Decision Report - Lead Member Decision
Forward Plan Reference: FP/24/03/15
Decision Date – 22 April 2024
Key Decision – Yes

Local Stop Smoking Services and Support Grant

Executive Member(s): Cllr Adam Dance - Lead Member for Public Health, Equalities and Diversity
Local Member(s) and Division: County Wide
Lead Officer: Rachel Handley, Consultant in Public Health
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Summary

1. Smoking is one of the leading causes of preventable illness and premature death. Somerset has a smoking prevalence of 12.6%, or around 77,000 smokers (2022). Smoking and its effects cost the Somerset system around £101.27 million a year in lost productivity, and a further £14.76 million cost to social care as those who smoke require care on average 10 years earlier than those who don't.

2. The government has determined to reduce smoking prevalence to just 5% by 2030. To support this ambition each Local Authority public health team has the opportunity to access additional ringfenced grant funding from 2024-2025 to 2028-2029 to expand local smokefree delivery services for 5 years.

3. In line with the grant criteria the funding will be used to:

    - Invest in enhancing the local authority commissioned stop smoking services and support, in addition to and while maintaining existing spend on these services and support from the public health grant. This must not replace other/existing programmes which currently support smokers to quit and should be used to:

    - Build capacity to deliver expanded local stop smoking services and support;

    - Build demand for local stop smoking services and support; and

    - Deliver increases in the number of people quitting.

4. Somerset Council Public Health currently delivers an in-house specialist Somerset SmokeFree Service (SSFS). This work will align and be embedded within the current service.

5. In order to reach 5% prevalence targets around 50,000 local people will need to quit between now and 2030. Our modelling suggests that by 2029 our stop smoking services need to have directly supported approx. 18,000 people to reach an outcome of being off cigarettes for four weeks (4 week quit). Others will quit by themselves (self-quitters).

6. Our planned communication and engagement work will support many others to quit including self-quitters without them needing to come to our service. The table below gives the projected number of quitters to be achieved through our SmokeFree service over the life of the grant.

Table 1. Projected 4 week quits over five years for Somerset (based on current performance and additional funding)

Estimated total 4 week quit rates as a combination of existing Somerset Smokefree service (SSFS) delivery and delivery from new funding						
	Current Rate (as reported in SSFS)	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total
Number of 4 week quits	1,520	2,035	2,550	4,096	4,611	4,611

7. The national grant funding to enable us to meet these targets is £743,000 for 24/25 based on Somerset's number of adults who smoke. We have not been informed of future annual allocations past year one. As our smoking prevalence for the population decreases our funding will decrease over the 5 years. We have estimated this variation to be a 5% reduction in funding. We have designed the service model to account for this. The table below gives the projected funding allocations for the life of the grant.

Table 2. Estimated annual grant allocations based on incremental reduction in adult smoking prevalence

	Confirmed Allocation	Estimated Allocation (5% annual reduction)
2024 - 2025	743,000	
2025 - 2026	Tbc	705,850
2026 – 2027	Tbc	670,557
2027 - 2028	Tbc	637,029
2028 - 2029	Tbc	605,178

8. Somerset's proposed use of the funds includes:

- Increasing staffing core capacity to deliver more quits, including recruiting at least 6 new members of staff to deliver a targeted approach to smoking cessation. We will not be spending more than 65% of the funding on staffing to enable flexibility as the funding reduces.
- Through those additional staff there will be more capacity and skill to enable additional partnership, engagement and training to enable the wider system to support more people to quit
- Developing new pathways to allow more flexibility for people to quit smoking in different ways, such as the provision of shorter-term behavioural support pathways and very brief advice offers. Whilst these developments will mean a universal improvement in access to smoking cessation, the benefits will be greatest for those groups with the highest smoking prevalence including a number of equality groups.
- Increasing the recommended and evidenced based products available for people to use to help them quit smoking such as Vapes, new medications e.g. Cytisine.
- Increasing engagement and outreach work with priority population groups that have higher smoking prevalence to reduce health inequalities from smoking. For example those living in social housing, accessing drug and alcohol services, who have serious mental illness or are from particular ethnic groups.
- Training more stakeholders to deliver behavioural based support to people they work with and have effective conversations to help people quit smoking
- Increasing communication and promotion of smokefree working with council, Integrated Care System and regional communications teams, involving our whole system in advocating for the benefits of quitting smoking and supporting us to achieve our targets.

