

Full equalities impact assessment

Directorate:

Public Health

Service:

Support to help people stop smoking provided by NHS Stop Smoking Services

Piece of work being assessed:

Sheffield Stop Smoking Service

Aims of this piece of work:

The Stop Smoking Service aims to provide evidence based interventions (counselling and support combined with stop smoking medicines) to support people to stop smoking. It also delivers stop smoking campaigns, training for frontline staff to provide stop smoking support to patients and co-ordinate this across a geographic area. The service is one of the central strands of tobacco control where interventions to stop smoking improve population health and life expectancy. The following aims to assess the Sheffield Stop Smoking Service with respect to the 6 equalities strands in terms of service uptake (measured by the number of people setting a quit date) and outcome (measured by the number of people quitting for 4 weeks).

Name of lead person:

Sheila Paul

Other partners/stakeholders involved:

Claire Holden Stop Smoking Service Manager
Carol Savage, Specialist Stop Smoking Adviser
Razia Bibi – Stop Smoking Adviser (BME communities)
Helen Bunter - Equalities Lead
Sheila Paul, Consultant in Public Health

Date of assessment:

Feb 2009

Who is intended to benefit from this piece of work?

Sheffield Stop Smoking Service; smokers using services to help quit smoking; and smokers as potential users of Stop Smoking Services. This EIA has been undertaken for Sheffield First for Health & Wellbeing Performance Monitoring Gp.

| | | |
|--------------------------------------|--|---|
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| Gender | <p>National evidence shows that there are gender differences in patterns of smoking and that these remain despite the decline in cigarette smoking since the 1970s. For example, the General Household Survey 2007 shows that levels of smoking are slightly higher among men than women (22% vs 20% respectively). Local data from the Sheffield Health and Illness Prevalence Survey 2 supports this and shows that 27.9% of men and 22.6% of women aged 18+ were smokers, based on self reportⁱⁱ. It must be noted that women are less likely to be heavier smokers than men and that a greater proportion of women than men have never smoked (59% and 50% respectively). While 67% of men and 70% of women report they want to give up, a higher proportion of women than men say they would find it difficult to go without smoking for a day (60% and 59% respectively) (measure of dependence).</p> <p>Table 1 shows the number of people setting a quit date (a measure of service uptake) and the number of people quitting (a measure of outcomes) by gender. Data for 2007/8 show a slightly lower uptake of NHS Stop Smoking Services among men and that men made up less than half quits through NHS Stop Smoking Services. These proportions were the same Q1 to Q3 2008/9.</p> <p>Men, however, had a slightly higher quit rate than women (in 2007/8 49% of men and 48% of women who set a quit date went on to quit. These figures were repeated between Q1 to Q3 2008/9) The Sheffield picture mirrors the national picture which shows that the success rate of giving up smoking using NHS Stop Smoking Services was slightly higher among men than women (53% versus 51% respectively) and that women made up a higher proportion of those quitting than men (NHSIC 2008).</p> <p><u>Table 1: Quit dates, quits by gender, Sheffield and England 2007/8</u></p> <table border="1" data-bbox="394 1310 1704 1455"> <thead> <tr> <th></th> <th colspan="2">Sheffield 2007/8</th> <th colspan="2">England 2007/8*</th> </tr> <tr> <th></th> <th>Quit dates set (measure of uptake of services) (% of total)</th> <th>Quits</th> <th>Quit dates set</th> <th>Quits</th> </tr> </thead> <tbody> <tr> <td>Men</td> <td>2613 (44%)</td> <td>1283 (45%)</td> <td>307289 (45%)</td> <td>162092 (46%)</td> </tr> </tbody> </table> | | Sheffield 2007/8 | | England 2007/8* | | | Quit dates set (measure of uptake of services) (% of total) | Quits | Quit dates set | Quits | Men | 2613 (44%) | 1283 (45%) | 307289 (45%) | 162092 (46%) | Yes |
| | Sheffield 2007/8 | | England 2007/8* | | | | | | | | | | | | | | |
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| | <table border="1" data-bbox="394 424 1704 464"> <tr> <td>Women</td> <td>3353 (56%)</td> <td>1596 (55%)</td> <td>373000 (55%)</td> <td>188708 (54%)</td> </tr> </table> <p>*Source: NHSIC 2008</p> <p>It must be noted that NHS Stop Smoking Services offer evidence based extra provision for pregnant smokers i.e. services are specifically targeted at pregnant women. This might be considered ‘positive action’ supporting this group and is in line with harm reduction measures for both the pregnant women and the child and national policy and good practice. In 2008/9, the proportion of women smoking at delivery was 14.4%. This is lower than the national average of 16.13% (based on 2005 data NHSIC 2008).</p> <p>A trawl of information sources has not been possible to establish rates of smoking among Transgender people.</p> | Women | 3353 (56%) | 1596 (55%) | 373000 (55%) | 188708 (54%) | |
| Women | 3353 (56%) | 1596 (55%) | 373000 (55%) | 188708 (54%) | | | |
| Race | <p>The prevalence of smoking varies greatly among different minority ethnic communities. Black and Minority Ethnic (BME) groups have been identified as a national priority for smoking cessation services in NICE guidance 2008. For example, national data show that men from Bangladeshi, Black Caribbean and Irish groups and Irish women have a higher prevalence of smoking than the general population and thereby higher need for SSS. Standardised risk ratios (SRR) vary and were 1.43 for Bangladeshi men, 1.30 among Irish men. Indian men were less likely to smoke (SRR 0.78). For many minority ethnic groups, research evidence shows that prevalence is lower among women than men e.g. fewer women from South Asian communities smoke compared with the general population (ONS 1999).</p> <p>This suggests that if the need for SS services varies by ethnic group, in an EIA it may not be enough to assess whether the uptake of services is in proportion to the demographic makeup of the Sheffield population. National rates of uptake of SSS or smoking prevalence rates by ethnic group may be more useful as a comparator.</p> <p>Table 2 shows the uptake of SSS and quits by BME groups in Sheffield and England 2007/8. This confirms that service uptake and quits by BME groups were slightly lower than the England</p> | Yes – low uptake of services among BME groups | | | | | |

