too should be made clear.

N/A

Question 8 – Final Proposal
In summary, what is your final proposal and which groups may be affected and how?

N/A

Question 9 – Review and Monitoring Arrangements
Describe what arrangements you will put in place to review and monitor the effects of your proposal.

N/A

Equality Analysis Prepared By: Joanne McCullagh
Position/Role: Public Health Specialist – Tobacco Control & Stop Smoking Services
Equality Analysis Endorsed by Line Manager and/or Chief Officer: Janet Walton, Head of Public Health Commissioning, Adults and Wellbeing, Adult Services, Health and Wellbeing Directorate
Decision Signed Off By: Dr Sakthi Karunanithi, Director of Public Health, Adult Services, Health and Wellbeing Directorate

Cabinet Member/Chief Officer or SMT Member: County Councillor Azhar Ali, Cabinet Member for Health & Wellbeing
Please remember to ensure the Equality Decision Making Analysis is submitted with the decision-making report and a copy is retained with other papers relating to the decision.
Where specific actions are identified as part of the Analysis please ensure that an EAP001 form is completed and forwarded to your Directorate's contact in the Equality and Cohesion Team.

Directorate contacts in the Equality & Cohesion Team are:

Karen Beaumont – Equality & Cohesion Manager
Karen.beaumont@lancashire.gov.uk
Contact for Adult & Community Services Directorate

Jeanette Binns – Equality & Cohesion Manager
Jeanette.binns@lancashire.gov.uk
Contact for Environment Directorate, Lancashire County Commercial Group and One Connect Limited

Saulo Cwerner – Equality & Cohesion Manager
Saulo.cwerner@lancashire.gov.uk
Contact for Children & Young Peoples Directorate

Pam Smith – Equality & Cohesion Manager
Pam.smith@lancashire.gov.uk
Contact for Office of the Chief Executive and the County Treasurer's Directorate

Thank you

Tobacco FREE Lancashire

Pan Lancashire Tackling Smoking In Pregnancy Project Group

Tackling Smoking in Pregnancy Action Plan 2014 - 2016

Abstract: This action plan refers to the Tobacco Free Lancashire Three year Tobacco Control Strategy for Lancashire 2014 - 2016[1]and the NICE guidance on smoking in pregnancy[2]. A comprehensive Pan-Lancashire programme needs to be undertaken to systemise and embed organisational change to ensure all pregnant smokers are offered effective support in order to reduce the rates of smoking. This would include the following components:

Lancashire County Council

Objective One: Standardised Opt Out Pathway across Lancashire

Definition – A 'Care pathway' is an agreed standardised approach to care of a pregnant woman which aims to reduce variability in practice and ensure a consistent approach by all those involved in her care. An 'opt out referral system' means that all women who smoke will automatically receive a referral to a stop smoking service unless she specifically states that she does not want one.

Activity/Action	Partners	Outcome/Outputs	Timescales – phased approach to completion
1. Standardisation of a clear smoking in pregnancy opt-out care pathway, including referral systems, raising the issue at every contact and protocols to reflect the evidence base and NICE guidance.	CCG's	Decrease in number of pregnant smokers opting out of referral process.	June – November 2014
2. Incorporation of stop smoking advice and CO monitoring at first maternity booking, CO monitoring at 20 weeks scan and CO monitoring at 36+ weeks gestation, supported by provision of CO monitors and CO screening information resources for pregnant women; ensuring every contact counts.	Stop Smoking Services Sonographers Maternity Services	Reduction in number of pregnant smokers not attending appointments at Stop Smoking Services. Implementation of electronic referral to Stop Smoking Services.	November 2014 – April 2015
3. Implementation of immediate and direct electronic referral system for frontline workers into local Stop Smoking Services.	Commissioners of Stop Smoking Services	Adoption of a standardised mandatory opt out pathway across Lancashire.	May 2015 – October 2015
4. Adoption of CO reading of 4ppm for opt out pathway to reflect the evidence of NICE smoking cessation secondary care	Maternity Services Stop Smoking	Increase number of pregnant smokers referred to Stop Smoking Service to 100%, unless they opt out.	June – November 2014

guidance and Pregnancy Challenge Group recommendation[2,3].	Services		
5. Identification of reasons for Did Not Attend (DNA's) attendance for support at Stop Smoking Services.	Maternity Services		June 2014 – October 2015
6. Inclusion of niche tobacco smoking products e.g. shisha in smoking in pregnancy care pathway.			June – November 2014

