Equality Impact Assessment [version 2.12]

Title: Bristol's Targeted Smoking Cessation Service - Commissioning	
☐ Policy ☐ Strategy ☐ Function ☒ Service ☐ Other [please state]	☐ New ☐ Already exists / review ☒ Changing
Directorate: Adults, Children, Education and Public Health	Lead Officer name: Jennifer Davies
Service Area: Public Health	Lead Officer role: Tobacco Control Lead and Senior Public Health Specialist

Step 1: What do we want to do?

The purpose of an Equality Impact Assessment is to assist decision makers in understanding the impact of proposals as part of their duties under the Equality Act 2010. Detailed guidance to support completion can be found here Equality Impact Assessments (EqIA) (sharepoint.com).

This assessment should be started at the beginning of the process by someone with a good knowledge of the proposal and service area, and sufficient influence over the proposal. It is good practice to take a team approach to completing the equality impact assessment. Please contact the Equality and Inclusion Team early for advice and feedback.

1.1 What are the aims and objectives/purpose of this proposal?

Briefly explain the purpose of the proposal and why it is needed. Describe who it is aimed at and the intended aims / outcomes. Where known also summarise the key actions you plan to undertake. Please use plain English, avoiding jargon and acronyms. Equality Impact Assessments are viewed by a wide range of people including decision-makers and the wider public.

The proposal is to allow Bristol City Council to accept the newly allocated funding for local authority smoking cessation services which is newly offered by the Department of Health and Social Care as part of the 'Stopping the Start' command paper. The proposal also seeks cabinet approval to grant delegated authority to procure and to award contract services in line with the funding agreement.

This proposal ensures the expanded provision of smoking cessation services focussing upon the communities in Bristol who are at the highest risk of poor health outcomes and health inequalities in Bristol.

- Tobacco is the one of the most preventable causes of ill health, disability and death, responsible for 1,300 deaths in Bristol each year.
- Total costs of smoking in Bristol are £227.9million every year, accrued across healthcare costs, social care costs, fire service costs, and lost productivity.
- Three-quarters of current smokers would never have started if they had the choice again, and there is strong public support for action: 77% of adults in England support government action to limit smoking or think the government should do more.

The theory of 'proportionate universalism' will be applied to this programme of work, whereby the relative intensity of the resource application is directly informed by the relative need of the populations targeted. All Bristol residents who smoke will be able to acess some level of smoking cessation support or information.

Smoking cessation services will offer target provision to the following high priority groups: pregnant women and those with young families, people from high smoking prevalence wards (typically strongly associated with wards with the highest deprivation), people from Black, Asian and Minoritised Ethnic communities, people referred via NHS health check or Serious Mental Illness physical examinations, and people with long term conditions. The

service will adapt its targeted approach in response to changing population needs and changing healthcare provision.

Communities will be engaged early on and will be closely involved in the design and delivery of smoking cessation interventions, ensuring that this work is appropriate, accessible, and helpful for the people we are trying to support.

1.2 Who will the proposal have the potential to affect?

☒ Bristol City Council workforce	☒ Service users	☒ The wider community
☒ Commissioned services	☒ City partners / Stakeholder organisations	
Additional comments: Future consultation will include strategic leads, practitioners and service users of local partner organisations including local BNSSG Integrated Care Board, North Somerset Council, South Gloucestershire Council and strategic leads at the Office for Health Improvements and Disparities. The resulting recommendations will be incorporated in any decision around spend of the funding allocation.		

1.3 Will the proposal have an equality impact?

Could the proposal affect access levels of representation or participation in a service, or does it have the potential to change e.g. quality of life: health, education, or standard of living etc.?

If 'No' explain why you are sure there will be no equality impact, then skip steps 2-4 and request review by Equality and Inclusion Team.

If 'Yes' complete the rest of this assessment, or if you plan to complete the assessment at a later stage please state this clearly here and request review by the Equality and Inclusion Team.

☒ **Yes**	☐ **No**	[please select]

Step 2: What information do we have?