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| | <p>average. In 2007/8, 5.5% of quit dates set and 5.2% of quits were among BME groups as a whole. This is lower than rates for NHS SSS in England as a whole - with 6.1% and 5.9% respectively. In Q1 to Q3 2008/9 in Sheffield, 6.1% of patients setting a quit date and 5.6% of quitters were among BME groups.</p> <p>Table2: people setting a quit date and successful quitters by ethnic group 2007/8</p> <table border="1"> <thead> <tr> <th rowspan="2"></th> <th colspan="4">Sheffield</th> <th colspan="5">England</th> </tr> <tr> <th colspan="2">Quit dates set</th> <th colspan="2">Quits</th> <th>Quit dates</th> <th>Proportion</th> <th>Quits</th> <th></th> <th>Quit rates</th> </tr> </thead> <tbody> <tr> <td>White</td> <td>3118</td> <td>94.5%</td> <td>1501</td> <td>94.8%</td> <td>577720</td> <td>84.9%</td> <td>296120</td> <td>84.41%</td> <td>51.0%</td> </tr> <tr> <td>Mixed</td> <td>43</td> <td>1.3%</td> <td>22</td> <td>1.4%</td> <td>8169</td> <td>1.2%</td> <td>4215</td> <td>1.20%</td> <td>52.0%</td> </tr> <tr> <td>Asian</td> <td>76</td> <td>2.3%</td> <td>30</td> <td>1.9%</td> <td>15210</td> <td>2.2%</td> <td>7673</td> <td>2.19%</td> <td>50.0%</td> </tr> <tr> <td>Black</td> <td>37</td> <td>1.1%</td> <td>21</td> <td>1.3%</td> <td>8869</td> <td>1.3%</td> <td>4013</td> <td>1.14%</td> <td>45.0%</td> </tr> <tr> <td>Other</td> <td>25</td> <td>0.8%</td> <td>10</td> <td>0.6%</td> <td>5486</td> <td>0.8%</td> <td>2677</td> <td>0.76%</td> <td>49.0%</td> </tr> <tr> <td>Ethnic group</td> <td>3299</td> <td>100.0%</td> <td>1584</td> <td>100.0%</td> <td>615454</td> <td>90.5%</td> <td>314698</td> <td>89.70%</td> <td>51.1%</td> </tr> <tr> <td>Not known</td> <td>2666</td> <td>44.7%</td> <td>1295</td> <td>44.9%</td> <td>64835</td> <td>9.5%</td> <td>36108</td> <td>10.29%</td> <td></td> </tr> <tr> <td>Total</td> <td>5965</td> <td></td> <td>2879</td> <td></td> <td>680289</td> <td></td> <td>350806</td> <td></td> <td></td> </tr> </tbody> </table> <p>*Source: NHSIC 2008 and Sheffield SSS</p> <p>Data recording issues The table shows a high level of missing data on the ethnic group of service users both in the Sheffield SSS and for SSS nationally. In 2007/8, 44% of quit dates set in the Sheffield SSS and 10% nationally did not have ethnic group recorded/refused. Data recording has improved. In Q1 to Q3 2008/9, ethnic group was not recorded for 18.5% of people setting a quit date and 18.8% of people who quit.</p> <p>In Sheffield, anecdotal evidence suggests higher rates of smoking among some new migrant communities e.g. Eastern European groups (personal communication, PCT Provider Services). Use of Stop Smoking Services among this ethnic group is, however, not measured directly in the National Minimum dataset for Stop Smoking Services.</p> | | Sheffield | | | | England | | | | | Quit dates set | | Quits | | Quit dates | Proportion | Quits | | Quit rates | White | 3118 | 94.5% | 1501 | 94.8% | 577720 | 84.9% | 296120 | 84.41% | 51.0% | Mixed | 43 | 1.3% | 22 | 1.4% | 8169 | 1.2% | 4215 | 1.20% | 52.0% | Asian | 76 | 2.3% | 30 | 1.9% | 15210 | 2.2% | 7673 | 2.19% | 50.0% | Black | 37 | 1.1% | 21 | 1.3% | 8869 | 1.3% | 4013 | 1.14% | 45.0% | Other | 25 | 0.8% | 10 | 0.6% | 5486 | 0.8% | 2677 | 0.76% | 49.0% | Ethnic group | 3299 | 100.0% | 1584 | 100.0% | 615454 | 90.5% | 314698 | 89.70% | 51.1% | Not known | 2666 | 44.7% | 1295 | 44.9% | 64835 | 9.5% | 36108 | 10.29% | | Total | 5965 | | 2879 | | 680289 | | 350806 | | | |
| | Sheffield | | | | England | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | <p><u>Sheffield SSS provision</u> The core Stop Smoking Service has a BME Stop Smoking Adviser who runs smoking cessation provision in the community. The service is implementing NICE guidance (2008) on Stop Smoking Services for 'hard to reach groups', including BME groups. Publicity is given about the NHS Asian Tobacco Helpline and the service offers support with the help of Interpreters as well as leaflets to help smokers to quit in minority languages. Two Stop Smoking Advisers uses their bilingual skills during stop smoking work.</p> <p>There is, however, a lack of evidence base on the effectiveness of stop smoking interventions for different BME groups in the UK and a lack of evidence about what works for different communities. In 2007/8 in England, quit rates by ethnic group were as follows: White (51%), Mixed (52%), Asian (50%), Black (45%) and Other (49%). Not recorded (56%) (NHSIC 2008). US evidence suggests no difference in the effectiveness of interventions across 'racial' groups (Coleman 2004).</p> | |
| Disability | <p>A review of published evidence has been unable to establish quantitative evidence on differences in level of smoking or uptake of stop smoking support among disabled groups. Further, disabled status is not included in the NHS National Minimum Dataset for Stop Smoking Services.</p> <p>Smoking is both a cause and may be a consequence of 'disability'. For example, it is estimated that 8% of those experiencing a stroke due to smoking will be left with a disability (Stroke Association 2002).</p> <p>National evidence also shows a relatively high prevalence of smoking in mental health patients (HDA 2004), particularly patients with co-morbidity such as alcohol and substance misuse problems. Smoking prevalence among psychiatric patients is reported to be 2-4 times the rate of the general population and to smoke more heavily than the general population (reported in Prochaska et al. 2004, HDA 2004 and</p> | Unable to establish from evidence |