Objective Two: Training

Definition – This objective aims to ensure a consistent approach to training for all staff involved in the care of pregnant women.

Activity/Action	Partners	Outcome/Outputs	Timescales – phased approach to completion
1. Consult and identify training requirements for midwives and maternity staff.	Maternity Services	Development and implementation of a consistent training package for maternity and frontline staff working with pregnant smokers.	November 2014 – April 2015
2. Development and delivery of mandatory brief intervention and CO monitoring training, including annual updates, with associated resources, for all maternity staff (including allied health professionals, neonatal staff and sonographers) to ensure routine delivery of advice and CO screening for all pregnant women; ensuring every contact counts.	Stop Smoking Services (Lancashire) Public Health Team (Blackpool)	Monitoring of the number of maternity and frontline staff trained in brief advice and brief intervention training, including CO monitoring training.	November 2014 – October 2015
	Maternity Services	Establish a baseline of the services that have received	

3. Delivery of Risk Perception training to Specialist Midwives and incorporation within the care pathway to reach out to pregnant smokers who do not engage with Stop Smoking Services.	Children and Young People Directorate	training sessions. Development and implementation of specialist training for specialist midwives.	November 2014 – April 2015
4. Deliver very brief advice training programme to allied frontline health and social care professionals e.g. children centre staff.	CCG's Commissioners of services	Increase in the number of trained staff who are able to provide brief advice/intervention and specialist advice to pregnant smokers resulting in a reduction in SATOD figures.	November 2014 – October 2015
5. Inclusion of e-cigarettes and niche tobacco smoking products in training materials to increase knowledge and understanding of the impact in pregnancy to maternity and frontline staff in brief advice and brief intervention training.		Undertake an audit sample of the number of staff training and referring pregnant smokers into Stop Smoking Service.	November 2014 – April 2015

Objective Three: Information and Support

Definition – This objective relates to the information and support provided to pregnant women, their partners, carers and families

Activity/Action	Partners	Outcome/Outputs	Timescales – phased approach to completion
1. Development and provision of tailored promotional materials and information, in partnership with pregnant women and new mothers, regarding the risks of smoking and health benefits for pregnant smokers,	Hospital Communication Department	Evaluation of increased awareness of risks of smoking in pregnancy, through the use of targeted campaigns.	November 2014 – April 2015

including social media.			June 2014 – April 2016
2. Provision of a 'Supporting a Smokefree Pregnancy Scheme' to increase quit rates among pregnant smokers up to three-months post-partum.	Local Authority Communication Department Tobacco Free Futures	Utilising new marketing strategies to increase referrals and continued attendance to Stop Smoking Services. Increased quit rates 3 months post-partum.	June 2014– November 2016
3. Provision of a Smokefree Homes and Cars scheme to reduce exposure to secondhand smoke and assist pregnant quitters and their families to remain smokefree.	Maden Centre Tobacco Free Futures	Increase the number of Smokefree Homes pledges.	May 2015 – October 2015
4. Development and implementation of new marketing strategies to promote Stop Smoking Services, with possible longer sessions treatment sessions and use of one-minute video uploads.	Public Health	Monitor of number of one-minute video uploads in place and number of times accessed.	May 2015 – October 2015 June – November 2014
5. Liaison and engagement with community leaders and forums, faith groups and childrens centres to raise awareness of Stop Smoking Services and smoking in pregnancy.	Community Faith Centres Public Health	Reduction in SATOD figures to 11% or less by 2015.	May 2015 – October 2015
6. Development of a smoking in pregnancy campaign to target under the 25 year age group.	Children's centres Jo McCullagh Star Buddies (North & Blackpool)	Implementation and evaluation of smoking in pregnancy campaign for under 25 year age group.	
7. Increase in capacity through the breastfeeding peer mentors programme	NCT in East	Monitoring of the number of	

and/or children's centre staff to deliver stop smoking brief advice to pregnant women and new mothers.	Families and Baby (Central) Katie Wharton	breastfeeding peer supporters trained.	

