Bristol City Council Equality Impact Assessment Form

(Please refer to the Equality Impact Assessment guidance when completing this form)

Name of proposal	Revised commissioning of stop smoking support services
Directorate and Service Area	People/ Public Health
Name of Lead Officer	Viv Harrison, Andrea Dickens

Step 1: What is the proposal?

Please explain your proposal in Plain English, avoiding acronyms and jargon. This section should explain how the proposal will impact service users, staff and/or the wider community.

1.1 What is the proposal?
The proposal is not to renew the current contracts with all providers in Bristol when they end at the end of September 2019. We will then commission a smaller but more targeted service for those with the greatest need of support to quit.

Step 2: What information do we have?

Decisions must be evidence-based, and involve people with protected characteristics that could be affected. Please use this section to demonstrate understanding of who could be affected by the proposal.

2.1 What data or evidence is there which tells us who is, or could be affected?
Smoking In 2017, 11% of Bristol adults smoke, down from 21% in 2012. It is now better than the national average for 2017 of 14.9%.[1] **Hospital admissions** There were over 4,100 smoking-related hospital stays[2] in Bristol in 2016/17, a rate of 2,162 per 100,000 of the population. This is significantly worse than the national average (1,685 per 100,000) and has stayed largely the same as the previous year **Smoking-related deaths** There were 1,745 smoking-attributable deaths[3] in the 3 year period 2014-16. This is a rate of 306 smoking-related deaths per 100,000 which is significantly worse than the England average (272 per 100,000). More work is required to identify the

[1] Annual Population Survey (APS) 2016, via Public Health Outcomes Framework, Feb 2018)
[2] Hospital admissions for diseases that are wholly or partially attributed to smoking in persons aged 35 and over, directly age standardised rate per 100,000 population. Source: Health and Social Care Information Centre, via Bristol Tobacco Control Profile 2016
[3] Source: ONS and smoking status from Integrated Household Survey / Annual Population Survey, plus Health and Social Care Statistics on Smoking – via Bristol Tobacco Control Profile 2018

reasons for this difference.

Smoking cessation services

The rate of "successful quitters at 4 weeks" per 100,000 smokers in Bristol has continued to fall[4] (1,538 per 100,000 in 2016/17). This rate is falling nationally, but Bristol remains significantly lower than the national average rate for smoking quitters (2,248 per 100,000).

There is no data or evidence to suggest that the following groups could be more affected than the general population who are able to access current services.

- Religious Belief
- Gender Reassignments
- Marriage and Civil Partnership

Research on health inequalities indicates the importance of improving access to public health services. The Marmot review recommends using a proportionate universalism approach to delivery of these services. Main population groups that require this level of support include:

- Socio-economic groups from quintiles 3,4 & 5 (highest deprivation areas)
- In deprived wards up to 75% of the smoking population are in the Public Health England 'Support Me' category meaning that they are most likely to need and access specialist support to stop smoking. Local Quality of Life Survey data shows the number of households with a smoker is 21.6%. However, this is significantly higher in the most deprived areas (29.1%). Variation across the city is from 3% of households in Hotwells and Harbourside to 40% in Hartcliffe & Withywood.
- People with mental health issues
    - Over 60% of those experiencing poor mental health smoke (national data)
      People with a diagnosis of Serious Mental Illness (SMI) are twice as likely to die from coronary heart disease which may be contributed to by the higher rates of smoking.
    - Respiratory Disease and COPD are closely linked to smoking prevalence**.** People with a diagnosis of SMI are four times as likely to die from respiratory disease as the general population**.**

The following groups could be affected:

- Gender- Higher rates in men although rates for women have increased over the past 20 years (PHOF).
    - Men are 3 times more likely to have cardiovascular disease which is strongly linked to smoking. A large number of cancers are linked to smoking.
    - Mortality from lung cancer is higher in more deprived areas and particularly in women
- Disability - People with learning disabilities
    - People with learning disabilities are three times more likely to die from respiratory disease. The Confidential Inquiry into premature deaths of

[4] Public Health England, via Bristol Tobacco Control Profile 2018

people with a learning disability [5] found that 38% of people with a learning disability died from an avoidable cause, (9% in comparison population of people without a learning disability. In this context the term an avoidable death is one that could have been avoided by the provision of good quality healthcare.
    - There is no/little data around smoking prevalence or quitting in this group so it is not possible to robustly link smoking to the increased mortality rate. [6]
- Sexual Orientation lesbian, gay, bisexual- c. 25% (ONS 2015 Cigarette smoking by Sexual Identity, by Country (England stats)

The following groups are included in the targeted approach which will be commissioned:

- Age
    - Older smokers are the most likely to suffer from long term conditions linked to their smoking. This group will be included in the targeted approach working with primary and secondary care providers.
    - The outcomes from smoking in pregnancy or smoking in the home with children could impact negatively both on the start in life for the child and as a result on their long term health and wellbeing. This is a key group for the new service.
- Pregnancy or maternity (including breastfeeding)
    - Smoking in pregnancy is highest in more deprived communities and this group is included in the targeted approach. In addition, a waiver is being sought to provide an interim service to this group to ensure service provision in the period between the existing and new contracts.
- Race - Cardiovascular Disease is linked to smoking and also closely linked with deprivation. Some BAME Groups have higher rates of CHD (South Asian) and Hypertension (Stroke) African Caribbean.
- The lowest life expectancy wards in Bristol are inextricably linked to race and poverty with the highest health inequalities and smoking prevalence. Public Health Outcomes Framework (PHOF) data shows that dual heritage populations have the highest prevalence rate of 22.4%. National data also shows high smoking prevalence in the Polish population (27.4% England 2017). There is a significant Polish population in Bristol which could equate to around 1700 Polish smokers.