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| | <p>el-Guebaly et al. 2002). Those with severe mental health problems are also likely to die 10 years earlier than those who do not have such problems. Research shows that a range of factors, biological and psychosocial, may reinforce the use of nicotine in groups with mental health problems (el-Guebaly et al. 2002). For example, for some health problems, nicotine through smoking is used as self-medication for certain disorders and may alleviate some side effects of antipsychotic medication (HDA 2004). The belief that mental health patients are not willing to quit has been challenged (el-Guebaly et al 2002). Approximately half of smokers with mental health problems want to stop smoking (HDA 2004).</p> <p><u>Sheffield SSS provision</u> Sheffield Health and Social Care Foundation Trust in association with the Sheffield Stop Smoking Service, is completing a pilot of smoking cessation support in community mental health services. This is one of a number of CSIP pilots on mental health and smoking and has found had a relatively low quit rate compared to other smoking cessation programmes. Work is planned to train up mental health staff to offer stop smoking support to patients and to brief Stop Smoking advisers on working with smokers who have mental health problems.</p> <p>The Sheffield Stop Smoking Service does provide support to people who are housebound, and are thereby known to experience functional disability. Since April 2008, the Stop Smoking Service has supported 39 housebound clients in their quit attempts offering support in patients own homes (1.3% of service users versus a prevalence of moderate or serious disability of 18% Health Survey for England – note definitions of disability vary across surveys).</p> <p>As noted, smoking is also a cause of disability. NHS Stop Smoking Services are included in pre-operative pathway at Sheffield Teaching Hospitals. In 2008/9 the number of referrals to NHS SSS from the hospital was 75 per month on average (total 765 referrals). Measures are being implemented to increase referrals of patients attending hospital in order to maximise outcomes.</p> | |