Objective Four: Performance Monitoring and Evaluation Definition – This objective relates to the way data on smoking in pregnancy will be collected, monitored and used to evaluate the effectiveness of this plan.			
Activity/Action	**Partners**	**Outcome/Outputs**	**Timescales – phased approach to completion**
1. Implementation of performance management systems to ensure effective evaluation of smoking in pregnancy care pathway.	Hospital - Information Governance	Implementation of monthly monitoring process, including CO validation at 36+ weeks data.	November 2014 – April 2015
2. Implementation of a Standard Operating Procedure and a monthly data validation to audit SATOD collection. This could be supported by the distribution of monthly performance stop smoking update to maternity services.	Hospital IT Departments CCG's	IT fit for purpose and inclusion of SATOD at 36+ weeks in addition to booking.	May 2015 – October 2015
3. Implementation of SATOD at 36+ weeks to establish a consistent measure.	Maternity Services	SATOD KPI in secondary care contracts.	June – November 2014
4. Implementation of SATOD as a KPI in secondary care contracts held with Clinical Commissioning Groups.	Public Health	Information governance process agreed and implemented.	November 2014 – April 2015

5. Review governance procedures to enable information data sharing processes and develop agreements about information sharing.		Reduction in SATOD figures to 11% or less by 2015.	June – November 2014

1. A Three-Year Tobacco Control Strategy for Lancashire, 2014-2016 '*Making tobacco less desirable, acceptable and accessible in Lancashire*' . Tobacco Free Lancashire
2. National Institute for Health and Clinical Excellence (2010). Quitting smoking in pregnancy and following childbirth. Public Health Guidance 26. London: NICE.
3. National Institute for Health and Clinical Excellence (2013) *Smoking Cessation in secondary care: acute, maternity and mental health services*. Public Health Guidance 48. London:NICE http://www.nice.org.uk/PH48
4. Action on Smoking and Health (2013) *Smoking Cessation in Pregnancy - A call to action*. http://www.ash.org.uk/pregnancy2013

Possible further developments – explore research proposals – E cigarettes in partnership with local universities

Glossary

CCG	Clinical Commissioning Group
CO Validation	Verifying whether someone is smoking using a Carbon Monoxide monitor
DNA	Did not attend
KPI	Key Performance Indicator
NICE	National Institute For Health and Care Excellence
SATOD	Smoking status at time of delivery
IT	Information Technology
NCT	National Childbirth Trust
4ppm	A reading less than 4ppm (parts per million) is normally that of a non-smoker
Antenatal	Pre-birth; during pregnancy
Breastfeeding peer mentors	Friendly help, information and support about breastfeeding.
Brief advice	A short informal intervention delivered opportunistically giving information on the importance of behaviour change.
Brief Intervention	A structured method to deliver advice and constitute a step beyond brief advice as it involves the provision of more formal help, such as arranging follow-up support. Brief interventions aim to equip people with tools to change attitudes and handle underlying problems.
E-cigarettes	Battery-operated device that mimic cigarettes, contain nicotine, sometimes has flavors added.
Neonatal	Neonatal units in hospitals specialise in the care of babies born early, with low weight or who have a medical condition that requires specialised treatment.
Shisha	Smoking tobacco, sometimes mixed with fruit or molasses sugar, through a bowl and hose or tube
Smokefree Homes and cars	Campaign to raise awareness of the dangers of second hand smoke for babies and children, and to encourage their parents and carers to protect their children by making their homes and cars smoke free.
Sonographer	Specialist who uses specialised equipment to create images of structures and evaluation of the developing foetus and the female reproductive system during pregnancy.
Star Buddies	Breastfeeding support for Blackpool mothers.
Supporting a Smokefree Pregnancy Scheme	Incentive scheme to increase quit rates with pregnant smokers, up to 3 months post-partum.
Post-partum	Period of time following childbirth; after delivery.
Risk Perception training	An opportunity for specialist midwife to explore new ways to reach out to those women not engaged with the service - including implementation of a risk perception tool with women who decline support at booking