Permission for use of urgent implementation was provided by the Leader of the Council on 22nd of March 2024 and the Chair of Scrutiny for Policies – Adults and Health on 28th of March 2024.

Recommendations

9. The Lead Member for Public Health, Equalities and Diversity in consultation with Executive Director for Resources and Corporate Services agrees to:

1. Authorise the Executive Director of Public and Population Health or their Deputy Director of Public Health (Service Director) to sign and deliver the grant agreement and any future annual MoU to draw down the Stop Smoking Services and Support Grant 2024 through to 2029.
2. Endorse the high level spend plan for the use of the stop smoking and support grant.

Note: The Leader of the Council and the Chair of Scrutiny for Policies – Adults and Health agreed to the use of urgent implementation of this decision

Reasons for recommendations

10. The decision is needed in order to draw down the national monies to support stop smoking in Somerset to enable us to meet national targets of no more than 5% of the adult population smoking by 2030, from a current baseline of 12% of our population smoking. There is an expectation that every local authority will take up this opportunity.

Other options considered

11. The option of not accepting the government monies was considered but this would mean we would not meet national 2030 targets of no more than 5% of the population smoking.

Links to Council Vision, Business Plan and Medium-Term Financial Strategy

12. Stop Smoking contributes to the ambitions outlined in the County Plan for Somerset around being:
    - A healthy and caring Somerset: Stopping smoking is one of the best things anyone can do for their health and is a system priority for ensuring a healthier Somerset. 2 out of every 3 long term smokers will die of a smoking-related illnesses. Smoking currently costs the Somerset healthcare system around £29.3 million a year (Health and Care costs). An expanded stop smoking service will strengthen our offer to improve the health of our population, through increased awareness of the benefits of stopping smoking and more opportunities to get support to quit.
    - A flourishing and more resilient Somerset: Smoking and its effects cost the Somerset system around £101.27 million a year in lost productivity, and £14.76 million cost to social care as those who smoke require care on average 10 years earlier than those who don't. Smoking is also associated with a decrease in mental wellbeing, which has wider effects on individual and community resilience. Increasing the support to help people to stop smoking will have wide reaching benefits for our county.
    - A fairer ambitious Somerset: Smoking is the leading cause of health inequalities, and communities and individuals who experience disadvantages consistently have the highest rates of smokers. By expanding and tailoring our services to key groups with the highest smoking rates, we will be significantly improving the health of those who tend to have the worst health outcomes. This targeted approach requires bespoke insights and engagement work and development of population-specific messages and support pathways and would be a core part of how the additional smoking grant fund is used.

Financial and Risk Implications

13. The Local Stop Smoking Services and Support Grant will be ring-fenced for use on local stop smoking services and support. The programme of work planned for this spend will be developed and delivered within the financial envelope available over the five years.

14. The current spend on support to stop smoking within the current ring-fenced public health grant will not enable Somerset to meet the national target of 5% smoking prevalence. This has a potential reputational risk for the Council in the future if smoking prevalence is not reduced and the Council did not take the opportunity to receive the additional funding and deliver additional support to the local population who smoke cigarettes.

15. Each financial year we are required to notify the Office for Health Improvement and Disparities if an underspend is forecast. This may impact future year allocations should the local authority report a significant and repeated underspend.

16. Funding for subsequent years is subject to spending review settlements. Currently the guidance is not clear on whether performance related pay (e.g. payment for the number of 4 week quits) will be a model for allocating future funding or whether smoking prevalence for the county as a whole will be used. The planned delivery model has taken this into consideration.

17. We have modelled a slight decrease in year-on-year annual funds for an anticipated variation of 5% reduced funding. As the programme is delivered, we expect the numbers of smokers to reduce each year, and therefore smoking prevalence to reduce. We anticipate additional financial pressures in the final years of this project in the form of needing additional Nicotine Replacement Therapy (NRT) when our service is at maximum capacity. To mitigate this we have modelled to offset these (NRT) costs with an increased use in vapes (other areas have seen 50-60% of clients preferring vapes to other NRT).

18. Anticipated increased national costs of NRT and Vapes over 5 years will put added financial pressure on the service. Close and accurate monitoring of usage and spend through the service database will ensure we will continue to monitor usage and move to cheaper products when/if they are available and update service user protocols to manage increasing spend such as limiting NRT products after 8 weeks of behavioural support to reduce longer term spend with minimal impact on service quits. We will also offset NRT costs with an increased provision in vapes which are cheaper (other areas have seen 50-60% of clients preferring vapes to other NRT).

