CABINET
SUPPLEMENTARY AGENDA

11 June 2025

The following report is attached for consideration and is submitted with the agreement of the Chairman as an urgent matter pursuant to Section 100B (4) of the Local Government Act 1972

6 TOBACCO HARM REDUCTION STRATEGY (Pages 3 - 24)

Report attached.

Zena Smith
Head of Committee & Election Services

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Equality & Health Impact Assessment (EHIA)

Document control

Title of activity:	Tobacco Harm Reduction Strategy 2024-2029
Lead officer:	Kate Ezeoke-Griffiths, Assistant Director For Public Health (Resources), Public Health Service
Approved by:	Mark Ansell, Director for Public Health, Public Health Service
Version Number	**V0.1**
Date and Key Changes Made	03/06/2025. This is the first Equality Health Impact Assessment on the Tobacco Harm Reduction Strategy
Scheduled date for next review:	3/06/2029.

Did you seek advice from the Corporate Policy & Legal? Please note that the Corporate Policy & Legal and Public Health teams require at least **5 working days** to provide advice on EHIAs.	Yes
Did you seek advice from the Public Health team?	Yes
Does the EHIA contain any confidential or exempt information that would prevent you publishing it on the Council's website? See Publishing Checklist.	No

Please note that EHIAs are **public** documents and unless they contain confidential or sensitive commercial information must be made available on the Council's EqHIA webpage.

Please submit the completed form via e-mail to READI@havering.gov.uk

1. Equality Health Impact Assessment Checklist

Please complete the following checklist to determine whether or not you will need to complete an EHIA and ensure you keep this section for your audit trail. If you have any questions, please contact READI@havering.gov.uk for advice from either the Corporate Diversity or Public Health teams. Please refer to **this Guidance** on how to complete this form.

About your activity

1	**Title of activity**	Tobacco Harm Reduction Strategy 2024 - 2029		
2	**Type of activity**	Strategic document		
3	**Scope of activity**	The strategy sets out the vision of the Havering Tobacco Harm Reduction Partnership (THRP) group to jointly reduce tobacco harm and address the rising youth vaping in Havering. The strategy is aimed at local residents including children and young people and groups disproportionately affected by smoking with higher smoking rates such as males, those experiencing substance misuse, with severe mental health conditions, as well as those living in more deprived parts of the borough and in routine and manual occupation. People working in Havering, local businesses, organisations and voluntary sector are also covered by the strategy The strategy sets out four strategic priorities over the coming years as: • Supporting smokers to quit and reducing variation in smoking rates. • Prevention - empowering individuals to avoid smoking and vaping. • Creating smoke-free environment to protect children and vulnerable from second-hand smoke • Strengthening local regulation and enforcement Progress will be tracked by specific targets and indicators with a focus on achieving a downward trend in smoking prevalence by 2028/29. Delivery is through a yearly action plan, refreshed annually in line with funding allocation, reflecting new developments and Havering's changing needs.		
4a	**Are you changing, introducing a new, or removing a service, policy, strategy or function?**	Yes	If the answer to <u>either</u> of these questions is **'YES'** Continue to question **5**.	If the answer to <u>all</u> of the questions (4a, 4b & 4c) is **'NO'** Go to question **6**.
4b	**Does this activity have the potential to impact (either positively or negatively) upon people from different backgrounds?**	Yes		

4c	**Does the activity have the potential to impact (either positively or negatively) upon any factors which determine people's health and wellbeing?**	Yes	Use the *Screening tool* before you answer this question.	If you answer **'YES'** Continue to question **5**.	
5	**If you answered YES:**	**Please complete the EHIA in Section 2 of this document.** Please see Appendix 1 for Guidance.			
6	**If you answered NO:**	*Provide an explanation on why your activity does not require an EHIA. This is essential, in case the activity is challenged under the Equality Act 2010.* *Keep this checklist for your audit trail.*			

Completed by:	Kate Ezeoke-Griffiths, Assistant Director For Public Health, (Resources)
Date:	03/06/2025

2. The EHIA – How will the strategy, policy, plan, procedure and/or service impact on people?

Background/context:
Overview and Impact Smoking harms nearly every organ of the body and causes serious harm to the health of both smokers and non-smokers. Many preventable illness such as cancer, heart and lung diseases which result in premature deaths are primarily caused by smoking. About 72% of lung cancer cases in the UK are caused by smoking. Smoking in pregnancy impacts the unborn child and its development. In men, smoking is a major risk factor for impotence whilst in women it is associated with increased risk of early natural menopause. Havering has seen a fluctuation in adult smoking prevalence in recent years rising from 10.3% in 2021 to 15.9% 2022. A three year range (2021 to 2023) indicates 12.4% (25,560) of adult smoking prevalence, compared to 11.6% for London and 12.4% for England averages according to the Office of Health Improvement and Disparities data. However, there is a clear disparity in smoking in Havering. Certain demographic groups are more disproportionately affected by smoking with higher rates among the main white population, males, those with substance misuse addiction, severe mental health conditions. Higher levels of smoking also exist amongst those in routine and manual occupation as well as those living in rented accommodation Economically, smoking has cost implications for the individual and wider society. It is estimated that 32,500 residents that smoke collectively spend £78.5M annually on tobacco, equating to around £2,400 per smoker per year according to Action on Smoking and Health, ASH. Given the prevailing high cost of living, quitting smoking will provide additional benefit in terms of savings.