Appendix D

Section 4

Equality Analysis Toolkit

Proposal to Reduce Rates of Smoking in Pregnancy in Lancashire County

For Decision Making Items

May 2014

lancashire.gov.uk

Lancashire County Council

What is the Purpose of the Equality Decision-Making Analysis?

The Analysis is designed to be used where a decision is being made at Cabinet Member or Overview and Scrutiny level or if a decision is being made primarily for budget reasons. The Analysis should be referred to on the decision making template (e.g. E6 form).

When fully followed this process will assist in ensuring that the decision- makers meet the requirement of section 149 of the Equality Act 2010 to have due regard to the need: to eliminate discrimination, harassment, victimisation or other unlawful conduct under the Act; to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and to foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having due regard means analysing, at each step of formulating, deciding upon and implementing policy, what the effect of that policy is or may be upon groups who share these protected characteristics defined by the Equality Act. The protected characteristic are: age, disability, gender reassignment, race, sex, religion or belief, sexual orientation or pregnancy and maternity – and in some circumstance marriage and civil partnership status.

It is important to bear in mind that "due regard" means the level of scrutiny and evaluation that is reasonable and proportionate in the particular context. That means that different proposals, and different stages of policy development, may require more or less intense analysis. Discretion and common sense are required in the use of this tool.

It is also important to remember that what the law requires is that the duty is fulfilled in substance – not that a particular form is completed in a particular way. It is important to use common sense and to pay attention to the context in using and adapting these tools.

This process should be completed with reference to the most recent, updated version of the Equality Analysis Step by Step Guidance (to be distributed) or EHRC guidance - EHRC - New public sector equality duty guidance

Document 2 "Equality Analysis and the Equality Duty: Guidance for Public Authorities" may also be used for reference as necessary.

This toolkit is designed to ensure that the section 149 analysis is properly carried out, and that there is a clear record to this effect. The Analysis should be completed in a timely, thorough way and should inform the whole of the decision-making process. It must be considered by the person making the final decision and must be made available with other documents relating to the decision.

The documents should also be retained following any decision as they may be requested as part of enquiries from the Equality and Human Rights Commission or Freedom of Information requests.

Support and training on the Equality Duty and its implications is available from the County Equality and Cohesion Team by contacting AskEquality@lancashire.gov.uk

Specific advice on completing the Equality Analysis is available from your Directorate contact in the Equality and Cohesion Team or from Jeanette Binns Jeanette.binns@lancashire.gov.uk

Name/Nature of the Decision

Proposal to Reduce Rates of Smoking in Pregnancy in Lancashire County

What in summary is the proposal being considered?

