# Equality impact assessment (EqIA)

This impact assessment should be completed for all human resources (HR) and corporate policies, projects or functions that apply to colleagues at NHS Humber and North Yorkshire Integrated Care Board (ICB).

There are five sections of this assessment, and all should be completed:

1. [HR / corporate impact analysis](#_HR_/_corporate)
2. [Equality data](#_Equality_data)
3. [Impact assessment](#_Impact_assessment)
4. [Action planning](#_Action_planning)
5. [Sign-off](#_Sign-off)

## HR / corporate policy impact analysis

| **Key questions** | **Information provided** |
| --- | --- |
| Policy: | Smokefree |
| Date of analysis: | 14 February 2024 |
| Completed by:(name, department, place) | Nicky Lowe, Head of Corporate Affairs and System Support |
| Aims and intended effects of this policy, project or function: | * Create a smokefree environment for everyone to enjoy.
* Protect and improve the health staff, those people whom the ICB serves and all who visit its sites.
* Protect individuals from the danger to their health of exposure to second-hand smoke.
* Align the ICB with the commitments made in the NHS Long Term Plan and the Government commitment to achieving a Smokefree generation by 2030.
 |
| Details of any significant changes to previous policy likely to have an impact on colleagues / other groups: | N/A |
| List of any other policies that are related to or referred to as part of this analysis: | NICE guidance NG-209 SUPPORT FOR STAFF |
| Who the policy, project or function will affect: | The policy applies to NHS Humber and North Yorkshire and all its employees and must be followed by all those who work for the organisation, including the Integrated Care Board, Integrated Care Partnership, those on temporary or honorary contracts, secondments, pool staff, contractors, visitors and students. |
| Engagement / consultation that has been done or is planned for this policy and this EqIA: | Staff Wellbeing Group, H&S Group, SPF |

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## Equality data

Equality data is internal or external information that may indicate how the activity being analysed can affect different groups of people who share one or more of the nine protected characteristics as detailed in the [Equality Act (2010)](https://www.gov.uk/guidance/equality-act-2010-guidance).

Examples of equality date could include:

* recruitment data (e.g., number of applications compared to our population profile, number of appointments)
* complaints made by groups who share / represent one or more protected characteristic
* grievances, decisions upheld or dismissals by protected group
* findings of the NHS Staff Survey
* data from the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports

This list is not exhaustive.

| **Key questions** | **Information provided** |
| --- | --- |
| Is any equality data available relating to the use of this policy / project / function: | No |
| **If yes**List the equality used to assess the impact of this policy / project / function: |  |
| **If no**List the data you will use to assess the impact of this policy / project / function: | National data |

## Impact assessment

Details of any potential impact of this policy / project or function on people from different protected characteristic groups should be included below.

This should be based on analysis of:

* the [equality data](#_Equality_data) listed
* insights gathered through engagement
* your knowledge of the substance of this policy