To the wider society impact are ranging including working days lost due to sickness absence, NHS costs for treatment of smoking caused illnesses, damage as well as injury caused by cigarettes fires.

Environmental impact associated with smoking is evident in every stage of the tobacco supply chain –includes deforestation for cultivation, energy-intensive curing processes, manufacturing and packaging and widespread cigarette butt litter.

This five-year tobacco harm reduction strategy is in response to the 2023 Stopping the Start Policy Paper, the National Tobacco Control Plan and is underpinned by recommendations from the tobacco harm reduction needs assessment. Development has been in partnership with a range of partners – internally with council services such as community mental health services, learning disability Team, education and trading standards and externally, with key organisations including BHRUT, community pharmacists and the Voluntary sector.

The ultimate goal of the strategy is to achieve a year-on-year reduction in the level of smoking across Havering to improve health and well-being of local residents.

**Expand box as required*

Who will be affected by the activity?
This is a population wide strategy aimed at local residents including children and young people and those groups more disproportionately affected by smoking with higher rates such as males, those with substance misuse, severe mental health conditions, as well as those living in rented accommodation and in routine and manual occupation People working in Havering, local businesses, organisations and voluntary sector are also covered by the strategy. **Expand box as required*

Protected Characteristic - Age: Consider the full range of age groups If there is an impact on under 18s, how have you / will you ensure their views are gained to inform decision making?		
Please tick (✓) the relevant box:		**Overall impact:**
Positive	*(✓)*	Smoking cuts across all ages in Havering but the prevalence is highest among those aged 31-35, at 18.99%, and lowest among adolescents aged 12-15, at 0.10%. Smoking prevalence in havering shows a steady rise with age peaking at 18.99% amongst those aged 31-35. Prevalence remains high amongst working age groups off 36-40 (17.80%), 41-45 (18.10%) and 46-50 (17.94%) age groups and gradually declines from 16.92% in the 51-55 group to 5.38% in those aged 76 and older. This shows smoking is predominant among those of working age groups in Havering. Whilst number of young people smoking is relatively low an estimated 10,200 children live in smoking households and are exposed to second hand smoke. The strategy will focus on different population groups who are either smoking, at risk of smoking and those exposed to tobacco including children and older
Neutral		
Negative		

		people. It will adopt tailored interventions that takes into account wider socio-economic factors as well unique risk factors and needs of the individual recognising life stages and age groups. Vaping needs assessment will inform evidence based intervention measures working with young people and will utilise incoming legislation through the Tobacco and vapes Bill to strengthen enforcement and regulation. The strategy will therefore have a positive impact on different population age groups in Havering. **Expand box as required*

Evidence:

Havering population is estimated to be 26 2000 according to 2021 census reports with a higher proportion of children aged 0-17 (22.3%) than 80% of local authorities in England. The combined impact of having both a large older population and a large growing young population is a Havering with the lowest proportion of working-age adults in London.

Whilst Vaping is recommended and beneficial to help stop smoking amongst adult it is not recommended as a recreational tool for either adults or young people.
Data shows an increasing population of young people taking up vaping due to targeted marketing of vapes with flavours and packaging which appeals to young people, social media as well as peer pressure.

A national Youth Survey in 2024 found 18% of 11–17-year-olds tried vaping, with 72% of 11–17-year-olds reported exposure to some form of vape promotion, mainly from shops (55%) and online (29%)[1]. In Havering a Youth Wellbeing Census (2023) revealed 12% of Havering pupils have experimented with vaping. Youth exposed to vaping are at risk of developing chronic respiratory issues like coughing, bronchitis and exacerbation of asthma, along with potential long-term cardiovascular consequences. Furthermore, vaping at young age can lead to nicotine dependence, which can adversely affect brain development.

**Expand box as required*

Sources used:

Havering tobacco harm reduction Needs Assessment

Havering Intelligence Hub – Population Intelligence Briefings

Census - Office for National Statistics (ons.gov.uk)

**Expand box as required*

Protected Characteristic - Disability: Consider the full range of disabilities; including physical, mental, sensory, progressive conditions and learning difficulties. Also consider neurodivergent conditions e.g. dyslexia and autism.		
Please tick (□) the relevant box:		**Overall impact:**
Positive	*(□)*	Smoking and disability are interconnected, with individuals with disabilities experiencing higher rates of smoking and being more likely to develop smoking-related disabilities such as respiratory problems, heart disease,
Neutral		

[1] https://ash.org.uk/resources/view/use-of-e-cigarettes-among-young-people-in-great-britain

Negative		stroke and blindness. Smoking contributes to the development of various disabilities, The strategy will prioritise groups with high smoking prevalence – including those with underlying health conditions or disabilities caused by smoking such respiratory problems, heart disease, but also focus on those with other disabilities with high smoking levels such as those with learning disability and physical. The Strategy places emphasis on a joined up approach across different organisations and the adoption of multi-faceted actions to reduce smoking and youth vaping working with partners, including the NHS, community and voluntary sector including the fire service to raise awareness of smoking and risk to health including significant risk of fires and injury for those disabled and homebound. The strategy will therefore have a beneficial impact on those who are disabled **Expand box as required*

Evidence:

According to census 2021, an estimated 38,449 of havering residents live with mental and physical disability. This is equivalent to 15.3% of the total Havering population and is slightly lower than London (15.6%) and England (17.7%) averages. An estimated 29,742 households in Havering had at least one person with a disability and of these households, 6,181 had two or more members with a disability.