Rates of smoking during pregnancy remain higher in Lancashire than England as a whole (18.3% vs. 12.7%) and it is highly unlikely that the County will achieve the national ambition to reduce smoking at time of delivery (SATOD) rates to 11% or less by the end of 2015. In response, reducing smoking in pregnancy is one of the key priority areas of Lancashire County Council's Strategy for Health and Wellbeing.
A scoping of the smoking in pregnancy pathways currently operating across Lancashire County was undertaken in January and February 2014. This highlighted significant variances in programme delivery and gaps in current provision in line with the inherited legacy of the three PCTs. Therefore, in line with NICE guidance, a comprehensive pan-Lancashire programme needs to be undertaken to systemise and embed organisational change to ensure all pregnant smokers are offered effective support in order to reduce the rates of smoking.
Further to this, a pan-Lancashire 'Tackling Smoking in Pregnancy' multi-disciplinary project group has been formulated as a sub-group of the Tobacco Free Lancashire Alliance, which has collectively developed a two-year 'Tackling Smoking in Pregnancy Action Plan. The plan will be jointly implemented by Public Health Teams, Maternity Services within Hospital NHS Trusts, CCG's, Stop Smoking Services and the Community and Voluntary Sector from Lancashire County, Blackburn with Darwen and Blackpool.
The proposed plan will facilitate implementation of a standardised opt-out pathway, comprehensive training for frontline staff, development of information for pregnant smokers and accurate data collection to reduce smoking rates during pregnancy and ensure every child in Lancashire has the best start in life. A two-year investment of £255k is recommended from the Public Health budget to fund the Lancashire County Council components of this plan between 2014 and 2016.

Is the decision likely to affect people across the county in a similar way or are specific areas likely to be affected – e.g. are a set number of branches/sites to be affected? If so you will need to consider whether there are equality related issues associated with the locations selected – e.g. greater percentage of BME residents in a particular area where a closure is proposed as opposed to an area where a facility is remaining open.

Yes – the proposal is part of a Pan Lancashire plan targeting pregnant women.

The proposed plan will facilitate implementation of a standardised opt-out pathway, comprehensive training for frontline staff, development of information for pregnant smokers and accurate data collection to reduce smoking rates during pregnancy and ensure every child in Lancashire has the best start in life.

The Public Health Outcomes Framework has emphasised the continued commitment to reducing health inequalities and increasing healthy life expectancy. In order to achieve this, giving every child the best start in life must be made a priority and this must include protecting babies from the damage of tobacco smoke, both before and after birth.
In view of this, decreasing smoking rates during pregnancy remains a public health priority in Lancashire and the earlier a mother can quit her habit the greater the health benefit for both herself and her baby.
The commissioning proposal to implement the Public Health components of a two-year 'Pan-

Lancashire Tackling Smoking in Pregnancy Action Plan' across Lancashire County will be programme managed by Public Health. However, this will be collectively implemented by the wider pan-Lancashire 'Tackling Smoking in Pregnancy' multi-disciplinary project group, which includes Public Health Teams, Maternity Services within Hospital NHS Trusts, Health Visiting teams in Community NHS Trusts, CCG's, Stop Smoking Services and the Community and Voluntary Sector from Lancashire County, Blackburn with Darwen and Blackpool.

Could the decision have a particular impact on any group of individuals sharing protected characteristics under the Equality Act 2010, namely:

- Age
- Disability including Deaf people
- Gender reassignment
- Pregnancy and maternity
- Race/ethnicity/nationality
- Religion or belief
- Sex/gender
- Sexual orientation
- Marriage or Civil Partnership Status

In considering this question you should identify and record any particular impact on people in a sub-group of any of the above – e.g. people with a particular disability or from a particular religious or ethnic group.

It is particularly important to consider whether any decision is likely to impact adversely on any group of people sharing protected characteristics to a disproportionate extent. Any such disproportionate impact will need to be objectively justified.

No. Approval of the commissioning proposal to implement the Public Health components of a two-year 'Pan-Lancashire Tackling Smoking in Pregnancy Action Plan' across Lancashire County is all embracing and as such, is not considered to have an adverse impact on any groups of individuals sharing protected characteristics.
This pan Lancashire proposal targets pregnant women, protecting babies from the damage of tobacco smoke, both before and after birth to ensure every child in Lancashire is given the best start in life. It is therefore designed to have a positive impact on both pregnant women and their babies.
Maternal smoking during pregnancy remains the greatest cause of foetal ill health and death. Babies born to women who smoke during their pregnancy are lighter than those born to non-smoking mothers and low birth weight is the most significant risk factor in perinatal and infant mortality. Rates of smoking during pregnancy remain higher in Lancashire than England as a whole (18.3% vs. 12.7%) and this is reflected in the greater rates of Lower Birth Weight prevalence across the County (8.2% compared to 7.3% nationally). Consequently, reducing smoking in pregnancy is one of the key priority areas of Lancashire County Council's Strategy for Health and Wellbeing.
Additionally, children of smokers are far more likely to become smokers themselves, which perpetuates cycles of health inequalities and deprivation. The Public Health Outcomes