| **Protected characteristic** | **No impact?** | **Positive impact?** | **Negative impact?** | **Evidence of impact and, if applicable, justification where are ‘genuine determining reason’ exists (see footnote)** |
| --- | --- | --- | --- | --- |
| **Age**This refers to people of all ages. |[x] [ ] [ ]  The prevalence of smoking in Great Britain is higher among younger adults. Around 20% of 16-34 year olds smoke, whereas less than 11% of adults aged 60 and over smoke. However, younger adults smoke less cigarettes a day, with those aged 16-24 smoking on average around 8 cigarettes a day, compared to around 13 per day at most among those aged 50-59 (House of Commons Library Briefing paper: Statistics on smoking 2017). Success at quitting smoking increases with age, with data for England from NHS Stop Smoking Services (April to Dec 2016) showing that 41% of those aged under 18 successfully quit compared to 56% of those aged 60 and over. |
| **Disability**People who have physical disabilities and / or impairments, learning disabilities, learning differences (for example, someone who is neurodiverse), people with mental health conditions, sensory loss and long-term chronic conditions (such as diabetes, HIV) or hidden, invisible or variable conditions |[x] [ ] [ ]  40% of adults with serious mental health conditions smoke (Department of Health Tobacco Control Plan for England 2017) as do 64% people in mental health settings (Health matters: smoking and quitting in England 2015). Smokers with mental health disorders are more likely to be heavily addicted to smoking than smokers in general (Royal College of Physicians and Royal College Psychiatrists Smoking and mental health 2013). However, the Tobacco control plan for England, notes that some health professionals can be reluctant to offer people with mental health conditions support to quit smoking, even though the proportion of people with a mental health condition who would like to quit, is similar to the proportion among smokers generally (Department of Health Tobacco Control Plan for England 2017). While the number of smokers in general has fallen by around 30% over the last 2 years, there has been little change in smoking prevalence among people with mental health problems (Health matters: smoking and quitting in England 2015). Regarding learning disabilities, no national data has been identified, but it was noted that one study has reported that smoking prevalence among adolescents with mild learning disabilities is higher than among their peer group (reported in Tobacco use: inequalities by protected characteristics and socioeconomic factors 2015). |
| **Gender reassignment**Refers to someone who is proposing to, is going through or has gone through a process to live in a gender that is different to the one assigned at birth. For example, Trans (transgender) people, non-binary people or gender fluid / gender queer people. |[x] [ ] [ ]  No national survey data have been identified on inequalities relating to tobacco use relating to people who have undergone or who are undergoing gender reassignment. |
| **Marriage or civil partnership**Refers to legally recognised partnerships (applies to employment only). |[x] [ ] [ ]  No national survey data have been identified on inequalities relating to this protected characteristic. |
| **Pregnancy and maternity**Refers to the pregnancy period and the first year after birth. |[ ] [x] [ ]  Over 10% of pregnant women currently smoke, but there is considerable variation in prevalence when factors such as age, income, and geographical area are taken into consideration. Smoking prevalence among pregnant women is higher among those aged under 20 than among older women. Pregnant women from manual occupation groups are five times more likely to smoke than women from managerial and professional occupations (Department of Health Tobacco Control Plan for England 2017). In 2014-2015, the prevalence of women who were smokers at the time of delivery ranged from 2% in central London to 27% in Blackpool NHS Digital Statistics on Smoking, England - 2016. The Tobacco Plan for England notes that although progress has been made in CO monitoring at antenatal appointments and referring pregnant women to stop smoking support, there is variation at local level in the extent to which all of NICE’s recommendations to support women to quit smoking in pregnancy are implemented (Department of Health Tobacco Control Plan for England 2017). |
| **Race**Refers to people of different races which can include colour, nationality, ethnic or national origins and different ethnic backgrounds, for example, Gypsy Romany and Traveller peoples. |[x] [ ] [ ]  There is some variation in smoking rates by ethnicity with higher smoking prevalence among Bangladeshi, Pakistani and Irish men and among Caribbean and Irish women (Health matters: smoking and quitting in England 2015). Smokeless tobacco is used predominantly by some South Asian communities in the UK and is more likely to be used by people of Bangladeshi heritage, and by women, older people and those from lower socio-economic groups within these communities (NICE guideline PH39 Smokeless tobacco: South Asian communities 2010).Smoking prevalence is higher among gypsies and travellers than among the general population, with data from a 2009 survey reporting that 47% smoke (Public Health England Tobacco use: inequalities by protected characteristics and socioeconomic factors (2015). While no data have been identified on the uptake of services to support smokers from these communities to quit, it is noted that engagement with health services is often poor. |
| **Religion or belief**Includes all religious and philosophical beliefs including having no religious belief, |[x] [ ] [ ]  Smoking prevalence varies by religion. Data from 2016, shows the highest prevalence among those identifying as having ‘no religion’ (19.6%). Similar smoking prevalence rates are reported by those identifying as Christian (13.9%) Buddhist (13.4%) and Muslim (12.9%). Those identifying as Jewish report a prevalence of 9.9%. The lowest rates were reported by those identifying as Hindu (6.5%) or Sikh (5.5%) (Public Health England Local Tobacco Control Profiles). |