Smoking and disability are interconnected, with individuals with disabilities experiencing higher rates of smoking and being more likely to develop smoking-related disabilities. People with disabilities are more likely to smoke than those without disabilities. One study found that 38.8% of adults with a disability were smokers compared to 20.7% of adults without a disability. Higher smoking and e-cigarette use in 20-year-olds with disabilities adds to further inequality to their lives. Increased awareness, targeted surveys and focused prevention and therapeutic interventions are required to reduce inequalities in this population

Although adults with learning disabilities (LD) are less likely to smoke than the general adult population, smoking rates among adolescents with mild LDs are higher than peers without mild LDs[2]. In Havering, the number of GP-registered patients recorded as having an LD who also smoke is 6.97-7.88%, a rate similar to the UK average of 6.2%[3]. Meanwhile, in adolescents, the prevalence of smoking at ages 14-17 are similar among adolescents with and without LDs. Evidence showed the prevalence of more frequent vaping was higher among girls with LDs than their female peers without LDs[4].

Expand box as required

[2] Emerson E and Baines S, 2010: Health inequalities and people with learning disabilities in the UK. Learning Disabilities Observatory.
[3] Smoking and People with an Intellectual Disability, 2016: University of Hertfordshire.
[4] Emerson E, 2023: The prevalence of smoking and vaping among adolescents with/without intellectual disability in the UK. Journal of Intellectual Disability Research.

Sources used:

Havering Intelligence Hub – Population Intelligence Briefings

Census - Office for National Statistics (ons.gov.uk)

Hanafin, J., Sunday, S., Shevlin, M. *et al.* Smoking and e-cigarette use in young adults with disabilities. *BMC Public Health* **25**, 1342 (2025). Published in https://doi.org/10.1186/s12889-025-22542-

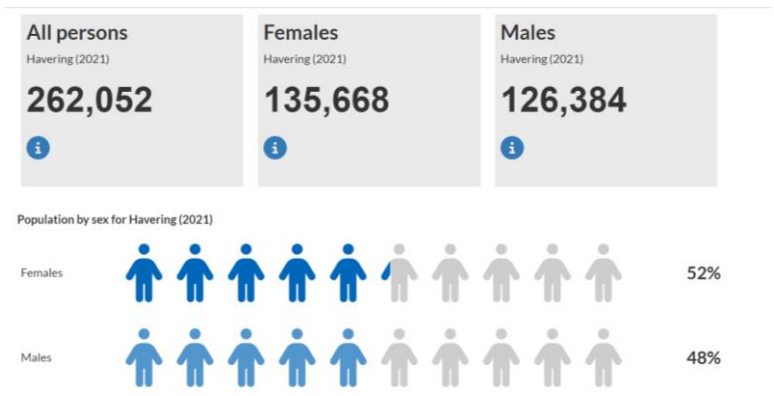
Havering Tobacco Harm reduction Needs Assessment

**Expand box as required*

Protected Characteristic – Sex / gender: Consider both men and women		
Please tick (✓) the relevant box:		**Overall impact:**
Positive	*(✓)*	Data from OHID demonstrates a significant gender disparity in smoking among Havering residents, with a higher proportion of males smoking (22.5%) compared to females (8.5%). This indicates that smoking is 2.5 times more prevalent in males than in females, mirroring trends observed at the national level where 14.6% of men smoke compared to 11.2% of women[5]. Reducing smoking prevalence amongst men is a key priority area of the strategy. Measures to reduce smoking levels amongst men will include developing tailored, intervention around man, particularly for routine and manual workers who tend to be largely men. The strategy therefore is expected to have a positive impact on men and will not disadvantage other genders. **Expand box as required*
Neutral		
Negative		

Evidence:

The 2021 Census showed approximately 262,052 people living in Havering of which, 52% (135,668) are females and 48% (126,384) males.



[5] Office for National Statistics, 2022: Adults smoking habits in Great Britain: 2022.

Gender Identity	Number	Percentage
Gender identity the same as sex registered at birth	196,462	93.67%
Gender identity different from sex registered at birth but no specific identity given	528	0.25%
Trans woman	228	0.11%
Trans man	212	0.10%
Non-binary	60	0.03%
All other gender identities	39	0.02%
Not answered	12,201	5.82%
Total	209,730	100.00%

Source: Office for National Statistics (ONS), Census 2021; Produced by: Havering PHI

**Expand box as required*

Sources used:

Havering Tobacco Harm reduction Needs Assessment
Havering Intelligence Hub – Population Intelligence Briefings
Public Health Profiles: OHID Data.
Office for National Statistics, 2022: Adults smoking habits in Great Britain: 2022.