19. This investment should not replace activity delivered as part the ring-fenced public health grant. It is intended to allow local authorities to deliver more or enhanced stop smoking support provision.

20. There is uncertainty of funding beyond the grant period. Long term plans would benefit the sustainability of the programme post funding period, these will be done in discussion with regional and national partners during the course of this grant funding.

21.

Please enter risk description					
PH0058 The public health ring fenced grant is under significant pressure. Meeting the statutory requirements of improving the health and wellbeing of the Somerset population is extremely challenging within the core ring fenced public health grant resulting in reduced provision.					
Likelihood	4	**Impact**	4	**Risk Score**	16
Please enter mitigation here					
This additional income from the grant will add to the funding currently spent on support to stop smoking.					

Legal Implications

22. As a condition of this award of funding Somerset Council have been required to sign an agreement drafted by the Office for Health Improvement and Disparities by 24 April 2024 in order to receive payment by 24 May 2024.

HR Implications

23. There are no significant HR implications arising from this report for current Somerset Council employees.

We aim to hire staff on fixed term contracts to enable the service to embed. We are not allocating more than 65% of the annual budget to staffing to give us adequate flexibility should there be significant changes to annual allocation in the future. Recruitment will be in line with the external grant monies available, using existing pay grades and role profiles, and sit the additional staff within the existing public health establishment including the current management structure.

This will include a short-term demand on the support of HR and Recruitment colleagues whilst the newly funded posts are recruited to and filled.

There will be a very minimal risk of redundancy pay as the new roles will be recruited to fixed term posts. Should posts be required to vary in length as the funding changes over the course of the grant, our recruitment processes include clauses for both early termination and business need extension.

Other Implications

Equalities Implications

24. The Equalities Impact assessment has been reviewed and updated as part of this key decision.

Our existing in-house SmokeFree services are already required to adhere to equality, inclusion and diversity standards. We aim to specifically strengthen our access, equality and diversity and human rights compliance through the additional funding and expanded service offer.

Access: our current SmokeFree service prioritises access and client satisfaction by providing a wide range of ways to engage with the service, including online groups, in person clinics and home visits for our maternity pathway (SmokeFree families). The new funding will enable us to expand our pathways further to include more bespoke routes for those who we know do not currently engage (such as those in social housing), as well as provide more accessible 'light' touch support offers.

Equality and Diversity: The new service model has been designed based on our assessment of need which includes equality data for prevalence of smoking in protected characteristic groups as well as uptake of our current service. This is detailed in our Equality Impact Assessment that sits alongside this decision paper. The impact assessment will be reviewed as we implement our new model with the additional grant funding. As part of our new model we will enhance our ability to monitor outcomes for protected characteristics so we can evaluate the impact of our new pathways more robustly.

Human Rights: as an internal provider our SmokeFree service is compliant with all legislation and is subject to quarterly quality and performance reviews that include governance aspects. This scrutiny and assurance standard and process will continue as part of our expanded service delivery model using this additional grant funding.

Delivery implications

Performance reporting: we already provide quarterly activity and performance reports to the Department of Health and this grant will continue to use these same reporting processes and indicators. The finance reporting requirements have not yet been released. We have allocated additional administrative capacity to support this.

Achieving targets: although there are no performance related pay targets, there are guidelines based on achieving the 5% smoking prevalence by 2030 and there may be additional targets for the funding in years 3-5. We have modelled increasing our workforce capacity to be able to deliver significant quit numbers to meet our trajectory.

Partnership working: our success depends in part on our ability to engage and support a much wider network of partners to both support people to quit smoking independently through very brief advice interventions, or by directing and support them to our services. There are risks that as other parts of the system experience significant resource pressures this work will become deprioritised. However, tobacco has been designated an Integrated Care System priority for population health and we have modelled for significant core capacity and skills to take on this partnership working.

Community Safety Implications

25. There are no community safety implications as part of accepting this grant funding.

Climate Change and Sustainability Implications

26. There will be increased travel across the county as a result of more delivery staff. The service model intends to have staff place-based as much as possible as well as remote digital support options to mitigate against increased car travel and encourage staff and service users to use active/public transport options.

The expected ban on disposable vapes through DEFRA for 2025-2026 will be supported by the service. The service will only be using rechargeable vapes as is OHID guidance under the national 'Stop to Swap' vape scheme. This only provides rechargeable vapes to local stop smoking services, no disposables will be used. Providers of vapes are expected to meet guidelines for safely disposing of vapes and batteries and the service will work with local partners (waste partnership) to communicate and promote safe disposal of batteries from vapes and cigarettes.

