Equality Impact Assessment

What is an Equality Impact Assessment (EIA) and why does the County Council do them?

The Public Sector Equality Duty (PSED) is an obligation within the Equality Act 2010 ("the Act"), which asks public authorities, like Hampshire County Council, to give 'due regard' to equality considerations, in particular to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.

- Advance equality of opportunity between people who share a protected characteristic and those who do not.

- Foster good relations between people who share a protected characteristic and those who do not.

This includes assessing the impact of policies and practices on individuals and communities with a protected characteristic, as defined in the Act and some other specific groups. The County Council uses EIAs to ensure it has paid 'due regard' to equalities considerations when there are changes to a service or policy, a new project or certain decisions.

EIA author	**Position & Department**	**Contact**
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Title:	Smokefree generation program and services
Related EIAs:	None

EIA for Savings Programme:	No
Service affected	Tobacco control programs: smoking prevention and cessation programs and services
Description of the service/policy/project/project phase	In October 2023, the government announced new grant funding to public health local authority teams as part of their ambition to create a Smokefree Generation by 2030 (where adult smoking prevalence is less than 5%). Hampshire County Council's annual allocation of the Smokefree Generation Grant amounts to £1,381,823 from 06 April 2024 through to 05 April 2029, which should be spent on specialist smoking cessation. Allocations are based on local smoking prevalence and it is anticipated that allocations will remain similar each year.
New/changed service/policy/project	The aims of the programs and services are to reduce smoking prevalence, to achieve the national and local target where adult smoking prevalence is less than 5%. The funding will ensure continued provision of specialist smoking cessation services to help smokers quit and also increase the quality, reach, and capacity of tobacco control programs and services, in order to improve health outcomes and reduce inequalities. The programs of work will address the three Tobacco Control Strategic aims, which are: - Helping smokers quit - Creating smokefree communities - Preventing smoking in young people

Engagement
Whilst no formal consultation was undertaken, some engagements have taken place via the Smokefree Hampshire Tobacco Control Alliance and the stop smoking services. An Alliance workshop was conducted in December 2023, and this was attended by various stakeholders across Hampshire, including NHS, education, voluntary and community sector organisations, housing, local authorities. Stakeholders were invited to take part in the discussions relating to proposals for tobacco control projects, programs and ways of working to meet the three strategic priorities (help smokers quit, create smokefree communities, prevent smoking uptake in young people) and use of the national funding. As part of the workshop, a survey was also sent to the stakeholders to provide their views. The information gathered from the workshop and the survey has been reviewed and will contribute to the development of proposals for the programs of work. Furthermore, the Hampshire tobacco control strategy which will guide this work was informed by client feedback, and ongoing insights work with local residents and workforce.

Equalities considerations - Impact Assessment

Age

Impact on public	Positive
Impact on staff	Positive
Rationale	Smoking affects people of all ages, both directly and indirectly through passive smoking. Smoking prevalence is strongly related to age. The smoking prevalence in the UK is higher among younger adults compared with older adults. Office for National Statistics ONS 2022 data shows that those aged 25-34 had the highest proportion of smokers (16.3%), whereas those aged 65 and over had the lowest proportion of current smokers (8.3%). In addition, according to NHS Stop Smoking Service data (2022/23), success at quitting smoking increases with age. 46.5% of those aged under 18 successfully quitting, compared to 57.0% of those aged 60 and over. In terms of quit attempts, there was no clear pattern by age, however the largest number of quit attempts came from the 45-59 year old age group (making up 33% of all attempts). **Children and young people** Children who live in households with smokers are often exposed to second-hand smoke which has a detrimental effect on their health. They are also more likely to become smokers, compared with those from non-smoking households. Most smokers start smoking in their teenage years and the earlier they start smoking, the more likely they are to smoke for longer and die prematurely. About two-thirds of adult smokers reported that they took up smoking before the age of 18 and over 80% before the age of 20 (Action on smoking and health ASH). Hence there is need to work to prevent the uptake of smoking by young people and also create smokefree communities and households to reduce exposure to second-hand tobacco smoke, and prevent intergenerational transmission of smoking. Also, there has been an increase in vaping in young people and this has raised various health, social and environmental issues. Vaping is currently recommended as a quit aid for smokers however, children and young people should not vape. Both tobacco and vape products are age restricted, and it is illegal to sell them to a person under 18 or proxy purchases for anyone under 18. Hence programs of work aimed at restricting access to tobacco products (including vapes) and prevention of smoking and

	vaping in young people are a key part of the tobacco control programs. The tobacco control programs and services will embed quality and diversity to meet the needs of different age groups.
Mitigation	