**Expand box as required*

Protected Characteristic – Ethnicity / race / nationalities: Consider the impact on different minority ethnic groups and nationalities

Please tick (✓) the relevant box:		**Overall impact:**
Positive	(✓)	Analysis of 2023 GP data reveals varying smoking rates among different ethnic groups in Havering, with higher prevalence among the main white population and individuals categorised as 'Other white background' and Irish. Rates of smoking are lowest within African population.
Neutral		
Negative		The strategy is prioritising the main white population and other white groups of high smokers to reduce the smoking prevalence. This will be jointly working with partners, organisations working with men as well as businesses. Obtaining more detailed data of those smoking is key to inform effective intervention across the different ethnic groups. The strategy will prioritise groups affected by smoking and will not disadvantage any group on the basis of ethnicity therefore, overall impact in terms of ethnicity will be positive.

**Expand box as required*

Evidence:
Havering is becoming more diverse. In 2021, White British remains the most common ethnic group in Havering, with 66.5% (174,232) of the population, down from 83.3% (197,615) in 2011. The next most common ethnic group is Asian, accounting for 10.7% (28,150) of the population, up from 4.9% (11,545) in 2011.

According to the 2021 Census, there are approximately 262,052 people living in Havering. White British remains the most common ethnic group in Havering, with 66.5% (174,232) of the population identifying in this group. The next most common ethnic group is Asian, accounting for 10.7% (28,150). Table below shows the ethnic breakdown in Havering according to 2021 census.

Ethnic Group	Havering (Number)	Havering (%)
Asian, Asian British or Asian Welsh	28150	10.7
Black, Black British, Black Welsh, Caribbean or African	21567	8.2
Mixed or Multiple ethnic groups	9747	3.7
White	197314	75.3
Other ethnic group	5274	2.0

Analysis of 2023 GP data reveals varying smoking rates among different ethnic groups in Havering, with higher prevalence among the main white population and individuals categorised as 'Other white background' and Irish, while rates are lowest within the African population.

Detailed breakdown data on groups under "Other White" is lacking but it is likely this group contains nationalities such as such as Eastern Europeans and the Gypsy, Roma and Traveller (GRT) communities, and there is a need for further analysis.
Insights from focus groups undertaken with Havering health visitors suggest higher smoking rates within these populations. They report that pregnant women from these ethnic groups live in households with multiple members of their extended family and family members reportedly actively encourage each other to smoke, which leads pregnant women to feel pressured to continue smoking, as well as exposing them and children to second hand smoke.

**Expand box as required*

Sources used:

Havering Tobacco Harm reduction Needs Assessment
Havering Intelligence Hub – Population Intelligence Briefings
Public Health Profiles: OHID Data.

Protected Characteristic – Religion / faith: Consider people from different religions or beliefs, including those with no religion or belief

Please tick (✓) the relevant box:	
Positive	
Neutral	*(✓)*
Negative	

Overall impact:
There is no evidence that smoking in Havering is linked to religion or faith. The strategy will not disadvantage any group on the basis of faith or religion so the overall impact is deemed as neutral

**Expand box as required*

Evidence:

According to Census 2021, the most commonly reported religion in Havering is Christian, with 52.2% of the total population in 2021 describing themselves as Christian. This is a reduction from 65.6% in 2011. No religion was the second most common response, with 30.6% identifying in this category, up from 22.6% in 2011. Other religions
Accounted for 11.7% of the total Havering population.

*Expand box as required

Sources used:
Havering Intelligence Hub – Population Intelligence Briefings

*Expand box as required

Protected Characteristic - Sexual orientation: Consider people who are heterosexual, lesbian, gay or bisexual

Please tick (✓) the relevant box:	
Positive	*(✓)*
Neutral	
Negative	

Overall impact:

Studies indicate that lesbian, gay, bisexual, and transgender (LGBT) adults are among groups with high smoking rates. The elevated smoking rates among LGBT populations can be attributed to a hostile and homophobic culture that results in stressors due to harassment, discrimination, and victimization. Additionally, tobacco industry documents indicate targeting LGB populations, which is likely to have resulted in increased use.

The strategy aims to support all populations and individuals across Havering to quit smoking and will not disadvantage any group on the basis of sexual orientation. By working with different groups and tailoring intervention to needs the overall impact of the strategy arising from sexual orientation is deemed as positive.

*Expand box as required

Evidence:
There are approximately 4,000 people in Havering identifying as either gay, lesbian or bisexual. This a significant number but proportionately less than the London and England averages.

Table: Estimated number and percentage of persons by sexual orientation, Havering, London and England

Sexual Orientation	Number	%	London	England
Heterosexual or straight	201,700	97.2%	88.9%	93.3%
Gay or lesbian	2,800	1.3%	2.6%	1.6%
Bisexual	1,100	0.5%	1.2%	1.1%
Other	-		0.7%	0.7%
Don't know or refuse	1,200	0.6%	6.5%	3.3%

Whilst there is no specific data on sexual orientation and smoking in Havering wider studies indicate that llesbian, gay, bisexual, and transgender (LGBT) adults are among groups with high smoking rates. The elevated smoking rates among LGBT populations can be attributed to a hostile and homophobic culture that results in stressors due to harassment, discrimination, and victimization. Additionally, tobacco industry documents indicate targeting LGB populations, which is likely to have resulted in increased use

In Great Britain, research findings suggest that inequalities in smoking persist between LGB people and heterosexual populations, and also within LGB groups. Across Great Britain, LGB people in certain areas may be more affected by smoking inequalities, and sexual minority women are amongst the most affected. Anti-smoking policies should therefore need to address these inequalities by taking into account variations by place and recognising that sexual minority populations are more vulnerable.