2.2 Who is missing? Are there any gaps in the data?

Evidence suggests although some population groups with protected characteristics experience the poorest health outcomes, many of these groups are not accessing existing services. Most of the data extracted around these population groups is national as local data is limited in identifying BAME and many other groups with protected characteristics. Despite equality monitoring being included in existing contracts this data is poorly recorded (or often not recorded at all) which makes it difficult to identify if we are reaching the populations with the poorest health

[5] Heslop,P; Blair, P.S,; et al.The Confidential Inquiry into premature deaths of people with intellectual disabilities in the UK: a population-based study.The Lancet, Volume 383, Issue 9920, 2014, Pages 889-895, ISSN 0140-6736, https://doi.org/10.1016/S0140-6736(13)62026-7 .

[6] Steinberg ML, Heimlich L, Williams JM. Tobacco use among individuals with intellectual or developmental disabilities: a brief review. Intellect Dev Disabil. 2009;47(3):197-207.

outcomes. Qualitative data is limited and often excludes those communities who do not currently use our services.
2.3 How have we involved, or will we involve, communities and groups that could be affected?
A public consultation has been undertaken. A workshop is planned to explore approaches for the new targeted service to which stakeholders and representatives of interested groups will be invited.

Step 3: Who might the proposal impact?

Analysis of impacts on people with protected characteristics must be rigourous. Please demonstrate your analysis of any impacts in this section, referring to all of the equalities groups as defined in the Equality Act 2010.

3.1 Does the proposal have any potentially adverse impacts on people with protected characteristics?
There will be some potential adverse impact where the service is not so widely available. However, the new targeted service will provide support to those in more deprived communities where it is most needed. In these wards up to 75% of the smoking population are in the Public Health England 'Support Me' category meaning that they are most likely to need and access specialist support to stop smoking. The lowest life expectancy wards in Bristol are inextricably linked to race and poverty with the highest health inequalities and smoking prevalence. Smoking in pregnancy is also highest in more deprived communities and this is another key targeted group for the new service.
3.2 Can these impacts be mitigated or justified? If so, how?
The revised service provision will be targeted at groups identified as needing most support. Where the reduction in the availability of service may adversely impact on groups, this can be mitigated through a robust and comprehensive commissioning specification. Increased private use of vaping devices (e-cigarettes) could help mitigate the impact on the wider smoking population. The impacts could be mitigated by primary care providing in-house support where needed as part of their routine support of patients. The impacts can be justified as substantial savings need to be achieved which means reductions in public health commissioned services are unavoidable.
3.3 Does the proposal create any benefits for people with protected characteristics?
Yes – there will be more targeted support for groups, including those with protected characteristics, where there is the greatest need to access stop smoking support services.
3.4 Can they be maximised? If so, how?
More targeted support will potentially make the service more available and accessible to some protected groups.

Step 4: So what?

The Equality Impact Assessment must be able to influence the proposal and decision. This section asks how your understanding of impacts on people with

protected characteristics has influenced your proposal, and how the findings of your Equality Impact Assessment can be measured going forward.

4.1 How has the equality impact assessment informed or changed the proposal?
We know that there are currently low levels of access to our services and poorer health outcomes for groups with deprivation and protected characteristics. The more targeted approach could be effective in addressing these issues.
4.2 What actions have been identified going forward?
• A consultation has been undertaken on the proposals and the responses considered in the final proposal. • 55% of respondents agreed or strongly agreed with the proposal. 36% disagreed or strongly disagreed. • Commentators were in agreement that we should focus support to stop smoking service on pregnant women, those with mental health needs and those living in the economically deprived areas. We were asked to work closely with NHS and other partners to explore how support to stop smoking services can be incorporated with mental health services. • Comments were received highlighting the loss of community and voluntary sector provision of stop smoking services, pointing out that these services are currently operating in deprived areas. • There is likely to be a potential impact on local community and voluntary sector providers. However, the new targeted service contract will be developed and delivered in and with communities and local community providers will have opportunities to bid for some of this work.
4.3 How will the impact of your proposal and actions be measured moving forward?
Equality monitoring will be a key specification for all services provided and data used to inform future service improvements.

Service Director Sign-Off:	Equalities Officer Sign Off:
	 Duncan Fleming
Date:15/5/2019	Date: 15/5/2019