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| Sexual orientation | <p>National evidence shows that, a quarter of lesbian and bisexual women currently smoke. It also shows that 21% of lesbian and bisexual women who smoke, smoke more than 20 cigarettes per day compared to 28% of women in general who smoke (Stonewall 2008). The adult gay smoking prevalence is up to twice that of adult heterosexuals (Harding et al 2004). For example, the Gay Men’s Sex Survey found that 41% of gay men smoke compared to the national average of 25% and that 67.3% of gay male smokers would like to quit smoking (Stonewall 2007). Relatively high rates of smoking among gay men and lesbians are supported by US evidence showing that gay men aged 20-65 years were 2.4 times as likely to be smokers (CI 1.75 to 2.45 times as likely) and lesbians 1.6 times as likely (CI 1.75 to 3.30 times as likely) (Gruskin and Gordon 2006). There is a lack of evidence base on the effectiveness of the effectiveness of anti-smoking interventions in LGBT groups in the UK (Harding et al 2004)</p> <p>Sexual orientation is not included in the NHS National Minimum Dataset for Stop Smoking Services and so there is no directly measured local data on service use by sexual orientation. Preventive messages and stop smoking campaigns have not been specifically targeted at the LGB community. The messages may be less effective in reaching LGB groups and may then possibly affect uptake of NHS Stop Smoking Services.</p> | Yes |
| Age | <p>There are differences in the proportion of smokers by age group – and therefore differences in the level of need for Stop Smoking Support (Table3). The highest prevalence is in the 18-34 age group. Success rates of giving up smoking increase with age (NHSIC 2008). Evidence shows that 39% of regular smokers start smoking < 16 years (GHS 2006).</p> <p>Table 3 shows that in Sheffield, the proportion of quit dates set by age group (col5) is similar to the proportion of smokers in each agegroup (column 3) (over 18 yrs only). This indicates good access to services by adult age group. In Q1 to Q3 2008/9, proportion of quit dates set by ageband was similar.</p> | Yes – as historically services to help people quit have primarily been targeted at adults. |