Among young people, compared with those completely heterosexuals, lesbian/gay, bisexual, and mostly heterosexual youths had their first cigarette at younger ages, and were more likely to be current smokers, with higher frequency of smoking. Sexual-orientation minorities are at greater risk for smoking during adolescence and emerging adulthood than heterosexuals.

**Expand box as required*

Sources used:

Office for National Statistics: Annual Population Survey

Trends in sexual orientation disparities in cigarette smoking: Intersections between race/ethnicity and sex - ScienceDirect

Understanding smoking behaviour in LGB populations across Great Britain: Quantitative analyses using secondary data : https://eprints.soton.ac.uk/469136/

Sexual-Orientation Disparities in Cigarette Smoking in a Longitudinal Cohort Study of Adolescents | Nicotine & Tobacco Research | Oxford Academic

**Expand box as required*

Protected Characteristic - Gender reassignment: Consider people who are seeking, undergoing or have received gender reassignment surgery, as well as people whose gender identity is different from their gender at birth

Please tick (✓) the relevant box:	
Positive	*(✓)*
Neutral	
Negative	

Overall impact:

Whilst there is data on Havering residents who can be classified as transgender there is no local evidence of smoking linked to gender reassignment in Havering. However, wider studies show that transgender and gender-expansive (TGE) people demonstrate elevated tobacco use largely attributed to transphobia.

The strategy aims to support all populations and individuals across Havering to quit smoking and will not disadvantage any group on the basis of gender reassignment. By working with different groups and tailoring intervention to needs the overall impact of the strategy arising from gender reassignment is deemed as positive.

**Expand box as required*

Evidence:
Census 2021 data shows there are over 1,000 residents aged over 16 in Havering who can be classified as transgender.

Detailed breakdown of gender identity in Havering for residents aged 16 and over

Gender Identity	Number	Percentage
Gender identity the same as sex registered at birth	196,462	93.67%
Gender identity different from sex registered at birth but no specific identity given	528	0.25%
Trans woman	228	0.11%
Trans man	212	0.10%
Non-binary	60	0.03%
All other gender identities	39	0.02%
Not answered	12,201	5.82%
Total	209,730	100.00%

Studies show that transgender and gender-expansive (TGE) people demonstrate elevated tobacco use largely attributed to transphobia.
In short, they propose that exposure to enacted, anticipated or internalised transphobia brings about a physiological stress response predisposing to or exacerbating physical illness and psychosocial conditions, which are associated with a greater prevalence of mental illness and participation in health risk behaviours. Cross-sectional and longitudinal evidence from the UK and abroad support the role of minority stress in depression, suicidal ideation or behaviour, smoking, problematic alcohol use and other health conditions

**Expand box as required*

Sources used:

Census - Office for National Statistics (ons.gov.uk)

Transphobia in the United Kingdom: a public health crisis | International Journal for Equity in Health | Full Text

**Expand box as required*

Protected Characteristic – Marriage / civil partnership: Consider people in a marriage or civil partnership

Please tick (✓) the relevant box:		**Overall impact:**
Positive	*(✓)*	There is no local evidence that smoking in Havering is linked to Marriage / civil partnership however, numerous studies point to marriage or civil partnership impacting smoking. Women who had partners, for example, were most likely to stop smoking if their partner also stopped smoking. These results emphasise the importance of a spouse's smoking habits on the likelihood of a smoker successfully quitting smoking. There is a dedicated specialist stop smoking service for pregnant women and their partners/household, including for post-partum support for women following birth to avoid relapse. This specialist service recognises the important role of Marriage / civil partnership on pregnant women quitting smoking or not by offering support to household members or spouse to quit. The strategy is committed to a continuation of specialist stop smoking provision for pregnant women and their household members as well as other
Neutral		
Negative		

		women in marriage/ partnership. Overall, the impact of the strategy on Marriage / civil partnership is deemed to be positive. **Expand box as required*

Evidence:

According to the 2021 census, 1 in 5 homes (21%) have a couple with dependent children while the percentage of households including a couple without children is 13.2%.
Numerous studies point to marriage or civil partnership impacting smoking. A prospective study on Social influences on smoking cessation in mid-life in UK, which examined whether smoking cessation was associated with marital status and smoking habits of a partner, socio-economic status and social participation showed that:

- smokers who had partners at baseline were more likely to quit than those who did not.
- compared to having a partner who smoked throughout, those who had a non-smoking partner throughout were more likely to quit and
- those who had a partner who smoked at baseline but stopped smoking in the next 4 years were even more likely to quit.
- there was no association with cessation for education or deprivation.