Framework has emphasised the continued commitment to reducing health inequalities and increasing healthy life expectancy. In order to achieve this, giving every child the best start in life must be made a priority and this must include protecting babies from the damage of tobacco smoke, both before and after birth.
Furthermore, the Tobacco Free Lancashire partnership has endorsed a three year Tobacco Control Strategy for Lancashire (2014-2016) addressing further actions to protect groups sharing protected characteristics. The partnership is committed to build a strategic partnership within Lancashire to support Tobacco Control programmes and action to reduce smoking prevalence and niche tobacco use, protect adults and children from exposure to second-hand smoke and help all residents to live tobacco free lives.

If you have answered "Yes" to this question in relation to any of the above characteristics, – please go to Question 1.

If you have answered "No" in relation to all the protected characteristics, please briefly document your reasons below and attach this to the decision-making papers. (It goes without saying that if the lack of impact is obvious, it need only be very briefly noted.)

Approval of the commissioning proposal to implement the Public Health components of a two-year 'Pan-Lancashire Tackling Smoking in Pregnancy Action Plan' across Lancashire County is not considered to have an adverse impact on any groups of individuals sharing protected characteristics. It is designed to have a positive impact on both pregnant women and protecting babies from the damage of tobacco smoke, both before and after birth.

Question 1 – Background Evidence
What information do you have about the different groups of people who may be affected by this decision – e.g. employees or service users (you could use monitoring data, survey data, etc to compile this). As indicated above, the relevant protected characteristics are:

- Age
- Disability including Deaf people
- Gender reassignment/gender identity
- Pregnancy and maternity
- Race/Ethnicity/Nationality
- Religion or belief
- Sex/gender
- Sexual orientation
- Marriage or Civil Partnership status (in respect of which the s. 149 requires only that due regard be paid to the need to eliminate discrimination, harassment or victimisation or other conduct which is prohibited by the Act).

  In considering this question you should again consider whether the decision under consideration could impact upon specific sub-groups e.g. people of a specific religion or people with a particular disability. You should also consider how the decision is likely to affect those who share two or more of

the protected characteristics – for example, older women, disabled, elderly people, and so on.

N/A.

Question 2 – Engagement/Consultation
How have you tried to involve people/groups that are potentially affected by your decision? Please describe what engagement has taken place, with whom and when.
(Please ensure that you retain evidence of the consultation in case of any further enquiries. This includes the results of consultation or data gathering at any stage of the process)

N/A.

Question 3 – Analysing Impact
Could your proposal potentially disadvantage particular groups sharing any of the protected characteristics and if so which groups and in what way?
It is particularly important in considering this question to get to grips with the actual practical impact on those affected. The decision-makers need to know in clear and specific terms what the impact may be and how serious, or perhaps minor, it may be – will people need to walk a few metres further to catch a bus, or to attend school? Will they be cut off altogether from vital services? The answers to such questions must be fully and frankly documented, for better or for worse, so that they can be properly evaluated when the decision is made.
Could your proposal potentially impact on individuals sharing the protected characteristics in any of the following ways:

- Could it discriminate unlawfully against individuals sharing any of the protected characteristics, whether directly or indirectly; if so, it must be amended. Bear in mind that this may involve taking steps to meet the specific needs of disabled people arising from their disabilities

- Could it advance equality of opportunity for those who share a particular protected characteristic? If not could it be developed or modified in order to do so?

- Does it encourage persons who share a relevant protected characteristic to participate in public life or in any activity in which participation by such persons is disproportionately low? If not could it be developed or modified in order to do so?