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|-------------------------------|---|-----------------------|----------------|------------|------------------|------------|----------------|------------|------------------|------------|--|-------------------|--|-----------|--|--|--|---------|--|--|--|----------------|-----------------------|----------------|------------|------------------|------------|----------------|------------|------------------|------------|------|-----------------|----|-----|-------|----|-------|-------|-------|------|-------|-------|-----|-----|------|--------|-----|--------|--------|--------|-------|--------|-------|-----|-----|------|--------|-----|--------|--------|--------|-------|--------|-------|-----|-----|------|--------|-----|--------|--------|--------|-------|--------|-----|-----|-----|-----|--------|-----|--------|--------|--------|-------|--------|-------|-----|------|------|---------|------|---------|--------|---------|-------|---------|--|
| | Table 3: Quit dates, quits and prevalence of smoking by ageband | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <thead> <tr> <th rowspan="2">Agegp</th> <th colspan="2">Prevalence (Engl)</th> <th colspan="4">Sheffield</th> <th colspan="4">England</th> </tr> <tr> <th>Current smoker</th> <th>Proportion of smokers</th> <th>Quit dates set</th> <th>Proportion</th> <th>Quits (verified)</th> <th>Proportion</th> <th>Quit dates set</th> <th>Proportion</th> <th>Quits (verified)</th> <th>Proportion</th> </tr> </thead> <tbody> <tr> <td>0-18</td> <td>21% (16-17 yrs)</td> <td>3%</td> <td>167</td> <td>2.80%</td> <td>52</td> <td>1.80%</td> <td>20823</td> <td>3.10%</td> <td>4281</td> <td>2.10%</td> </tr> <tr> <td>18-34</td> <td>29%</td> <td>29%</td> <td>1788</td> <td>30.00%</td> <td>751</td> <td>26.10%</td> <td>194641</td> <td>28.60%</td> <td>50174</td> <td>24.00%</td> </tr> <tr> <td>35-44</td> <td>25%</td> <td>21%</td> <td>1584</td> <td>26.60%</td> <td>750</td> <td>26.10%</td> <td>166213</td> <td>24.40%</td> <td>51494</td> <td>24.70%</td> </tr> <tr> <td>45-59</td> <td>23%</td> <td>27%</td> <td>1459</td> <td>24.50%</td> <td>765</td> <td>26.60%</td> <td>184694</td> <td>27.10%</td> <td>60721</td> <td>29.10%</td> </tr> <tr> <td>60+</td> <td>12%</td> <td>17%</td> <td>968</td> <td>16.20%</td> <td>561</td> <td>19.50%</td> <td>113918</td> <td>16.70%</td> <td>42072</td> <td>20.20%</td> </tr> <tr> <td>Total</td> <td>22%</td> <td>100%</td> <td>5966</td> <td>100.00%</td> <td>2879</td> <td>100.00%</td> <td>680289</td> <td>100.00%</td> <td>20874</td> <td>100.00%</td> </tr> </tbody> </table> | | | | | | | | | | Agegp | Prevalence (Engl) | | Sheffield | | | | England | | | | Current smoker | Proportion of smokers | Quit dates set | Proportion | Quits (verified) | Proportion | Quit dates set | Proportion | Quits (verified) | Proportion | 0-18 | 21% (16-17 yrs) | 3% | 167 | 2.80% | 52 | 1.80% | 20823 | 3.10% | 4281 | 2.10% | 18-34 | 29% | 29% | 1788 | 30.00% | 751 | 26.10% | 194641 | 28.60% | 50174 | 24.00% | 35-44 | 25% | 21% | 1584 | 26.60% | 750 | 26.10% | 166213 | 24.40% | 51494 | 24.70% | 45-59 | 23% | 27% | 1459 | 24.50% | 765 | 26.60% | 184694 | 27.10% | 60721 | 29.10% | 60+ | 12% | 17% | 968 | 16.20% | 561 | 19.50% | 113918 | 16.70% | 42072 | 20.20% | Total | 22% | 100% | 5966 | 100.00% | 2879 | 100.00% | 680289 | 100.00% | 20874 | 100.00% | |
| Agegp | Prevalence (Engl) | | Sheffield | | | | England | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Current smoker | Proportion of smokers | Quit dates set | Proportion | Quits (verified) | Proportion | Quit dates set | Proportion | Quits (verified) | Proportion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Total | 22% | 100% | 5966 | 100.00% | 2879 | 100.00% | 680289 | 100.00% | 20874 | 100.00% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | *Source: NHSIC 2008 and Sheffield SSS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <p><u>Young people</u></p> <p>On the basis of table 3, a low proportion of service users are <18 years, given a smoking prevalence of 21% in the 16-17 year age group. Evidence shows that there is potential for discrimination in access to services for young people. There is, however, a lack of evidence about what works to reduce uptake of smoking among young people and which cessation interventions are effective for young people. Local evidence shows that cessation rates through Stop Smoking Services are much lower than adults (11-15%, Sheffield pilot 2003). As a result, in 2005, the local Primary Care Trusts decided to target SSS primarily at adults (report to the Tobacco Control Programme Board, September 2008).</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <p>Reducing smoking among young people is a major challenge. In order to reduce the uptake of smoking, smoking is included in PSHE under Healthy Schools Status. NICE guidance on evidence-based</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | | |
|--------------------------------------|---|---|
| Single Equality Scheme strand | Baseline data and research on the population that this piece of work will affect What is available? What does it show? Are there any gaps? Use both quantitative and qualitative research and user data. Include consultation with users if available | Is there likely to be a differential impact? |
| | interventions to reduce smoking prevalence among young people is expected in 2010. | |
| Religion/belief | A review of published evidence has been unable to establish quantitative evidence on differences in level of smoking or uptake of stop smoking support among religious groups. Religion/belief is not included in the NHS National Minimum Dataset for Stop Smoking Services. Smoking prevalence among some ethnic groups with predominantly Muslim populations remains relatively high. For example, among Bangladeshi and Pakistani populations, overall smoking prevalence was 40% among Bangladeshi men and 29% among Pakistani men compared with 24% among the male general population (ONS 2004). It has been not possible to establish local rates of smokeless tobacco use. | Unknown as unable to measure |

