Equality Impact Assessment

The Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022

Description of Policy

Title of policy/ strategy/ legislation	The Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022
Minister	Maree Todd, MSP, Minister for Public Health, Women's Health and Sport
Lead Official	Karen MacNee, Deputy Director, Head of Health Improvement
SG Officials involved in EQIA	**Name** and **Team** Jules Goodlet-Rowley: Head of Healthy Living Unit Lily Green: Tobacco Control and Gambling Team
Directorate	Population Health Directorate
New policy and/or legislation	Scottish Government will lay regulations before the Scottish Parliament to introduce an enforceable prohibition of Smoking outside hospital buildings, providing a smoke-free perimeter of 15 metres. This primarily supports the de-normalisation of smoking on hospital grounds in order to help reduce the use of tobacco across the population and to reinforce that the NHS should be seen as an exemplar of health promotion within society and to support people to in their efforts to stop smoking. The secondary aim is to help prevent and reduce exposure to second-hand smoke by people in NHS hospital grounds, at entrances and near windows/vents to buildings.

Screening

Policy Background and Aim

The Scottish Government's 2013 strategy, Creating a Tobacco – Free Generation[1], set the ambitious target of a tobacco-free generation by 2034. This means that a child born in 2013 would turn 21 in a country largely devoid of smoking, with an adult smoking rate of 5% or less. This goal was carried forward in a revised action plan in 2018[2] and, as part of a commitment in Programme for Government 21/22, a refreshed Tobacco Action Plan will be going live in 2023. To achieve this ambition, tobacco use must be put out of sight and out of mind, and our young people must be protected from second hand smoke.

The Smoking, Health and Social Care (Scotland) Act 2005[3] made it an offence to smoke in wholly or substantially enclosed public spaces, which included smoking inside a hospital building.

In April 2015, all NHS Health Boards in Scotland implemented smoke free policies across their grounds[4] as health promoting health services[5] but there have been significant issues around compliance. Health Boards have reported difficulties in enforcing smoke-free policies as there is no sanction that can be applied if someone refuses to comply with the policy, other than asking the person to leave the grounds. However, this may not be possible should a person be a patient. It is also difficult to enforce on large hospital grounds where a person could easily re-enter undetected.

[1] Creating a Tobacco-Free Generation A Tobacco Control Strategy for Scotland (www.gov.scot)
[2] Raising Scotland's tobacco-free generation: our tobacco control action plan 2018 - gov.scot (www.gov.scot)
[3] Smoking, Health and Social Care (Scotland) Act 2005 (legislation.gov.uk)
[4] NHS Smokefree (smokefreegrounds.org)
[5] CEL 01 (2012) - Health Promoting Health Service: action in hospital settings (scot.nhs.uk)

Smoking therefore around Scotland's hospitals continues to present a potential health risk to patients, visitors and staff, some of which are particularly vulnerable.

To address these compliance issues, section 20 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 ("the 2016 Act") inserted new sections 4A to 4D into the Smoking, Health and Social Care (Scotland) Act 2005 ("the 2005 Act"), creating new offences of permitting others to smoke in the no-smoking area outside hospital buildings and smoking in the no-smoking area outside hospital buildings. The no-smoking area outside a hospital building is the area lying immediately outside the hospital building and bounded by a perimeter a specified distance from the building, so far as the area forms part of hospital grounds. The distance from the building is specified in these Regulations as 15 metres (15m). Section 20 of the 2016 Act will be commenced for the purposes of laying and then making these Regulations and will come fully into force when these Regulations come into force.

The primary aim of this policy therefore is to introduce an enforceable 15m smoke-free perimeter around hospital buildings to support the de-normalisation of smoking. The secondary aim, is to prevent or reduce the harms of second hand smoke at hospital entrances and exits. It is believed that this action will help to further reduce the use of tobacco across the population and will support NHS Boards in becoming exemplars in providing smoke-free environments and promoting healthy choices.