2.1 What data or evidence is there which tells us who is, or could be affected?

Please use this section to demonstrate an understanding of who could be affected by the proposal. Include general population data where appropriate, and information about people who will be affected with particular reference to protected and other relevant characteristics: How we measure equality and diversity (bristol.gov.uk)

Use one row for each evidence source and say which characteristic(s) it relates to. You can include a mix of qualitative and quantitative data e.g. from national or local research, available data or previous consultations and engagement activities.

Outline whether there is any over or under representation of equality groups within relevant services - don't forget to benchmark to the local population where appropriate. Links to available data and reports are here Data, statistics and intelligence (sharepoint.com). See also: Bristol Open Data (Quality of Life, Census etc.); Joint Strategic Needs Assessment (JSNA); Ward Statistical Profiles.

For workforce / management of change proposals you will need to look at the diversity of the affected teams using available evidence such as HR Analytics: Power BI Reports (sharepoint.com) which shows the diversity profile of council teams and service areas. Identify any over or under-representation compared with Bristol economically active citizens for different characteristics. Additional sources of useful workforce evidence include the Employee Staff Survey Report and Stress Risk Assessment

Data / Evidence Source [Include a reference where known]	**Summary of what this tells us**
Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities (publishing.service.gov.uk)	COVID-19 did not create health inequalities, but rather the pandemic exposed and exacerbated longstanding inequalities affecting Black, Asian and Minoritised Ethnic groups in the UK. Smoking is associated with economic disadvantage, as well as Covid 19 incidence and severity.
Tobacco and Ethnic Minorities - ASH	Nationally, there is a higher smoking prevalence amongst men of mixed ethnicity (22%) than men of white ethnicity (17%). Men are overall more likely to smoke than women, but there is also a higher prevalence of smoking among women of mixed ethnicity (19%) compared to white women (14%).
Health inequalities and smoking - ASH	Smoking is the single largest driver of health inequalities in England. Smoking is far more common among people with lower incomes. The more disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related disease and premature death.
Deprivation and the impact on smoking prevalence, England and Wales - Office for National Statistics	Smoking is far more common amongst people from more deprived communities, with 33% of all smoking adults belonging to the two most deprived population deciles in 2021; compared to 10% belonging to the least deprived population deciles.
Young people and smoking - ASH	The proportion of children who have ever smoked continues to decline. School based education interventions and taxation remain the most popular methods of preventing initiation of smoking.
Bristol Pupil Voice Survey Results	Approximately 2% of secondary school students in Bristol have smoked a cigarette in the previous 7 days (2022).
Overview: NHS Long Term Plan tobacco commitments - ASH	Outlines the NHS ambitions to deliver NHS smoking cessation interventions within maternity, inpatient and mental health settings.
Quality of life in Bristol	The wards in Bristol with the highest prevalence of resident smokers are Hartcliffe and Withywood (31%) and Lawrence Hill (26%).
Pregnant women smokers - Local Maternity Data set	Smoking at Time of Delivery is 8.6%, similar to the England average of 9.1%.
Current provider performance reports (not publicly available)	People from Black, Asian and Minoritised Ethnic communities are underrepresented within the service compared to what could reasonably be expected, based upon prevalence data.
Director of Public Health Report 2021 (bristol.gov.uk)	Gender impact on premature death from cardiovascular disease.
Additional comments: Commissioners have previously funded additional work, in response to inequalities highlighted by Covid, to engage people from Black, Asian and Minoritised Ethnic communities who are currently underrepresented in service. We have been able to evidence some success in reaching people from Black, Asian and Minoritised Ethnic communities and increasing uptake of the service within these groups. There remains room for improvement and the new service will include a focus on ensuring acceptability and accessibility of the service for people from Black, Asian and Minoritised Ethnic communities.	