- Will the proposal contribute to fostering good relations between those who share a relevant protected characteristic and those who do not, for example by tackling prejudice and promoting understanding? If not could it be developed or modified in order to do so? Please identify any findings and how they might be addressed.

N/A

Question 4 –Combined/Cumulative Effect

Could the effects of your decision combine with other factors or decisions taken at local or national level to exacerbate the impact on any groups?

For example - if the proposal is to impose charges for adult social care, its impact on disabled people might be increased by other decisions within the County Council (e.g. increases in the fares charged for Community Transport and reductions in respite care) and national proposals (e.g. the availability of some benefits) . Whilst LCC cannot control some of these decisions, they could increase the adverse effect of the proposal. The LCC has a legal duty to consider this aspect, and to evaluate the decision, including mitigation, accordingly.

If Yes – please identify these.

N/A

Question 5 – Identifying Initial Results of Your Analysis

As a result of your analysis have you changed/amended your original proposal?

Please identify how –

For example:

Adjusted the original proposal – briefly outline the adjustments

Continuing with the Original Proposal – briefly explain why

Stopped the Proposal and Revised it - briefly explain

N/A

Question 6 - Mitigation

Please set out any steps you will take to mitigate/reduce any potential adverse effects of your decision on those sharing any particular protected characteristic. It is important here to do a genuine and realistic evaluation of the effectiveness of the mitigation contemplated. Over-optimistic and over-generalised assessments are likely to fall short of the "due regard" requirement.

Also consider if any mitigation might adversely affect any other groups and how this might be managed.

N/A

Question 7 – Balancing the Proposal/Countervailing Factors

At this point you need to weigh up the reasons for the proposal – e.g. need for budget savings; damaging effects of not taking forward the proposal at this time – against the findings of your analysis. Please describe this assessment. It is important here to ensure that the assessment of any negative effects upon those sharing protected characteristics is full and frank. The full extent of actual adverse impacts must be acknowledged and taken into account, or the assessment will be inadequate. What is required is an honest evaluation, and not a marketing exercise. Conversely, while adverse effects should be frankly acknowledged, they need not be overstated or exaggerated. Where effects are not serious, this too should be made clear.

N/A

Question 8 – Final Proposal

In summary, what is your final proposal and which groups may be affected and how?

N/A

Question 9 – Review and Monitoring Arrangements
Describe what arrangements you will put in place to review and monitor the effects of your proposal.

N/A

Equality Analysis Prepared By: Joanne McCullagh
Position/Role: Public Health Specialist – Tobacco Control & Stop Smoking Services
Equality Analysis Endorsed by Line Manager and/or Chief Officer: Janet Walton, Head of Public Health Commissioning, Adults and Wellbeing, Adult Services, Health and Wellbeing Directorate
Decision Signed Off By: Dr Sakthi Karunanithi, Director of Public Health, Adult Services, Health and Wellbeing Directorate
Cabinet Member/Chief Officer or SMT Member: County Councillor Azhar Ali, Cabinet Member for Health & Wellbeing
Please remember to ensure the Equality Decision Making Analysis is submitted with the decision-making report and a copy is retained with other papers relating to the decision.
Where specific actions are identified as part of the Analysis please ensure that an EAP001 form is completed and forwarded to your Directorate's contact in the Equality and Cohesion Team.

Directorate contacts in the Equality & Cohesion Team are:

Karen Beaumont – Equality & Cohesion Manager
Karen.beaumont@lancashire.gov.uk
Contact for Adult & Community Services Directorate

Jeanette Binns – Equality & Cohesion Manager
Jeanette.binns@lancashire.gov.uk
Contact for Environment Directorate, Lancashire County Commercial Group and One Connect Limited

Saulo Cwerner – Equality & Cohesion Manager
Saulo.cwerner@lancashire.gov.uk
Contact for Children & Young Peoples Directorate

Pam Smith – Equality & Cohesion Manager
Pam.smith@lancashire.gov.uk
Contact for Office of the Chief Executive and the County Treasurer's Directorate

Thank you