Equalities Impact Assessment Action Plan

| Strand | Issue | Action required | How will you measure the impact/outcome? | Timescale | Lead |
|--------|---|---|--|------------------------------|--|
| Gender | Slightly lower uptake of Stop Smoking Services among men than women. Men also made up less than half quits through Stop Smoking Services – despite slightly higher prevalence of smoking. | <ul style="list-style-type: none"> • Improve advertising of the local SSS in target publications shown to be better at reaching men in Q4 2008/9. • Assess the evidence base on interventions which aim to improve uptake by men of SSS. • Consider resourcing social marketing to identify barriers | Ongoing monitoring of service uptake and quits by gender. Change in service uptake by men | Q2 2009/10 Q3 2009/10 | Claire Holden (Stop Smoking Service Manager) Katy Davison (Communications Team) |

| Strand | Issue | Action required | How will you measure the impact/outcome? | Timescale | Lead |
|--------|--|---|---|---|---|
| | | <p>to accessing the service and triggers to change behaviour – targeting routine and manual male smokers.</p> <ul style="list-style-type: none"> Target male smokers identified to be at risk of cardiovascular disease through the new Vascular Screening programme and refer to Stop Smoking Services. | No. referrals from Vascular Screening Programme | Q4 2009/10 | John Soady (Public Health) |
| Race | Data on service uptake and effectiveness by ethnic group not complete (high level of missing data) | <ul style="list-style-type: none"> Improve ethnic coding of data in National Minimum dataset for Stop Smoking Services towards at least national levels of completeness e.g. by briefing all stop smoking advisers about the importance of ethnic monitoring. Purchase more ethnically sensitive stop smoking materials for use by SSS Advisers | <p>Ongoing monitoring of service uptake and quits by ethnic group.</p> <p>Year by year improvement in level of data completeness of ethnic coding – towards national level of 90% completeness (note: some patients refuse to give this information).</p> | <p>ongoing</p> <p>by Mar 2010</p> <p>April 2009</p> | <p>Bill Macauley (Information Manager).</p> <p>“</p> <p>Claire Holden (SSS Manager)</p> |