Cigarette butts make up 66% of litter items in terms of litter numbers, and the majority of cigarette filters are non-biodegradable. 590,000 cigarettes are consumed a day, resulting in 31 tonnes of waste annually, and 13 tonnes of street litter annually. Supporting more people in Somerset to quit smoking will reduce the waste burden of cigarettes.

Health and Safety Implications

27. There are no health and safety implications for accepting this grant funding.

Health and Wellbeing Implications

28. This service area is primarily aimed at improving population health and wellbeing. Over the duration of this grant funding we anticipate being able to support an additional 10,300 people to quit smoking through our services, significantly reducing the burden of poor health and premature death related to smoking for our population. This does not include the additional health and wellbeing benefits for those who we will be preventing from second hand smoke exposure.

    In addition, this grant funding will positively impact on our cross-system work to reduce health inequalities, as we will be targeting health inequality groups and designing bespoke service pathways to enable more disadvantaged groups to achieve 4 week quits.

Social Value

29. This grant enables us to expand our current service and therefore provide more employment opportunities for Somerset. A core part of our expanded service will include training a wide range of partners on basic healthy lifestyle messages, including the VCFSE sector. This work will provide benefits for the population of Somerset beyond the direct smoking cessation support delivered by our smokefree practitioners.
    Smoking significantly reduces the productivity of those who smoke, including through smoking-related lost earnings, smoking-related unemployment and smoking-related early deaths. Collectively for Somerset this loss of productivity amounts to £101.3 million a year. By supporting more people to quit through this grant funding we will be supporting the wider Somerset economy.
    Approximately £17 million a year is given as informal care to supporting 13,579 people in Somerset with smoking-related care needs. Helping more people to stop smoking will have a positive impact on carers and reduce the burden of across on our communities so they can take part in other activities.

Scrutiny comments / recommendations:

30. Agreement from the Opposition spokesperson was gained on 9 April 2024, and a briefing and discussion took place on 9 April 2024 with Adults and Health Scrutiny Chair.

    If the decision is taken to accept this grant funding, our implementation plans for the grant funding will be taken to an Adults and Health Scrutiny workshop for their input.

Background

31. In October 2023 the Prime Minster announced a comprehensive plan to create a smokefree generation. The plan acknowledged harms smoking causes to our society and evidence-based measures to reduce smoking prevalence.

32. Currently 1 in 8 people (12.9%) in England smoke. The government has determined to reduce smoking prevalence to just 5% by 2030. To support this ambition each Local Authority public health team has the opportunity to access additional ringfenced grant funding from 2024-2025 to 2028-2029 to expand local smokefree delivery services for 5 years.

33. The Secretary of State for Health and Social Care has determined that the grant will be paid based on the understanding that the funding will be used to:

- Invest in enhancing local authority commissioned stop smoking services and support, in addition to and while maintaining existing spend on these services and support from the public health grant.
- Build capacity to deliver expanded local stop smoking services and support;
- Build demand for local stop smoking services and support; and
- Deliver increases in the number of people setting a quit date and 4 week quit outcomes.

34. The Government's ambition for this investment is to see 360,000 people set quit dates, with 198,000 successful quits (measured as 4-week quits) in England each year. For Somerset this means 50,000 quitters.

Background Papers

Smoking Profile - Data - OHID (phe.org.uk)

Stopping the start: our new plan to create a smokefree generation - GOV.UK (www.gov.uk)

www.gov.uk/government/news/smokefree-generation-one-step-closer-as-bill-introduced

Smoke-free generation: tobacco control plan for England - GOV.UK (www.gov.uk)

The delivery of the new Tobacco Control Plan, House of Commons, 16 November 2021 | Local Government Association

Report Sign-Off (

	Officer Name	Date Completed

Legal & Governance Implications	David Clark	28/3/24
Communications	Peter Elliott	8/4/24
Finance & Procurement	Nicola Hix	3/4/24
Workforce	Dawn Bettridge	8/4/24
Asset Management	Oliver Woodhams	10/4/24
Executive Director / Senior Manager	Louise Woolway	28/3/24
Strategy & Performance	Alyn Jones	2/4/24
Executive Lead Member	Cllr Adam Dance - Lead Member for Public Health, Equalities and Diversity	8/4/24
Consulted:	Councillor Name	
Local Division Members	NA – county wide	
Opposition Spokesperson	Opposition Spokesperson - Public Health & Equalities - Cllr Lucy Trimnell	9/4/24
Scrutiny Chair	Scrutiny For Policies - Adults and Health Committee - Cllr Gill Slocombe	9/4/24