Disability

Impact on public	Positive
Impact on staff	Neutral
Rationale	There is a significant association between smoking and disability, with people who have ever smoked being 2.35% more likely to be disabled than those who have never smoked (ASH). Evidence shows that smoking prevalence is higher in people with mental health conditions and that smoking rates increase with the severity of the illness. In addition, people with mental health conditions smoke significantly more, have increased levels of nicotine dependency, and are therefore at even greater risk of smoking-related harm. This population group also suffer high levels of inequalities in health outcomes and they have higher levels of mortality rates compared to the general population, partly attributed the high smoking rates (ASH). The smoking prevalence in adults with a long-term mental health condition is 19.6% in Hampshire, compared to 10.2% in the general population. However there are great variations across the county, with prevalence of smoking in adults with long term mental health conditions ranging from 29.2% in Gosport to 12.% in Winchester. Furthermore, evidence has shown that mental health professionals have reported reluctance to engage with patients about smoking, which is likely to have an effect on service users who may benefit from quitting (ASH). The tobacco control program and services will contribute towards improving pathways for smoking cessation and providing specialist stop smoking services which will include targeted priority groups. People with serious mental health conditions are one of the priority groups for the specialist smoking cessation service with the aim to reduce smoking rates in this population group using various evidence based interventions. The service will continue to provide personalised support to help smokers quit through behavioural support and Nicotine Replacement Therapies (NRT) (including vaping). This will also include the provision of accessible services and outreach services to areas and populations with high smoking rates. Equality and diversity policies will be embedded throughout the programs and policies to ensure adequate support for smokers to quit and prevent passive smoking.

Mitigation	

Gender Reassignment

Impact on public	Neutral
Impact on staff	Neutral
Rationale	No data on gender reassignment inequalities related to smoking. The tobacco control programs and services offered will not be affected or influenced by a person's gender reassignment. Equality and diversity policies will be embedded throughout the programs and policies to ensure adequate support for smokers to quit and prevent passive smoking.
Mitigation	

Pregnancy and Maternity

Impact on public	Positive
Impact on staff	Neutral
Rationale	Smoking during pregnancy can cause serious pregnancy related health problems for mother and baby including still birth, premature birth, eclampsia, and low birthweight. Smoking prevalence in pregnancy among women is higher among those aged under 20 compared to older women. Pregnant women in routine and manual occupation groups are more likely to smoke in women from managerial and professional occupations (Department of Health and Social Care DoH). In Hampshire the number of women recorded as smoking at the time of delivery is 8.6%, which is similar to the England average of 8.8% and the South East region (8.1%). Reducing smoking prevalence during pregnancy is a key national and local priority. The tobacco control programs and services will include evidence based targeted specialist support for pregnant women to support them to quit during pregnancy and to quit for

	good, to minimise risk to their health and their baby's health. This also includes raising awareness of the harms of smoking and passive/second hand smoke in pregnancy. Equality and diversity policies will be embedded throughout the programs and policies to ensure adequate support for smokers to quit and prevent passive smoking.
Mitigation	

Race

Impact on public	Positive
Impact on staff	Neutral
Rationale	Tobacco use causes health problems across all ethnicities, but the way people from different ethnicities use tobacco varies (ASH) Some ethnic minorities are more likely to use smokeless tobacco (predominantly South Asian communities in the UK) and shisha pipes (particularly Middle Eastern and South Asian Britons). However smoking remains the most common form of tobacco use in all communities. There is evidence of variations in smoking rates by ethnicity with higher smoking prevalence certain ethnic minority groups and between men and women within the ethnic groups. Data from the England Health survey (2019) shows that the proportion of current smokers varied with ethnicity, between 11% and 32% for men and between 2% and 23% for women. An analysis of the Annual Population Survey data (2019) found that the percentage of adults who smoked was higher than average in the Mixed (19.5%) and White (14.4%) ethnic groups. It was lower than average in the Chinese (6.7%), Asian (8.3%) and Black (9.7%) ethnic groups The Hampshire population is less diverse than England as a whole. Around 92.6% of residents identified themselves as belonging to White ethnic groups compared to the national average of 81%. 3.8% identified as Asian, Asian British, or Asian Welsh, 1.9% as mixed or multiple ethnicity groups and 1% as Black, Black British, Black Welsh, Caribbean or African. Urban areas tend to have higher ethnic diversity. The tobacco control strategy on which all the tobacco control programs and services will be anchored aims to reduce health inequalities through coordinated action across all partners to help smokers quit, reduce the risks of second-hand smoke and also reduce the prevalence of smoking across all ethnicity. This includes targeted interventions that are tailored to specific groups and are culturally sensitive and acceptable to the communities. Equality and diversity policies will be embedded throughout the programs and policies to ensure adequate support for smokers to quit and prevent second hand smoking.