Setting a perimeter around buildings focusses on the areas where there is the highest level of traffic of people on foot leaving and entering the hospital who could be exposed to second hand smoke, and where there is a risk of smoke entering hospital buildings as a result of people smoking close to the building, in particular at entrances.

As highlighted in the policy memorandum for the 2016 Act[6], there is evidence from studies of second-hand smoke in outdoor environments which suggest that smoke-drift from outside can lead to levels of second-hand smoke inside building entrances and windows which may be high enough to warrant concern for people inside a building. Outdoor tobacco smoke has been found at least 3m from designated smoking areas, without taking in to account wind conditions which can cause the smoke to drift further.[7] The highest risk from smoke-drift is dependent on the environment, with areas of high wind distributing outdoor tobacco smoke further, but a perimeter of 15m reduces the risk significantly.

Further to this, the policy supports those visiting for cessation treatment, who have given up or who have reduced their smoking, and who might find it difficult to pass through areas close to entrances where people have congregated to smoke. This policy will help people who have been advised to stop or reduce their smoking for periods of medical treatment. Social acceptability has a strong bearing on health behaviours and evidence shows that quitting is made more difficult if a smoker's social environment is filled with smokers.[8]

Policy Consultation

A consultation titled *Prohibiting Smoking Outside Hospital Buildings* ran from 8 October 2019 to 17 January 2020[9]. The consultation was made available online at https://consult.gov.scot/. The consultation sought views on proposed regulations aimed at making it an offence to smoke outside

[6] Policy Memorandum (parliament.scot)
[7] Quantification of Outdoor Tobacco Smoke Exposure at Outdoor Smoking Facilities - PubMed (nih.gov)
[8] Introduction.pdf (tobaccoinaustralia.org.au)
[9] Prohibiting smoking outside hospital buildings: consultation - gov.scot (www.gov.scot)

hospital buildings or knowingly permit others to smoke there, to allow the regulations to be finalised and laid in the Scottish Parliament. The consultation sought views on the three points:

- The distance from hospital buildings which will form the perimeter of the no-smoking areas outside a hospital building, and how the perimeter around the building is determined in so far as whether the perimeter ends the specified distance from a wall or from any part of the building structure or otherwise.

- The manner of display, form and content of no-smoking notices.

- Whether there are any exceptions required for specific hospitals or specific buildings, or specific areas of land which should not be considered hospital grounds or part of the no-smoking areas respectively under the definitions in the Act.

The full public consultation[10] for the 2016 Act, which took place in 2015, identified substantial support for this appropriate regulation.

The 2019 consultation received 559 responses, comprising 513 individual responses and 46 organisational responses. The consultation attracted responses from a diverse range of organisations. NHS bodies represented almost half of all organisation responses (e.g. NHS Boards, hospitals and health and social care partnerships). Further, three NHS responses included the feedback and views gathered through their own consultation process which involved staff and/or patients. This was followed by third sector organisations (e.g. health improvement organisations/charities as well as smokers' rights bodies). Other public sector bodies were represented by local government and a related membership body. Educational institutions who responded comprised medical professionals' institutions and a health research consortium.

The consultation attracted responses from those who strongly supported the proposals as well as some who did not. A clear majority of respondents agreed that the perimeter of the no-smoking area should be 15m from hospital buildings (72%). Organisations noted stronger levels of agreement with the proposal than individuals. Many of the respondents that were in favour of setting the perimeter at 15m considered the proposed distance "necessary", "justified" and/or "sufficient" to significantly reduce health risks for patients, visitors and staff.

The majority of respondents agreed that the perimeter of the no-smoking area should be measured from the outside wall of a building, and include all the land and areas beneath canopies or overhangs, even where they measure more than 15m from the side of the hospital building (72%). Organisations noted stronger levels of agreement with the proposal than individuals.

Several concerns around the practical management of patients should a perimeter ban be imposed in mental health settings were expressed by those working in and having experience of such settings. These included fears that smokers may not agree to hospital admission if they were unable to smoke, that a ban could add risks to safety and security, and that cigarettes were commonly used as a de-escalation technique to calm situations.