| Strand | Issue | Action required | How will you measure the impact/outcome? | Timescale | Lead |
|--------|---|---|--|---|--|
| | <p>Consider Stop Smoking provision for new migrant communities with higher rates of smoking e.g. Eastern European communities</p> | <ul style="list-style-type: none"> Estimate levels of need for stop smoking support in BME communities. Identify good practice in working with BME groups in Sheffield and outside to increase access to and uptake of services. We will start by consulting Patient and Public Involvement leads and EPHP leads to determine ways in which the service can improve uptake by BME groups. <p>Set up clinics in community settings targeting two minority ethnic groups with relatively high rates of smoking in the first instance. As part of this, explore the feasibility of establishing regular stop smoking groups in Mosques.</p> <ul style="list-style-type: none"> Re-audit NHS SSS against NICE guidance (2008) within | <p>No. of new clinics in faith settings</p> <p>Reaudit of NICE guidance produced</p> | <p>Annual Health Needs Assessment by May 2009</p> <p>Sep 2009</p> <p>Sep 2009</p> <p>Dec 2009</p> | <p>Sheila Paul (Cons in PH) Ann Richardson (Public Health Intelligence Team)</p> <p>Razia Bibi (SSS BME Lead),</p> <p>Razia Bibi (SSS BME Lead)</p> <p>Claire Holden (SSS Manager)</p> |

| Strand | Issue | Action required | How will you measure the impact/outcome? | Timescale | Lead |
|------------|--|---|---|---|--|
| | | 18 months to assess progress | | | |
| Disability | <ul style="list-style-type: none"> Estimates of smoking in some disabled groups may be higher than the general population e.g. people with mental health problems. Smoking acts as a cause of some forms of disability | <ul style="list-style-type: none"> Monitor uptake of services by housebound clients and develop awareness among healthcare professionals of SSS to help housebound patients. Train mental health staff in brief intervention and referral and train SS staff in working with people with mental health problems. Consultation needs to be undertaken with local Disability Groups and providers and offer training for staff on smoking cessation. <p>Promote awareness of availability of British Sign Language interpreters with SSS</p> <ul style="list-style-type: none"> Ensure SSS is integrated into new population Vascular Screening Programme and | <p>Regular feedback via Tobacco Control Programme Board and reporting mechanisms.</p> <p>Ongoing monitoring of number of quit dates and quit rates among programmes for mental health patients.</p> <p>No of groups consulted with.</p> <p>Number of referrals from vascular screening programme after Q4</p> | <p>Monthly 2009/10 to Tobacco Control Programme Board</p> <p>March 2009</p> <p>Dec 2009</p> <p>May 2009</p> <p>April 2010</p> | <p>Bill Macauley (Information Manager)</p> <p>Maggie Milne (Training Lead for the SSS) Tony Flatley and Rose Hogan (SHSCT)</p> <p>Maggie Milne (Training Lead for the SSS)</p> <p>Claire Holden (SS Manager)</p> <p>John Soady (Public Health)</p> |