Mitigation	

Religion or Belief

Impact on public	Positive
Impact on staff	Neutral
Rationale	Some evidence suggest that smoking prevalence varies by religion. An analysis of health outcomes of people of different religious identities in England and Wales showed that in 2016 to 2018 smoking prevalence was significantly higher among those identifying as having no religion (18%) than those who identified as Muslim (11%), Christian (11%), Hindu (5%), Jewish (4%), Sikh (2%), or with "any other religion" (9%) (ONS). According to the Census 2021 data, 42.8% people in Hampshire identified themselves as having no religion, 47.8% as Christian, Hindu 1.4% and less that 1% for each of the other religions (5.71% did not respond to the question) (Hampshire JSNA). Tobacco control programs and services will support people regardless of their religion and these will embed equality and diversity policies. This includes targeted interventions that are tailored to specific groups and are culturally sensitive and acceptable to the communities. Equality and diversity policies will be embedded throughout the programs and policies to ensure equality of access to help smokers quit and prevent second hand smoking.
Mitigation	

Sex

Impact on public	Positive
Impact on staff	Neutral
Rationale	In the UK, men are more likely to smoke than women. In 2022, 14.6% of men reported as current smokers, compared with 11.2% of women; this difference has been consistent since 2011 (ONS).

	In terms of vaping, a higher proportion of men aged 16 and over reported vaping daily or as an occasional user (9.5%), compared with women (7.9%). However, there has been a significant increase in the proportion of females aged 16-24 years who were reported as daily e-cigarette users in 2022 (6.7%), compared with 1.9% in 2021 (ONS 2022). The tobacco control programs and services will be available equitably to meet the diverse range of people irrespective of a person's gender/sex. The tobacco control strategy on which all the tobacco control programs and services will be anchored aims to reduce health inequalities through coordinated action across all partners. This includes targeted interventions that are tailored to specific groups most in need, for example, pregnant women and the provision of services, and services. The services and programs will therefore work to support individuals from priority groups and use a range of locations, formats (i.e. face to face and online), and times for smoking cessation activities, providing greater flexibility in accessing services. Equality and diversity policies will be embedded throughout the programs and policies to ensure adequate support for smokers to quit and to prevent second hand smoking.
Mitigation	

Sexual Orientation

Impact on public	Positive
Impact on staff	Neutral
Rationale	Some evidence shows that Lesbian, gay, bisexual and transgender (LGBT) people are more likely to smoke than the general population. Rates are particularly high for LGBT women and bisexual men, with the inequality particularly pronounced when compared with heterosexual women and men (ONS, 2019). According to the 2021 census, 91.3% of people in Hampshire identified as straight or heterosexual, 1.2% as gay or lesbian, 1.1% as bisexual (6.2% did not answer the question) The tobacco control programs and services will meet the needs of all people regardless of sexual orientation. In addition, some programs and services will be tailored to ensure equal access to service. These will also work to encourage openness and use inclusive language. The tobacco control strategy on which all the tobacco control programs and services will be anchored aims to reduce health inequalities through coordinated action across all partners to help smokers quit, reduce the risks of second-hand smoke and smoking prevalence. Equality and diversity policies will be embedded throughout the programs and policies.

Mitigation	

Marriage and Civil Partnership

Impact on public	Neutral
Impact on staff	Neutral
Rationale	Smoking, including passive smoking, affects everyone. Spouses who smoke or those who live with a spouse or a member of the household who smokes are likely to be harmed by the exposure to the tobacco smoke. Tobacco control programs and services will be provided to individuals irrespective of their marital or civil partnership status. Some programs and services will be extended to support other members of the household to stop smoking or become smokefree, for example, if a pregnant woman lives in a household with a smoker, the offer for support is often extended to the smokers in the household. However, this is provided irrespective of relationship status. Equality and diversity policies will be embedded throughout the programs and policies to ensure equality of access irrespective of an individual's marriage or civil partnership status.
Mitigation	