Because of the concerns raised regarding mental health settings, we decided to seek further clarification and sought additional detail and input from the Royal College of Psychiatrists in Scotland and assessed in detail the comments provided by the NHS and various psychiatric groups. After thorough examination of the arguments and the implications of exempting such

[10] *A Consultation on Electronic Cigarettes and Strengthening Tobacco Control* which ran from 10 October 2014 to 2 January 2015

hospitals, the Scottish Government formed the view that these concerns can be mitigated against and that there are no compelling, fundamental reasons to exempt psychiatric hospitals from the proposed legislation.

Who will it affect?

This EQIA builds on the EQIA conducted for the 2016 Act published in August 2015.[11] We have a good understanding, based on decades of data, of who smokes tobacco across the Scottish population in terms of some equalities characteristics and socio-economic status.

Creating a designated smoke-free area in NHS hospital grounds will impact protected characteristic groups who work in or use hospitals as patients, the elderly, disabled and pregnant in both positive and negative ways. However, it is expected that a strong public health rationale and the positive outcomes they will deliver outweigh any disproportionate impacts on protected characteristic groups. Anyone needing to work in, visit or use hospital buildings could be affected.

The following organisations were contacted as part of the original EQIA for the 2016 Bill that led to these Regulations and were contacted in 2022 again for this review. No changes have been requested:

- Age Scotland;
- Children First Scotland;
- Inclusion Scotland;
- Black and Ethnic Minority Infrastructure Scotland;
- Scottish Women's Convention;
- Engender;
- Equality Network;
- Interfaith Scotland; and
- Scottish Transgender Alliance.

What might prevent the desired outcomes being achieved?

Achieving the desired outcomes will be dependent on, and will involve a need for those working at, admitted to or visiting hospital buildings, to take action to adopt new behaviour and adopt the regulations and responsibilities. Communication and regulation processes could impact on the desired outcomes, such as not realising that they are within 15m of a hospital building. This is expected to be offset by clear signage on hospital grounds regarding the banning of smoking within 15m of a hospital building. We will know that the policy outcome has been achieved when there is a decrease in communications received by Scottish Government, Hospital Boards and Local Authorities regarding second hand smoke outside hospitals. It is also anticipated that over time, there will be a reduced number of enforcements needed due to behaviour change and expectations regarding the inability to smoke within 15m of a hospital building.

Stage 1: Framing

Results of framing exercise

[11] Equalities Impact Assessment (EQIA) for the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill - gov.scot (www.gov.scot)

Since the introduction of the 15m perimeter smoking ban would impact anyone attending a hospital building, there has been engagement with a broad range of stakeholders as detailed in the screening section of this document in addition to a public consultation that took place in 2019.

Initial Summary Reflection

It's expected that the main impacts of this proposal will support NHS Boards in becoming exemplars in providing smoke free environments and promoting healthy choices.

However, there would be a mixed equality impact on those with the following protected characteristics:

- Persons with disabilities
- Elderly persons
- Pregnant persons and new parents
- Low incomes

Interaction with Other Policies (Draft or Existing)

Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016

The proposed regulations when laid and approved would enact the new sections included in the 2016 Act (section 20).

Extent/Level of EQIA required

This EQIA specifically focussing on the introduction of an enforceable ban on smoking within 15m of a hospital building as defined above builds on the EQIA completed for the Act 2016. Not a significant amount of information has changed since this date, with the exception of the further consultation carried out in 2019 which features repeatedly through this document.

Stage 2: Data and evidence gathering, involvement and consultation

This section includes the results of the evidence gathering (including the framing exercise), including qualitative and quantitative data and the source of that information, whether national statistics, surveys or consultations with relevant equality groups.