| Strand | Issue | Action required | How will you measure the impact/outcome? | Timescale | Lead |
|-----------|---|---|---|---|--|
| | | <p>other chronic disease programmes.</p> <ul style="list-style-type: none"> Continue to increase uptake of services through hospitals. | <p>2009/10</p> <p>Monitor change in number of referrals from hospitals</p> | <p>Monthly to Tobacco Control Programme Board</p> | <p>Reem Abbas and Sandra Dundas (Hospital Stop Smoking Advisers)</p> |
| Sexuality | <ul style="list-style-type: none"> LGB people may not benefit from targeted campaigning. | <ul style="list-style-type: none"> Assess health education materials to help people quit for LGB communities in conjunction with the Centre for HIV and Sexual Health - and utilise these in the main Stop Smoking Service. Explore potential for offering SSS for LGB groups with Centre for HIV and Sexual Health. <p>Include Stop Smoking in health events run by the Centre for HIV and sexual health.</p> <ul style="list-style-type: none"> Ensure Stop Smoking advisers undertake regular | <p>Feedback via Tobacco Control Programme Board and reporting mechanisms</p> <p>No. of new groups offered</p> <p>No. CHIV events supported by Stop Smoking Service</p> <p>Training in staff Performance Development</p> | <p>April 2010</p> <p>April 2010</p> <p>April 2010</p> <p>April 2010</p> | <p>Claire Holden (SSS Manager) or Team Leader and Steve Slack, Centre for HIV and Sexual Health</p> <p>“</p> <p>“</p> <p>Claire Holden (SSS Manager)</p> |

| Strand | Issue | Action required | How will you measure the impact/outcome? | Timescale | Lead |
|--------|--|--|--|---|---|
| | | <p>Diversity Training</p> <ul style="list-style-type: none"> Explore potential for collecting data on sexual orientation of service users. | Reviews | April 2010 | “ |
| Age | Low numbers of young people using SSS. Currently NHS Stop Smoking Services in Sheffield are primarily aimed at adults. | <ul style="list-style-type: none"> The Tobacco Control Programme Board should conduct a review of Stop Smoking Services for young people (<18). Apply for resources to appoint a Young Person’s Stop Smoking Adviser in commissioning intentions process and Area Based Grant. Implement NICE guidance on evidence based interventions for young people, expected 2010. Communications plan to include advertising Stop Smoking Services in age-appropriate media | <p>Report to Tobacco Control Programme Board</p> <p>No. of quit dates set and quits for <18s</p> <p>tbc</p> <p>Increased service uptake among 18-25by ageband</p> | <ul style="list-style-type: none"> Review to TCPB Q4 2008/9 Q4 2008/9 2010 (following publication of NICE guidance) ongoing | <p>Giles Ratcliffe and Sheila Paul (Public Health)</p> <p>Sheila Paul (Public Health), Healthy Schools Team</p> <p>Sheffield Stop Smoking Service with support from Clinical Audit</p> <p>Katy Davison (Communications)</p> |

| Strand | Issue | Action required | How will you measure the impact/outcome? | Timescale | Lead |
|-----------------|---|--|---|---|--|
| | | <ul style="list-style-type: none"> Explore feasibility of Social Marketing approach on cessation or prevention of uptake of smoking among young people in 2010. Explore feasibility of working with Children's Centres to establish stop smoking support | <p>Service redesigns its offer of stop smoking support to young people</p> <p>No. referrals from Children's Centres</p> | <p>Insight work planned Q4 2009/10.</p> <p>April 2010</p> | <p>Katy Davison (Communications) Sheila Paul (Public Health)</p> <p>Carol Savage (Specialist Stop Smoking Adviser)</p> |
| Religion/Belief | <ul style="list-style-type: none"> Possible high rates among smoking prevalence among some Moslem communities, especially among men. | <ul style="list-style-type: none"> Consult VAS and explore links with Faith communities and leaders with a view to establishing Stop Smoking provision. Explore possibility of collecting data on religion | No. of new groups established in faith settings | <p>March 2010</p> <p>April 2010</p> | <p>Razia Bibi (Stop Smoking Adviser) with EPHP Leads and Tanyat Basharat (Shipshape Smoking Adviser)</p> |

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ⁱ Methodology - This EIA utilises both published and local data to assess service performance against the 6 equalities strands. Data are used for 2007/8 as this provides the most up to date complete full years' worth of data for which comparative data is available. Data from April to December 2008 are also presented – as this data includes information on patients who have completed a programme of quit support. It is noted that there is at the time of writing there is no complete comparative data available for 2008/9 on Stop Smoking Services in England. The action plan was produced with members of the Stop Smoking Team.

ⁱⁱ The higher overall prevalence by gender may be accounted for by regional differences which show that Yorkshire and Humber (as well as NE and NW regions) have relatively high rates of cigarette smoking.