Somerset Equality Impact Assessment

Before completing this EIA, please ensure you have read the EIA guidance notes – available from your Equality Officer or www.somerset.gov.uk/impactassessment

Organisation prepared for (mark as appropriate)	Somerset Council	X	NHS Somerset		NHS Somerset NHS Foundation Trust	

Version	V1	Date Completed	28.3.2024

Description of what is being impact assessed

In October 2023 the government published Stopping the start: our new plan to create a smokefree generation - GOV.UK (www.gov.uk) This outlines the proposed action from the government to protect future generations from the harms of smoking and included additional funding over a 5 year period from 2024 until 2029. This funding is for local authorities to expand their smokefree delivery capacity to increase more smoking quits. This funding is based on an annual allocation and local services submitting annual plans and reporting requirements for achieving an increase in people quitting smoking.

For year 2024-2025 Somerset has been allocated £743,000. In line with the spending requirements our plan is focused on expanding our existing smokefree delivery workforce to deliver more quits through the current model, whilst increasing our capacity for partnership working and the development of more flexible delivery pathways to specifically enable health inequality groups to achieve sustainable quits.

This EIA uses existing data from our current service alongside national data sources, to inform key equality areas for us to focus on should there be agreement to accept the new funding.

For some protected characteristics there is limited analysis of how their access and outcomes within our local service might vary against the wider population and this is noted as an area for development. Details on the proposed changes to our service as part of the additional grant funding are given in the mitigating factors.

Evidence

What data/information have you used to assess how this policy/service might impact on protected groups? Sources such as the Office of National Statistics, Somerset Intelligence Partnership, Somerset's Joint Strategic Needs Analysis (JSNA), Staff and/ or area profiles,, should be detailed here

Smoking Profile - Data - OHID (phe.org.uk)
Action on Smoking and Health - ASH

Primary care data (Quality Outcomes Framework) for Somerset shows that Somerset has a slightly higher smoking prevalence than the England average – 15.1% in 2022/23 compared to 14.7%. The Annual Population Survey for 2022 gives a slightly lower figure of 12.6% which is comparable to the England average of 12.7%.

Age

ONS data from 2022 shows that across the UK the highest proportion of smokers were aged 25-34 years (16.3%), and those over 65 had the lowest proportion (8.3%). Our current local SmokeFree Service 2022/23 data aligns with this picture and has significantly higher numbers being referred to the service in the 25-34 age bracket, although we observed a more significant drop off rate for this age group in setting a quit date or following through to a 4-week quit rate.

Age	All referred individuals	Individuals setting a quit date	Individuals achieving 4 week quit	% of all individuals who achieved 4 week quit	% of individuals setting a quit date who achieved 4 week quit
0-24	291	148	95	32.65	64.19

25-34	642	367	207	32.24	56.40
35-44	351	222	126	35.90	56.76
45-54	305	222	149	48.85	67.12
55-64	374	254	184	49.20	72.44
65+	297	212	152	51.18	71.70

Disability

Smoking is a cause of significant disability. Specific studies suggest that smoking prevalence is higher amongst those with disabilities.[1] A Public Health England report from 2015 suggested that those who use learning disability services smoke less than the general population, but those with both asthma and learning disabilities are twice as likely to smoke as those who have asthma and do not have learning disabilities.[2]

The best reported association relates to smoking prevalence amongst those with a mental health diagnosis: for 2022 to 2023 GP Patient Survey data for England showed the odds of being a current smoker were 2.4 times higher for those with a long-term mental health condition compared to those without a long-term health condition. [3] Smoking is the leading cause of a 10–20-year reduction in life expectancy for people with serious mental illness. Feedback from partners in NHS Somerset report smoking prevalence of over 60% on inpatient mental health wards, and across our ICB 39% of people with a serious mental illness smoke.

The service collects data on mental health, disability both physical and learning, diagnosed long term conditions and any additional needs such as hearing, sight, access additional needs.