2.2 Do you currently monitor relevant activity by the following protected characteristics?

☒ Age	☒ Disability	☐ Gender Reassignment
☐ Marriage and Civil Partnership	☒ Pregnancy/Maternity	☒ Race
☐ Religion or Belief	☒ Sex	☐ Sexual Orientation

2.3 Are there any gaps in the evidence base?

Where there are gaps in the evidence, or you don't have enough information about some equality groups, include an equality action to find out in section 4.2 below. This doesn't mean that you can't complete the assessment without the information, but you need to follow up the action and if necessary, review the assessment later. If you are unable to fill in the gaps, then state this clearly with a justification.

For workforce related proposals all relevant characteristics may not be included in HR diversity reporting (e.g. pregnancy/maternity). For smaller teams diversity data may be redacted. A high proportion of not known/not disclosed may require an action to address under-reporting.

Our understanding of the evidence base is restricted on both a national and local level by the quality of the equalities data available. For example, current local smoking cessation data does not have a straightforward way of collecting up-to-date and accurate gender identity data sets, given the age of the software in use and technical possibilities concerned. Within the data collected there are additional gaps, for example – most but not all ethnicities are listed within tick box methods of data collection. In some instances, particularly concerned pregnant women, some data characteristics may not be shared as numbers are so small as to be potentially identifiable. Both providers and commissioners must maintain an awareness of the limitations of the data collection methods in use and continue to make the service as accessible and equitable as possible as well as being led by ongoing feedback from service users and stakeholders.

2.4 How have you involved communities and groups that could be affected?

You will nearly always need to involve and consult with internal and external stakeholders during your assessment. The extent of the engagement will depend on the nature of the proposal or change. This should usually include individuals and groups representing different relevant protected characteristics. Please include details of any completed engagement and consultation and how representative this had been of Bristol's diverse communities.

Include the main findings of any engagement and consultation in Section 2.1 above.

If you are managing a workforce change process or restructure please refer to Managing a change process or restructure (sharepoint.com) for advice on consulting with employees etc. Relevant stakeholders for engagement about workforce changes may include e.g. staff-led groups and trades unions as well as affected staff.

Future consultation will include strategic leads, practitioners and service users of local partner organisations including local BNSSG Integrated Care Board, North Somerset Council, South Gloucestershire Council and strategic leads at the Office for Health Improvements and Disparities. The resulting recommendations will be incorporated in any decision around spend of the funding allocation.
Existing needs analysis will be utilised wherever applicable, to build upon survey results i.e. People Power engagement, Lawrence Hill art research, Maternity Equity Audit 2022, Beezeebodeez Healthy Weight pilot; and feedback will be used to inform the commissioning of the new service.
Commisisoners will work closely with BCC Communities team and Community Health Champions to maximise opportunities to work with our target populations and design an intervention which works for them.
Provider(s) of smoking cessation services will be required to engage with communities for both design of interventions and also evaluation of service delivery.

2.5 How will engagement with stakeholders continue?

Explain how you will continue to engage with stakeholders throughout the course of planning and delivery. Please describe where more engagement and consultation is required and set out how you intend to undertake it. Include any targeted work to seek the views of under-represented groups. If you do not intend to undertake it, please set out your justification. You can ask the Equality and Inclusion Team for help in targeting particular groups.

Providers of smoking cessation services will be required to work very closely with identified high-risk communities to build upon existing community assets, and support and motivate these groups of people to take action to improve their health and stop smoking. This will require ongoing engagement with priority groups, likely in the form of focus groups, surveys, service user feedback etc (this will form part of the providers bid and subsequent contract). The service will build upon knowledge gained from community focussed work undertaken with priority groups elsewhere within the Bristol public health team, particularly the Black, Asian and Minoritised Ethnic communities work undertaken by BeezeeBodeez around healthy weight.

A collaborative, community-focussed approach will utilise skills and resources of Bristol Community Health Champions to deliver smoking cessation interventions and related support. Health Champions are motivated and enthusiastic Bristol residents who are empowered and supported to work within their communities to effect change.

Opportunities for a 'test and learn' pilot scheme with a local provider to work with communities to collaboratively design and deliver smoking cessation interventions with communities and for communities will be explored. Any launch of this scheme will include careful evaluation.

Step 3: Who might the proposal impact?