| **Sex**This refers to biological sex eg male / female / intersex. |[x] [ ] [ ]  In Great Britain, men are more likely to smoke than women, with an estimated 18% of men and 15% of women being smokers. In 2016, 56% men and 63% of women had never smoked. Among smokers in England, more women set a quit date than men in almost all age groups, however men self-report a higher successful quit rate than women (House of Commons Library Briefing paper: Statistics on smoking 2017). Data from 2014 - 2015 suggest that in Great Britain, men are more likely than women to be electronic cigarette users (6.3% of all men aged 16 and over compared to 4.9% of all women aged 16 and over), but there is considerable variation by age group with the most likely age for men to use electronic cigarettes being 16-24 years. Among women this was the least likely age group, with the most common age group for them being 50-59 years Office for National Statistics - Adult smoking habits in the UK 2017). |
| **Sexual orientation**Refers to who a person is attracted to, for example gay, lesbian, bisexual, asexual and heterosexual (straight). |[x] [ ] [ ]  Around 24% of adults who identify themselves as being lesbian, gay or bisexual are smokers, compared to just over 16% of those who identify themselves as being heterosexual (Public Health England Local Tobacco Control Profiles 2016). This may be partly explained by their younger age profile and because the prevalence of smoking is higher among younger people. Lesbian, gay, bisexual and transgender people are less likely to have never smoked and less likely to have given up smoking than the general population (Public Health England Tobacco use: inequalities by protected characteristics and socioeconomic factors 2015). These groups often report limited access to health services (ASH Smoking and the LGBT community - Action on Smoking and Health 2016). |
| **Socio-economic deprivation**Refers to the different financial situations people may be experiencing, for example, working poverty and cost of living impacts for people from different backgrounds (not Band exclusive) |[x] [ ] [ ]  **Income level** – there are significant inequalities, with smoking rates almost three times higher among those on the lowest incomes compared to those on the highest income. **Occupation** - in Great Britain in 2016, 26% of those in routine and manual occupations were smokers compared to just over 11% of those in managerial and professional occupations (House of Commons Library Briefing paper: Statistics on smoking 2017). In England, the largest absolute number of attempts to quit is among smokers from routine and manual occupations. However, the highest quit rates are among smokers who are retired or from managerial and professional groups. The lowest quit rates are among those who are long-term unemployed or who have never worked (NHS Digital Statistics on NHS Stop Smoking Services in England: April 2016 to March 2017). **Geographical area** - smoking prevalence varies significantly by geographical region with data from 2014 showing smoking prevalence to be 17% in London, the South East and South West compared to over 19% in the North East, North West and Yorkshire and The Humber (NHS Digital Statistics on Smoking, England - 2016). However, in 2016, 60% of quitters in Yorkshire and Humber were successful, compared to 45% in the south west (NHS Digital Statistics on NHS Stop Smoking Services: England, April 2016 to December 2016). People from deprived areas are more likely to smoke and less likely to quit. Smoking is increasingly concentrated in more deprived areas (Health matters: smoking and quitting in England 2015). The tobacco control plan notes that the sale of illicit tobacco undermines public health policy by offering a cheaper alternative to those for whom price may otherwise be reason to stop smoking (Department of Health Tobacco Control Plan for England 2017). There are concerns that access to illicit tobacco is greatest in more deprived areas (NICE guideline PH14 Review decision 2014) |
| **Working carers**Refers to anyone who cares, unpaid, for a friend or family member who due to their illness, disability, mental health condition or an addiction cannot cope without their support.Working carers can be considered protected under the Equality Act (2010) by association. |[x] [ ] [ ]  No national survey data have been identified on inequalities relating to this protected characteristic. |

‘Genuine determining reason’ means an action is proportionate to the legitimate aims of the organisation (please seek further advice).

## Action planning

As a result of the analysis of the impact of this policy / project or function on people from different protected characteristic groups, this section should detail the mitigating actions to be taken to reduce any identified impacts and those responsible for ensuring these actions are taken.

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| --- | --- | --- | --- | --- |
| **Identified risk** | **Recommended actions** | **Responsible lead** | **Completion date** | **Review date** |
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## Sign-off

All EqIAs for HR and corporate policies, projects or functions that apply to ICB colleagues must be signed-off by the corporate affairs team - send a copy of the relevant policy and EqIA to: hnyicb-hull.hnypolicyenquiries@nhs.net

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| --- | --- |
| **Key questions** | **Sign-off responses** |
| I agree / disagree with this assessment and action plan | Yes / No (delete as appropriate) |
| **If no (you disagree)**Reasons for not approving and actions that should be taken (including timelines and those responsible): |  |
| Signed: |  |
| Date: |  |

ENDS