Gender Re-assignment

[1] Eric Emerson, Smoking among adults with and without disabilities in the UK, *Journal of Public Health*, Volume 40, Issue 4, December 2018, Pages e502–e509, https://doi.org/10.1093/pubmed/fdy062

[2] 20150520_Tobacco_use_a_health_inequalities_briefing_for_London.pdf (publishing.service.gov.uk)

[3] Smoking profile for England: statistical commentary, March 2024 update - GOV.UK (www.gov.uk)

No data is routinely collected nationally or regionally on gender reassignment and smoking prevalence or use of smokefree services. One study reported that smoking prevalence was 50% for males-to-females and 20% for female-to-males, although results should be interpreted with caution due to small numbers.[4]
Gender reassignment data is not routinely collected by our SmokeFree service, it is collected if clients share this information but is not a mandatory field.

Marital / Civil Partnership Status
ONS England data for 2022 shows higher smoking prevalence (%) for those who are cohabiting or single.

Married or civil partnership	8.4
Cohabiting	17.8
Single	17.3
Widowed, divorced or separated	15.3

Relationship status is collected by the smokefree service.

Pregnancy and maternity
Smoking is the leading cause of modifiable risk factors for poor birth outcomes. 10% of women smoke annually during pregnancy which was 480 women in 2022, and is above the England Average prevalence. The Smokefree families service support women and their loved ones to quit smoking as early as possible in the pregnancy to reduce the harms from smoke. The service offers an incentivised pathway and flexible behavioural support programme.

Race
ONS England data for 2022 shows higher smoking prevalence (%) for mixed race and other compared to White.

[4] De Cuypere G. T'Sjoen G. Beerten R. Selvaggi G. De Sutter P. (2005) Sexual and physical health after sex reassignment surgery. Arch Sex Behav 34: 679–690.

White	13.2
Mixed	17.0
Asian	7.4
Chinese	4.7
Black	8.4
Other	13.6

Service data from 2021-2022 shows that 99% of people quitting smoking in the smokefree service are white. Race is captured as a mandatory data field for everyone in service.

Religion and Belief

ONS England data for 2022 shows higher smoking rates in some groups compared to others but there is limited impact of religion on access to smoking cessation services.

No religion	14.9
Christian	11.3
Buddhist	8.1
Hindu	6.1
Jewish	6.8
Muslim	10.7
Sikh	3.3
Other religion	14.7

Data on religion is collected by the smokefree service as an optional data entry.

Sex

National data compiled by ASH[5] suggests that smoking prevalence is slightly higher in men than in women – 14.6% and 11.2% respectively in 2022.

The service collects data on sex. For the year 2021 – 2022 38% of people who quit were male and had an average quit rate at 4 weeks of 59%. 62% were female with an average 4 week quit rate of 58%, 28% (183) of women were pregnant and quit smoking during their pregnancy with the average quit rate was 54%.

Even after adjusting for our maternity specific pathways, there is still higher engagement in our service from females.

Sexual Orientation

The annual population survey (APS) for 2018 highlights smoking prevalence in gay and lesbian people is 23.1% and 23.3% for bisexual people. NHS Digital in 2021, based on health survey for England (HSE) data from 2011 to 2018 reported that LGB women smoking prevalence is 31% compared with heterosexual women at 16%.

The service collects data on sexual orientation as an optional data set based on the higher expected prevalence of smoking.

Veterans

National data from 2020 has shown a higher smoking prevalence amongst armed forces personnel, ranging from 17-27%. The 2021 Census shows that there are 27,902 armed forces veterans living in Somerset or 5.8% of the population over 16.
Local data indicates that between April 2022 and March 2023 2.6% of clients were either veterans or member of the armed forces although this data field is not completed routinely.

Other

Nationally and locally there is a strong correlation between deprivation and smoking, to the extent that smoking is the main driver of health inequalities in the UK. Whilst data is collected on deprivation as part of our current service this is not routinely analysed to enable better targeting. National data on social housing suggests a smoking prevalence of approx. 60%.

[5] Smoking-Statistics-Fact-Sheet.pdf (ash.org.uk)

Who have you consulted with to assess possible impact on protected groups and what have they told you? If you have not consulted other people, please explain why?

For this decision paper we have not undertaken any consultation with equality groups as this paper related to the decision to accepting the grant funding. Once the grant funding has been approved, our aim is to work with target groups with higher smoking prevalence to explore how to provide support offers that are best suited to those cohorts access and engagements needs. As part of that development and outreach work we will be involving relevant individuals and groups to co-produce our offer. Groups that we have already identified as requiring specific outreach and consultation include

- Disability: Those experiencing serious mental illness
- Employment and sex: Those in manual or routine occupation
- Race and ethnicity: those who are non-white, Gypsy and Travellers and refugees.
- Deprivation: Those living in social housing and those living in areas of deprivation

As we continue to review our service data against equality groups we will be able to identify where other groups require further consultation.