Analysis of impacts must be rigorous. Please demonstrate your analysis of any impacts of the proposal in this section, referring to evidence you have gathered above and the characteristics protected by the Equality Act 2010. Also include details of existing issues for particular groups that you are aware of and are seeking to address or mitigate through this proposal. See detailed guidance documents for advice on identifying potential impacts etc. Equality Impact Assessments (EqIA) (sharepoint.com)

3.1 Does the proposal have any potentially adverse impacts on people based on their protected or other relevant characteristics?

Consider sub-categories and how people with combined characteristics (e.g. young women) might have particular needs or experience particular kinds of disadvantage.

Where mitigations indicate a follow-on action, include this in the 'Action Plan' Section 4.2 below.

GENERAL COMMENTS (highlight any potential issues that might impact all or many groups)	
Wherever the service comes into contact with a person who is smoking but who does not meet the eligibility criteria for access to treatment, they will receive a brief intervention in smoking cessation and be signposted to free online NHS smoking cessation resources and interventions to support nicotine detoxification I.e. licenced nicotine replacement therapy, or electronic cigarettes.	
PROTECTED CHARACTERISTICS	
Age: Young People	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	Service is available to anyone aged 13 or over as per national protocols however they tend to be unattractive to young people. It is unlikely that a smoking addicted young person will want to reach out to a smoking cessation service.
Mitigations:	Additional work will be undertaken to support young people who want to stop smoking, such as Healthy Schools, training and education for Health Visitors and School Nurses, the establishment of a Children and Young Peoples Illegal Tobacco Action Group to facilitate wider multidisciplinary working that is likely to be more effective at tackling smoking amongst young people.
Age: Older People	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	It is possible that older adults could be less inclined or less confident to engage with the service digitally or via telephone. Older adults may be less likely to encounter any promotion from the service that is digital or online.
Mitigations:	The service will offer face to face interventions for anyone who prefers this, including older adults. The service will develop strong working relationships with primary care

	services to ensure that those in contact with older adults who meet the requirements for service eligibility can be referred (if they are less likely to call or go online to self refer).
Disability	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	Disabled people with long term conditions and/or disability are more likely to be targeted by the service for both promotional purposes and to receive interventions from health professionals which lead to referral to the service. Given the association between smoking prevalence and deprivation, people who are disabled and/or have long term health issues and may experience higher levels of deprivation are more likely to access the service and to be a recipient of any promotional activity. All promotion and engagement will be undertaken in a sensitive non judgmental manner and will remain entirely optional. The provider will be required to ensure that the service is entirely accessible to Disabled people and that reasonable adjustments are made, in line with BCC contract conditions as a minimum.
Mitigations:	
Sex	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	As there is a generally higher smoking prevalence amongst men than women, men may be more likely to be targeted by the service for both promotional purposes and to receive interventions from health professionals which lead to referral to the service. Smoking is one of the many risk factors for cardiovascular disease. Premature death from cardiovascular disease disproportionately affects men at both a local and national level. All promotion and engagement will be undertaken in a sensitive non-judgmental manner and will remain entirely optional.
Mitigations:	
Sexual orientation	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	People who identify as lesbian, gay, bisexual or other non-heterosexual sexualities are statistically more likely to smoke compared to heterosexual people. The service commissioned is targeted and not universal, therefore not all LGB+ people will be eligible for a service.
Mitigations:	People of any sexual orientation must be made welcome and safe within the service. The service will be asked to explore opportunities to ensure that they are inclusive employers and to ensure they visibly make LGB+ people feel welcome i.e. environmental cues. For LGB+ people not eligible for the service, they can be signposted to free online NHS resources and/or over-the-counter medication to support their quit attempt.
Pregnancy / Maternity	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	Pregnant women are the priority target population for the service, and they will represent a significant proportion of the service user population. Women will be receiving an intervention as part of their medical care within NHS maternity services or they can self-refer to the service. Smoking during pregnancy has lifelong negative impacts upon the health of the child, such as an increased risk of several respiratory conditions, learning difficulties, attention/hyperactivity problems, obesity, diabetes, and complications of ear nose and throat health.
Mitigations:	Participation in smoking cessation interventions is voluntary and informed consent is obtained. Women are able to withdraw consent and remove themselves from treatment at any time with impunity. The service works closely with maternity services to ensure that all interventions are delivered in a sensitive and compassionate, non-judgmental manner. All service staff to receive specialist training in supporting pregnant women to stop smoking.
Gender reassignment	Does your analysis indicate a disproportionate impact? Yes ☐ No ☐
Potential impacts:	People who have undergone gender reassignment are statistically more likely to smoke compared to cisgender people. The service commissioned is targeted and not universal, therefore not all transgender people will be eligible for a service.