These results emphasise the importance of a spouse's smoking habits on the likelihood of a smoker successfully quitting smoking.

**Expand box as required*

Sources used:

Census - Office for National Statistics (ons.gov.uk)

Social influences on smoking cessation in mid-life: Prospective cohort of UK women | PLOS One

**Expand box as required*

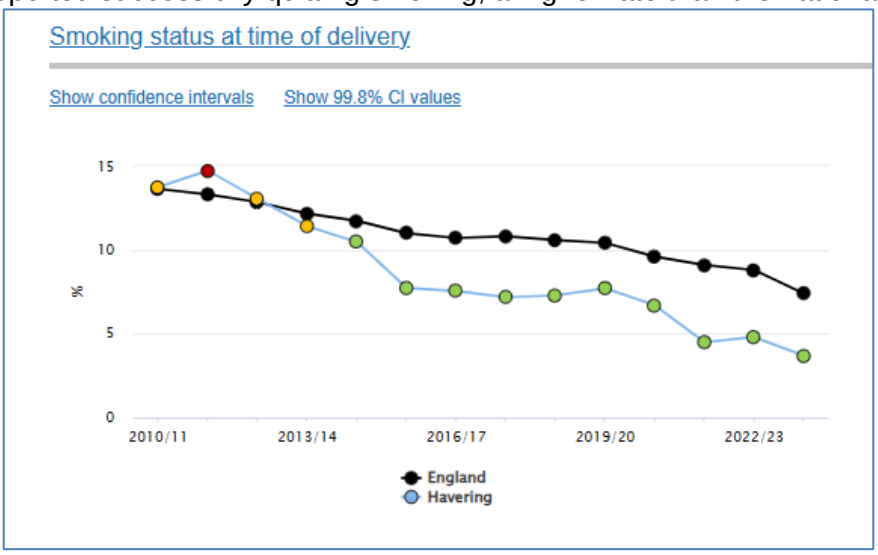
Protected Characteristic - Pregnancy, maternity and paternity: Consider those who are pregnant and those who are taking maternity or paternity leave		
Please tick (✓) the relevant box:		**Overall impact:**
Positive	*(✓)*	Smoking during pregnancy poses significant health risks to both the mother and the unborn child. Pregnant smokers face increased risks of low birth weight (babies are typically 250g lighter), miscarriage (up to three times more likely), premature birth (up to 27% more likely) and stillbirth (twice as likely). Additionally, smoking triples the risk of sudden unexpected death in infancy (SUDI)[6]. There is a dedicated specialist stop smoking service for pregnant women and their household, including post-partum support for women following birth to avoid relapse. This specialist service has contributed to sustained downward trend in smoking amongst pregnant women over time. The strategy is committed to a continuation of specialist stop smoking provision for pregnant women and their household members and to deliver the upcoming legislation on expanding smoke free environment to reduce the number of children exposed to second hand smoke. It will also continue to
Neutral		
Negative		

[6] Action on Smoking and Health, 2018: Smoking in pregnancy challenge group. Review of the Challenge

		prioritise women living in more deprived areas to reduce the inequality of access to stop smoking provision. Overall, the impact of the strategy on Pregnancy, maternity and paternity is positive. *Expand box as required*

Evidence:

Over the past decade, the percentage of pregnant women smoking at the time of delivery in Havering has consistently declined, from 13.1% in 2012/13 to 3.7% in 2023/24. This rate is lower than both London (3.9%) and significantly lower than national average for England (7.4%). Recent NHS Digital data shows that from April 2022 to March 2023, 64% of pregnant women in Havering self-reported successfully quitting smoking, a higher rate than the national average[7].



There is inequality associated with smoking during pregnancy. Nationally, smoking prevalence among pregnant women is markedly higher in disadvantaged groups and younger women (20 years old) compared to older and more affluent groups. Pregnant women in the most deprived areas of England are over five times more likely to smoke than those in the least deprived areas[8].

In Havering, local data from the pregnancy stop smoking service from April 2022 to March 2023 reflects similar disparities in service uptake by age, ethnicity and socio-economic status. Higher uptake were seen in pregnant women and their household members aged 25-35 (67%), followed by those aged 18-24 (18%). The majority were White British (60%) or White other (25%), reflecting the borough's demographic makeup.

Socioeconomically, the majority of service uptake were from more deprived areas of Havering, such as Rainham (25%) and Harold Hill (22%), with 50% in routine and manual occupations and 33% having never worked or being long-term unemployed.