Analysis of impact on protected groups

The Public Sector Equality Duty requires us to eliminate discrimination, advance equality of opportunity and foster good relations with protected groups. Consider how this policy/service will achieve these aims. In the table below, using the evidence outlined above and your own understanding, detail what considerations and potential impacts against each of the three aims of the Public Sector Equality Duty. Based on this information, make an assessment of the likely outcome, before you have implemented any mitigation.

Protected group	Summary of impact	Negative outcome	Neutral outcome	Positive outcome
Age	Adults between 25-34 have the highest smoking prevalence. Our current service shows a pattern of access that matches the smoking prevalence of smoking by age group, with higher rates of 25-34 year olds accessing the service. However, there are more lost to follow up in this age bracket, suggesting the current service is not providing an offer that	☒	☐	☐

	suits this age group.			
Disability	National data suggests that those with a diagnosis of severe mental illness have higher smoking prevalence that the rest of the population. Some studies suggest that those with physical and learning disabilities may have higher prevalence. Whilst our service does have an optional data entry on disability this is not routinely completed or analysed to evaluate access or outcomes for a range of disabilities. This may mean we have an unknown under representation of disability groups in our service despite our mitigating measures in place (accessible information on the service and how to access it, a wide range of options for support that can be adapted to individual needs, clear policies on inclusion and non-judgement for staff). The group that is most likely to be under-represented, based on national data, is those with a severe mental illness.	☒	☐	☐
Gender reassignment	No specific impact has been identified in national data. General policies of inclusion are in place for our service such as appropriate training, resources, advice and guidance to ensure staff are able to help people of any gender to feel welcome and safe within the service. Despite this, without specifically collecting and analysing service data on gender reassignment it is possible that there is underrepresentation in our service for this protected group.	☐	☒	☐

Marriage and civil partnership	No specific impact has been identified through national data although those who are married have a lower rate of smoking. However there may be unmet need or under-representation that is not captured.	☐	☒	☐
Pregnancy and maternity	Our service already prioritises this part of our population due to the additional challenges to engagement with this group and the significant public health impacts of smoking. We have a specific maternity pathway are in place already across the service to support people during their pregnancy. This pathways includes close working with midwifery teams across Somerset.	☐	☐	☒
Race and ethnicity	Similar to national stop smoking service use, our service has almost 100% English/Welsh/Scottish/Northern Irish/British in treatment despite these categories only making up 94% of our population. This means that our service is currently under-utilised by other racial and ethnic groups, despite research that shows other ethnic groups often have higher rates of smoking. Whilst there is a general need to continue ensure that all staff are culturally competent, and have access to appropriate training, resources, advice, and guidance on supporting those from all ethnic groups (including the provision of resources in other languages and the use of interpreters), there is also a specific need to understand more about which racial groups we are not reaching and why. This specific work needs to include exploring racial groups such as Gypsy and Traveller communities and our refugee and asylum seeking populations, who are often more transient and are likely to have higher rates of smoking as well as requiring	☒	☐	☐

	more bespoke support offers.			
Religion or belief	No specific impact has been identified in national data or research to suggest that religion affects access to smoking services. As part of our general inclusion policies we will continue to ensure that all staff are culturally competent, and have access to appropriate training, resources, advice and guidance relation to religion and belief.	☐	☒	☐
Sex	The service currently supports maternity specific pathways and mixed sex groups and online support. As our service is under-represented by males, who have a higher smoking prevalence, some work is needed to address this.	☒	☐	☐
Sexual orientation	Higher prevalence of smoking is identified nationally but limited data is available locally. As part of our routine inclusion policies our service already targets promotion, engagement and partnership opportunities with local LGBTQ groups to ensure relevance of support, as well as ensuring staff have appropriate training to deliver inclusive and non-judgemental support to all. However as we do not routinely collect or analyse data on sexual orientation we may have under-representation from this group.	☒	☐	☐
Armed Forces (including serving personnel, families and	Veterans' data is inadequately collected by the current service and given the higher prevalence of smoking in this group it is possible that veterans are under-represented in our service.	☒	☒	☐

veterans)				
Other, e.g. carers, low income, rurality/isolation, etc.	Statistics on lower income groups and people living in more deprived communities are not routinely analysed as part of our service, and it is likely that these group are under-represented in our current service. Similarly social housing is not part of our data collection but it is likely that those in social housing are under-represented in our service.	☒	☐	☐

Negative outcomes action plan

Where you have ascertained that there will potentially be negative outcomes, you are required to mitigate the impact of these. Please detail below the actions that you intend to take.