	People of any gender must be made welcome and safe within the service. The service will be asked to explore opportunities to ensure that they are inclusive employers and to ensure they visibly make transgender people feel welcome i.e. environmental cues. For transgender not eligible for the service, they can be signposted to free online NHS resources and/or over-the-counter medication to support their quit attempt.
Mitigations:	
Race	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	There is a higher smoking prevalence amongst men and women from mixed ethnicities compared to white ethnicities. This means that smoking harms are also more likely amongst people from mixed ethnic backgrounds. The service may at times target provision towards geographical locations and/or community assets that are frequented by people from Black, Asian and Minoritised Ethnic community backgrounds.
Mitigations:	The service will build upon the existing evidence base and work closely with other community assets to engage with people in a positive, respectful and culturally sensitive manner. Engagement will be undertaken to understand how this can be done, both as part of service design and a part of ongoing service delivery.
Religion or Belief	Does your analysis indicate a disproportionate impact? Yes ☐ No ☒
Potential impacts:	
Mitigations:	
Marriage & civil partnership	Does your analysis indicate a disproportionate impact? Yes ☐ No ☒
Potential impacts:	
Mitigations:	
OTHER RELEVANT CHARACTERISTICS	
Socio-Economic (deprivation)	Does your analysis indicate a disproportionate impact? Yes ☒ No ☐
Potential impacts:	Smoking is far more common among people with lower incomes. The more disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related disease and premature death. The service may apply the theory of proportionate universalism and target more intensive promotion and engagement activities within areas of higher deprivation in Bristol, as these areas are likely to have a higher proportion of people smoking, who want help to stop smoking, and would benefit their health significantly by stopping smoking.
Mitigations:	Community based work will be undertaken along with existing community assets to ensure that any targeted engagement is done in a sensitive and appropriate manner. Engagement with the service will remain voluntary.
Carers	Does your analysis indicate a disproportionate impact? Yes ☐ No ☒
Potential impacts:	
Mitigations:	
Other groups [Please add additional rows below to detail the impact for any other relevant groups as appropriate e.g. asylum seekers and refugees; care experienced; homelessness; armed forces personnel and veterans]	
Potential impacts:	
Mitigations:	

3.2 Does the proposal create any benefits for people based on their protected or other relevant characteristics?

Outline any potential benefits of the proposal and how they can be maximised. Identify how the proposal will support our Public Sector Equality Duty to:

- ✓ Eliminate unlawful discrimination for a protected group
- ✓ Advance equality of opportunity between people who share a protected characteristic and those who don't
- ✓ Foster good relations between people who share a protected characteristic and those who don't

The service will advance equality of opportunity between people who share a protected characteristic and those who don't, as it will work to remove the single largest determinant of health inequalities – smoking. Improved health outcomes are associated with improved quality of life, educational attainment, employment etc. REF

Step 4: Impact

4.1 How has the equality impact assessment informed or changed the proposal?

What are the main conclusions of this assessment? Use this section to provide an overview of your findings. This summary can be included in decision pathway reports etc.

If you have identified any significant negative impacts which cannot be mitigated, provide a justification showing how the proposal is proportionate, necessary, and appropriate despite this.