Expand box as required

[7] Statistics on Women's Smoking Status at Time of Delivery: England - NHS England Digital
[8] Royal College of Paediatrics and Child Health (2020). Smoking in pregnancy, State of Child Health.
* e.g. Social Prescribers, Local Area Co-Ordinators, Health Champions

Sources used:
Havering Tobacco Harm reduction Needs Assessment

Smoking Profile - Data | Fingertips | Department of Health and Social Care

Havering Intelligence Hub – Population Intelligence Briefings

**Expand box as required*

Socio-economic status: Consider those who are from low income or financially excluded backgrounds

Please tick (✓) the relevant box:		**Overall impact:**
Positive	*(✓)*	Smoking is strongly associated with socio-economic status. People in more disadvantaged areas are more likely to smoke and less likely to quit. About 1 in 4 people in routine and manual occupations smoke compared with 1 in 10 people in managerial and professional occupations. Those experiencing mental health conditions and those with substance misuse also have higher levels of smoking. Pregnant women from more disadvantaged areas and those younger tend to smoke more compared to pregnant women in older and from more affluent areas. The association between smoking and deprivation underscores the critical role of socioeconomic status in shaping smoking behaviours. Action is already underway to address higher smoking levels in communities living in more deprived parts of the borough through commissioning of community pharmacy stop smoking provision in more deprived locations such as Romford, Harold Hill and Rainham and also, through specialist Adviser led service which priorities support to individuals with higher levels of smoking such as those routine and manual work and those living in rented accommodation. The Strategy aims to continue to prioritise those with lower socio- economic background and emphasis a joined up approach across different organisations with adoption of multi-faceted actions, tailored interventions including bespoke communication to reduce smoking and youth vaping and overall impact is therefore positive. **Expand box as required*
Neutral		
Negative		

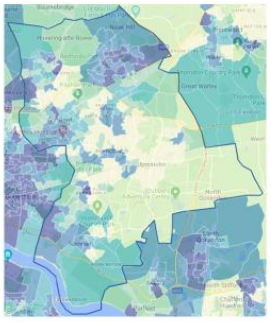
Evidence:

In Havering, smoking prevalence varies across different socioeconomic groups. The tobacco control data over the years shows that residents who have never worked / unemployed long term as well as those in routine and manual occupations have both consistently exhibited higher smoking rates as shown in below table. A large proportion of men are in routine and manual occupations which may account for high rates of smoking in this group.

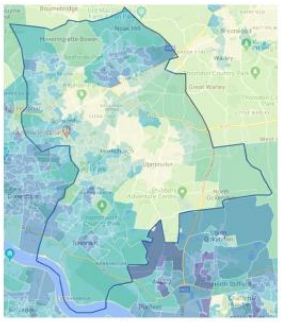
	Managerial and professional	Intermediate	Routine and Manual	Never worked and long term unemployment
2011	19.3%	20.3%	34.7%	19.9%
2012	23.6%	19.1%	25.1%	27.5%
2013	20.7%	20.2%	27.0%	27.5%
2014	17.4%	18.2%	30.8%	31.8%
2015	12.3%	7.8%	31.3%	31.6%
2016	7.9%	16.6%	30.0%	20.7%
2017	5.8%	16.3%	31.3%	25.4%
2018	8.2%	13.7%	27.1%	31.8%
2019	12.0%	13.3%	20.7%	20.1%
2020	12.4%	12.6%	8.6%	15.4%
2021	6.0%	8.1%	11.4%	28.2%
2022	15.4%	16.7%	28.1%	15.0%
2023	11.1%	11.4%	14.4%	12.4%

Source: OHID, based on Office for National Statistics data

Additionally, Havering smokers are disproportionately clustered in more deprived areas. While detailed ward-level analysis for smoking prevalence in Havering is unavailable, Local Insights suggests a clear link between high smoking rates and socioeconomic disadvantage. Local Insights maps indicate that areas characterised by deprivation, rented or social housing and routine and manual occupations tend to have higher smoking prevalence.



Social rented housing (Census 2021)



Routine Occupations (Census 2021)

Source: Havering Local Insight

Further examination of the data reveals striking differences in smoking rates among demographic groups in Havering. For instance, 29% of Havering's residents renting in private housing smoke while 22.5% of social housing tenants smoke. These groups are concentrated in areas with higher levels of deprivation within the borough. The association between smoking prevalence and socioeconomic factors underscores the critical role of socioeconomic status in shaping smoking behaviours within Havering.

Frequency of smoking is also associated with lower socio-economic status. A 2024 survey commissioned by ASH found that daily smoking is more than twice as common in the lowest social group (DE, 12.5%) than in the highest (AB, 5.5%). Lower cigarette consumption per day is associated with higher socio-economic status.

**Expand box as required*

Sources used:

Havering Tobacco Harm reduction Needs Assessment

Smoking Profile - Data | Fingertips | Department of Health and Social Care

Havering Intelligence Hub – Population Intelligence Briefings

ASH Smoke free GB Survey 2024.

**Expand box as required*

Health & Wellbeing Impact: Please use the Health and Wellbeing Impact Tool on the next page to help you answer this question.

Consider both short and long-term impacts of the activity on a person's physical and mental health, particularly for disadvantaged, vulnerable or at-risk groups. Can health and wellbeing be positively promoted through this activity?

Please tick (✓) all the relevant boxes that apply:	
Positive	*(✓)*
Neutral	
Negative	

Overall impact:
Smoking harms nearly every organ of the body and is widely recognised as a leading cause of many preventable illness such as cancer, heart and lung diseases the strategy. The purpose of the strategy is to offer evidence based support to smokers to quit, make smoking less visible, create smoke free environments and tackle vaping among young people.

The ultimate goal of the strategy is to achieve a year-on-year reduction in the level of smoking to improve health and well-being of local residents and it will therefore have an overall positive impact.