Action taken/to be taken	Date	Person responsible	How will it be monitored?	Action complete
Age: higher drop out rates in our service for younger people despite their higher rates of smoking prevalence. The new grant funding will enable us to explore why younger people do not follow up with the service. It is anticipated that many in the younger age bracket will prefer shorter behavioural support offers and vapes instead of other Nicotine Replacement Therapy, and we will be able to monitor the	Detailed project plan to be finalised once there is agreement to accept this grant.	Rachel Handley	All of these actions will be reviewed as part of our Quarterly review of our service and annual report	☐

impacts of rolling out these alternative pathways. In addition, our Service will continue to gain feedback and report on outcomes from different age groups to ensure service provision meets their needs and preferences, such as through the provision of online and remote support. **Disability**: our new model will have two areas of focus initially. The primary focus will be to engage with those with severe mental illness and build partnerships with relevant organisations so that we can explore what support offers best suit those individuals as well as improving our outreach. Our secondary focus will be to review our data capture methods within our service against all disability types so we can better identify if other groups are under-represented. **Gender reassignment:** generic inclusion policies are in place but there is more work to do to ensure routine completion of data fields so that any gaps in access or outcomes can be identified and followed up with further enquiry and consultation. The service will also be asked to explore opportunities to ensure that they are inclusive employers and that they visibly make transgender people feel welcome i.e. environmental cues.				

Relationship status: unlikely impact but we will review our data capture methods within our service against relationship status so we can better identify if any groups are under-represented. **Pregnancy and maternity:** The service will continue to build on our current maternity pathway by carrying out further consultation and engagement work to understand how best to support his group pregnant people and their loved ones and family members. **Ethnicity and race:** to ensure we reach non-white populations we will need to carry out consultation with different groups. Key groups are likely to include refugee and asylum seekers, Eastern European, and Gypsy and Travellers. Our engagement work will inform how best to develop bespoke ongoing outreach and engagement as well as the type of support offer available. This will form part of our outreach and engagement plan alongside our wider health inequalities work. Our aim would be to see a higher proportion of non-white individuals accessing our service and achieving a successful quit. **Religion and belief**: unlikely impact on uptake and outcomes from our service but				

we will review our data capture methods within our service against religion so we can better identify if any groups are under-represented. **Sex**: New delivery plans include workplace health targeted work which should form part of the transformation to ensure more men engage in the smokefree service to quit smoking. Should we continue to see a lower uptake from men we may need further consultation to understand how to address this. **Sexual orientation:** generic inclusion policies are in place but there is more work to do to ensure routine completion of data fields so that any gaps in access or outcomes can be identified and followed up with further enquiry and consultation. **Veterans:** Ensuring that this data field is accurately and routinely completed will enable us to evaluate how accessible our service is to this group and if further consultation is required. **Deprivation and income:** As smoking is the leading driver of health inequalities, a significant proportion of this additional grant will be used to address this, and engage				

with groups who live in areas of deprivation or have lower income. As well as analysing our service outcomes by deprivation more routinely, we seek to work with other partners who have access to areas of deprivation to identify smokers in these areas and provide targeted messaging and offers. We plan to carry out a similar approach to outreach engagement and more routine data collection for evaluation with workplaces for routine and manual, shift and care workplaces, and with social housing. **Overall**: our model for the additional grant includes some targeted engagement and outreach work as detailed above but also will include the universal expansion of our types of support, such as the provision of light touch support and access to vapes to help people to quit. It is anticipated these more flexible pathways, alongside our partnership work across the Somerset system to quip more of our front line workers to talk to people about quitting and signpost to support, will improve access to **all** of these protected groups.				
If negative impacts remain, please provide an explanation below.				

Completed by:	Rachel Handley
Date	27th March 2024
Signed off by:	Rachel Handley
Date	27th March 2024
Equality Lead sign off name:	Tom Rutland
Equality Lead sign off date:	11th April 2024
To be reviewed by: (officer name)	Rachel Handley
Review date:	April 2025