Summary of significant negative impacts and how they can be mitigated or justified:

Young people are unlikely to choose to access support to stop smoking services for help to stop smoking. Young people aged 13+ will be offered a sensitive and appropriately tailored intervention wherever required. Additional tobacco control work is already undertaken by Public Health and will continue to ensure that other more acceptable and affective avenues of support are provided to young people.

The service will mainly be delivered digitally which could negatively impact some older people, for this reason the service will continue to offer face to face or telephone support to anyone who would prefer this method of communication.

People who identify as lesbian, gay, bisexual, or other sexuality, or who have undergone gender reassignment, are statistically more likely to smoke compared to heterosexual and/or cisgender people. The service will ensure it offers an LGBT+ friendly service provision wherever people meet the eligibility criteria and will display environmental cues indicating a safe space.

Pregnant women will be a priority population for the service due to the very significant risk of harm that smoking presents to the mother, the unborn child, and the child after birth. The service will collaborate with maternity services to engage women in a sensitive and non-judgmental manner and all treatment will remain optional. All service staff to receive specialist training in supporting pregnant women to stop smoking.

People from mixed ethnic backgrounds have been demonstrated as more likely to smoke than people from white backgrounds. For this reason, the service may at times target provision towards geographical locations and/or community assets that are frequented by people from these ethnic backgrounds. The service will build upon the existing evidence base and work closely with other community assets to engage with people in a positive, respectful, and culturally sensitive manner.

The service may at times target geographical locations based upon there being higher levels of deprivation, which is strongly associated with higher levels of smoking. Men with long term conditions exacerbated by smoking may be more likely to receive an intervention from the service given that men are more likely to smoke than women. Community based work will be undertaken along with existing community assets to ensure that this work is done in a sensitive and appropriate manner. Engagement with the service will remain voluntary.

Summary of positive impacts / opportunities to promote the Public Sector Equality Duty:

The service will advance equality of opportunity between people who share a protected characteristic and those who don't, as it will work to remove the single largest determinant of health inequalities – smoking.

4.2 Action Plan

Use this section to set out any actions you have identified to improve data, mitigate issues, or maximise opportunities etc. If an action is to meet the needs of a particular protected group please specify this.

Improvement / action required	Responsible Officer	Timescale
Service specification to include instruction for: • Face to face service provision available upon request by service user. • Close working with maternity services to support pregnant women appropriately • Staff trained in supporting pregnant women (NCSCT package) • Service to work in a community asset-based manner, focussing on collaboration with community groups who represent our priority populations	Jennifer Davies	September 2023
Service to explore opportunities to sign up to a visible support scheme or similar, with approval from commissioners, and ensure LGB+ people feel welcome to both work in and receive a service from the provider.	Jennifer Davies/Service Provider	April 2024 and ongoing
Service to work collaboratively with community assets to co-produce elements of service delivery in order to maximise engagement with underrepresented groups i.e. people from Black, Asian and Minoritised Ethnic communities.	Jennifer Davies/Service Provider	April 2024 and ongoing

4.3 How will the impact of your proposal and actions be measured?

How will you know if you have been successful? Once the activity has been implemented this equality impact assessment should be periodically reviewed to make sure your changes have been effective your approach is still appropriate.
Key performance indicators will be designed to understand how well the service is engaging with and supporting people with protected characteristics including what their treatment outcomes may look like compared to those without protected characteristics. This will be reported quarterly to commissioners and the provider and commissioner will work together, drawing upon other national and local resources as needed to improve service provision.

Step 5: Review

The Equality and Inclusion Team need at least five working days to comment and feedback on your EqIA. EqIAs should only be marked as reviewed when they provide sufficient information for decision-makers on the equalities impact of the proposal. Please seek feedback and review from the Equality and Inclusion Team before requesting sign off from your Director[1].

Equality and Inclusion Team Review: ***Reviewed by Equality and Inclusion Team***	**Director Sign-Off:** Christina Gray C A Gray
Date: 9th November 2023	Date: 9th November 2023

[1] Review by the Equality and Inclusion Team confirms there is sufficient analysis for decision makers to consider the likely equality impacts at this stage. This is not an endorsement or approval of the proposal.