Poverty

Impact on public	Positive
Impact on staff	Neutral
Rationale	Evidence shows that there are significant inequalities in smoking and health outcomes, with smoking rates almost three times higher among those on the lowest incomes compared to those on the highest income. Those in routine and manual occupations are more likely to smoke compared to those in managerial and professional groups. Similarly, smoking prevalence is higher in the most deprived neighbourhoods compared with the least deprived. In 2021, approximately one-third (33.1%) of all smoking adults in England lived in the two most deprived deciles (ONS). In addition, although smokers from more deprived

	communities are just as motivated to quit smoking as other smokers, they tend to be more heavily addicted and face greater barriers to quitting, such as effects of poverty. As a result, they are less likely to be successful quitters. Smoking also adds financial burden to individuals and households, further exacerbating the inequalities. Whilst Hampshire is a relatively affluent county, there are areas of deprivation where populations experience worse health outcomes and smoking rates are higher. Hampshire is the 16th least deprived upper tier local authority in England (rank out of 151 authorities). The most deprived areas in Hampshire are in Rushmoor, Havant, Gosport and Eastleigh, with pockets also in the New Forest. Adult (18+) smoking prevalence is particularly high in Rushmoor, Gosport. 2021/22 Quality and Outcomes Framework (QOF) data, which is based on GP level data (meaning captures those who are registered with a GP) also shows high smoking prevalence in Havant, Gosport, and Rushmoor for those aged 15+. Tobacco control programs and services will work to support people to stop smoking, and become smokefree to reduce the impact of smoking on health as well as reduce the cost. The provision of free services, including specialist services and evidence based support such as NRT and vape starter kits for free will help support smokers to quit and lessen the financial burden of quitting smoking or becoming smokefree. The specialist services and other programs will offer targeted support and extended reach particularly for those in areas of deprivation and routine and manual occupations. The services and programs will therefore work to support individuals from priority groups and use a range of locations, formats (i.e. face to face and online), and times for smoking cessation activities, providing greater flexibility in accessing services. Equality and diversity policies will be embedded throughout the programs and policies to ensure adequate support for smokers to quit and prevent second-hand smoking.
Mitigation	

Rurality

Impact on public	Positive
Impact on staff	Neutral
Rationale	Hampshire is a diverse county with large rural areas, which could make it a challenge for some people to access services, including smoking cessation services. There are rural communities throughout Hampshire County of varying sizes, with largest numbers residing in Winchester, Test Valley, New Forest, Basingstoke and Deane, and East Hampshire. According to the Joint Strategic Needs Assessment (JSNA), the population density varies greatly across the county, from 190.5 people per square kilometre in Winchester to 3,337.3

	people per square kilometre in Gosport. Nearly 22% of the population of Hampshire was categorised as living in rural areas. Hampshire's rural communities have a higher proportion of older people, and a smaller proportions of young adult age groups compared to the urban population. Rural areas tend to have better health outcomes compared with urban areas. This often masks small pockets of rural deprivation and associated poor health outcomes. This also includes issues around accessibility of health and care services, transport issues, and digital access or exclusion in some areas. The tobacco control programs and services will support all people living in rural and urban areas. This includes provision of online services, outreach service offer and working with local partners to ensure the services and programs reach those in rural areas and improve equal access to services/programs.
Mitigation	

Geographical Impact:All Hampshire

Equality Statement

Additional information:

Smoking continues to be the most important cause of preventable ill health and premature death, and main driver of health inequalities in Hampshire. Smoking is a major risk factor for many diseases such as lung cancer, chronic obstructive pulmonary disease, and heart disease. It is also strongly linked with cancers in other organs, including the lip, mouth, throat, bladder, kidney, stomach, liver, and cervix. Smoking is no longer considered a lifestyle choice but a preventable addiction that requires treatment. Effective tobacco control measures can reduce the rates of smoking in the population by preventing uptake in non-smokers and by supporting current smokers to quit and normalising smokefree environments.

The current tobacco control programs and services are consistent in using the principle of proportionate universalism to address the social gradient in health and associated inequalities by providing the different levels of support required to enable all residents to access tobacco dependence treatment. This is further enhanced by targeting localities and population groups that have higher smoking prevalence. The target populations for the specialist smoking cessation services are: routine and manual workers, People diagnosed with mental health condition, pregnant women who smoke, and people living in areas of deprivation.

The tobacco control programs and services that are evidence based contribute towards improving health and wellbeing and reducing inequalities across the most vulnerable population groups.

Overview Statement:

A summary assessment to show that due regard to the Public Sector Equality Duty has been paid, which is undertaken when a full EIA is not needed:

EIA reference number: 00560

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