**Expand box as required*

Do you consider that a more in-depth HIA is required as a result of this brief assessment? Please tick (✓) the relevant box

Yes ☐ **No** ✓☐

Evidence:

**Expand box as required*

Sources used:

**Expand box as required*

3. Health & Wellbeing Screening Tool

Will the activity / service / policy / procedure affect any of the following characteristics? Please tick/check the boxes below

The following are a range of considerations that might help you to complete the assessment.

Lifestyle YES ☐ NO ☐	**Personal circumstances** YES ☐ NO ☐	**Access to services/facilities/amenities** YES ☐ NO ☐
☐ Diet	☐ Structure and cohesion of family unit	☐ to Employment opportunities
☐ Exercise and physical activity	☐ Parenting	☐ to Workplaces
☐ Smoking	☐ Childhood development	☐ to Housing
☐ Exposure to passive smoking	☐ Life skills	☐ to Shops (to supply basic needs)
☐ Alcohol intake	☐ Personal safety	☐ to Community facilities
☐ Dependency on prescription drugs	☐ Employment status	☐ to Public transport
☐ Illicit drug and substance use	☐ Working conditions	☐ to Education
☐ Risky Sexual behaviour	☐ Level of income, including benefits	☐ to Training and skills development
☐ Other health-related behaviours, such as tooth-brushing, bathing, and wound care	☐ Level of disposable income	☐ to Healthcare
	☐ Housing tenure	☐ to Social services
	☐ Housing conditions	☐ to Childcare
	☐ Educational attainment	☐ to Respite care
	☐ Skills levels including literacy and numeracy	☐ to Leisure and recreation services and facilities
Social Factors YES ☐ NO ☐	**Economic Factors** YES ☐ NO ☐	**Environmental Factors** YES ☐ NO ☐
☐ Social contact	☐ Creation of wealth	☐ Air quality
☐ Social support	☐ Distribution of wealth	☐ Water quality
☐ Neighbourliness	☐ Retention of wealth in local area/economy	☐ Soil quality/Level of contamination/Odour
☐ Participation in the community	☐ Distribution of income	☐ Noise levels
☐ Membership of community groups	☐ Business activity	☐ Vibration
☐ Reputation of community/area	☐ Job creation	☐ Hazards
☐ Participation in public affairs	☐ Availability of employment opportunities	☐ Land use
☐ Level of crime and disorder	☐ Quality of employment opportunities	☐ Natural habitats
☐ Fear of crime and disorder	☐ Availability of education opportunities	☐ Biodiversity
☐ Level of antisocial behaviour	☐ Quality of education opportunities	☐ Landscape, including green and open spaces
☐ Fear of antisocial behaviour	☐ Availability of training and skills development opportunities	☐ Townscape, including civic areas and public realm
☐ Discrimination	☐ Quality of training and skills development opportunities	☐ Use/consumption of natural resources
☐ Fear of discrimination	☐ Technological development	☐ Energy use: CO2/other greenhouse gas emissions
☐ Public safety measures	☐ Amount of traffic congestion	☐ Solid waste management
☐ Road safety measures		☐ Public transport infrastructure

4. Outcome of the Assessment

The EHIA assessment is intended to be used as an improvement tool to make sure the activity maximises the positive impacts and eliminates or minimises the negative impacts. The possible outcomes of the assessment are listed below and what the next steps to take are:

Please tick (✓) what the overall outcome of your assessment was:

(✓)			
	1. The initial screening exercise showed a strong indication that there will be no impacts on people and need to carry out an EHIA. 2. The EHIA identified **no significant concerns** OR the identified **negative concerns** have already been **addressed**		**Proceed with implementation** of your activity
	3. The EHIA identified some **negative impact** which still needs **to be addressed**		**COMPLETE SECTION 5:** **Complete action plan** with measures to mitigate the and finalise the EHIA
	4. The EHIA identified some **major concerns** and showed that it is **impossible to diminish negative impacts** from the activity to an acceptable or even lawful level		**Stop and remove** the activity or **revise** the activity **thoroughly.** **Complete an EHIA on the revised proposal.**

5. Action Plan

The real value of completing an EHIA comes from identifying the actions that can be taken to eliminate/minimise **negative** impacts and enhance/optimise positive impacts. In this section you should list the specific actions that set out how you will mitigate or reduce any **negative** equality and/or health & wellbeing impacts, identified in this assessment. Please ensure that your action plan is: more than just a list of proposals and good intentions; if required, will amend the scope and direction of the change; sets ambitious yet achievable outcomes and timescales; and is clear about resource implications.

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer

Add further rows as necessary

***** You should include details of any future consultations and any actions to be undertaken to mitigate negative impacts.

** Monitoring: You should state how the impact (positive or negative) will be monitored; what outcome measures will be used; the known (or likely) data source for outcome measurements; how regularly it will be monitored; and who will be monitoring it (if this is different from the lead officer).

6. Review

In this section you should identify how frequently the EHIA will be reviewed; the date for next review; and who will be reviewing it.

Review: **Scheduled date of review:** 3/06/2029. **Lead Officer conducting the review:** TBA **Expand box as required*

Please submit the completed form via e-mail to READI@havering.gov.uk
Thank you.

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