Characteristic	Evidence gathered and Strength/Quality of evidence	Source (full reference details in appendix)	Data gaps identified and action taken
Age	**Elderly persons more likely to be hospital patients** and therefore more likely to be exposed to others smoking when entering and then leaving the building. These groups may feel vulnerable to the effects of second hand smoke and may find it harder to move away from groups of smokers which currently congregate near entrances.	Prohibiting smoking outside hospital buildings: consultation analysis, 2020.	It is not expected that there are material data gaps with regards to this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.
	Elderly persons & mobility Those struggling with mobility may find it harder to comply with the smoke-free area rules and may be more tempted to knowingly commit an offence.	Prohibiting smoking outside hospital buildings: consultation analysis, 2020.	No further mitigating action can be taken in legislation, however it is intended that enforcement officers and hospital staff would offer the necessary support to such individuals in the first instance to prevent them from inadvertently committing an offence. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.

	Elderly persons & understanding Smokers who do not have the capacity to fully understand the policy may inadvertently commit an offence by smoking within the perimeter.	Prohibiting smoking outside hospital buildings: consultation analysis, 2020.	No further mitigating action can be taken in legislation, however it is intended that enforcement officers and hospital staff would offer the necessary support to such individuals in the first instance to prevent them from inadvertently committing an offence. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.
	Difference in smoking prevalence by age group There are significant differences in smoking prevalence by age group. The highest proportions of self-reported current smokers were recorded among those aged 25-54 (21 - 22%) and the lowest smoking prevalence was among those aged 75 and over (7%). There was a significant association between age and previous smoking status in 2019, which again is consistent with previous years. Among all adults, the lowest proportion of	Scottish Health Survey (SHeS) 2019, last updated September 2020.	It is not expected that there are material data gaps with regards to this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.

	ex-regular smokers in 2019 was found among those aged 16-24 (6%) while 35 - 37% of those aged 65 and over reported having smoked regularly in the past. The highest mean number of cigarettes smoked per day by current smokers in 2019 was among those aged 45-74 (14.6 - 15.0 cigarettes) and the lowest among those aged 16-24 (7.6 cigarettes).		
	The majority of young people are non-smokers In 2018, almost all 13 year olds (97%) were non-smokers. 2% were regular smokers and 2% were occasional smokers. Similar to 2015, in 2018, smoking was more common among 15 year olds but the prevalence was still low: 7% were regular smokers and 6% were occasional smokers in Scotland.	Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS): Smoking Report 2018.	It is not expected that there are material data gaps with regards to this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.
	Smoking accelerates age-related cognitive decline Elderly smokers have increased risks of dementia and cognitive decline.	Smoking as a risk factor for dementia and cognitive decline: a meta-analysis of prospective studies, 2007	It is not expected that there are material data gaps with regards to this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.

	Children more vulnerable to Health hazards of second-hand smoke Estimates for key measures of health damage attributable to passive smoking, which for children each year causes: • Over 20,000 cases of lower respiratory tract infection • 120,000 cases of middle ear disease • At least 22,000 new cases of wheeze and asthma • 200 cases of bacterial meningitis • 40 sudden infant deaths - one in five of all SIDs.	Tobacco Advisory Group of the Royal College of Physicians report, 2010.	It is not expected that there are material data gaps with regards to this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.
	Young People exposed to normalised smoking more likely to pick it up Smoking initiation is associated with a wide range of risk factors including: parental and sibling smoking, the ease of obtaining cigarettes, smoking by friends and peer group members,	Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis	

	socio-economic status, exposure to tobacco marketing, and depictions of smoking in films, television and other media		
Disability	**Psychiatric Units** 1) Some views expressed in the 2019 consultation indicated that although they agreed with the proposal, certain hospitals re. mental health provisions should be exempted as: • smokers may not agree to hospital admission if they were unable to smoke • a ban could add risks to safety and security • cigarettes were commonly used as a de-escalation technique to calm situations 2) An additional questionnaire to Health Boards where 17 boards responded highlighted that all either agreed with the 15m perimeter or preferred a wider or whole site ban. 5 boards raised that they felt exemptions should be given for psychiatric units, mental	1) Prohibiting smoking outside hospital buildings: consultation analysis, 2020. 2) Health Board Questionnaire on the proposals 2017 3) Exempting mental health units from smoke-free laws would worsen health inequalities for people with mental health problems, 2006	We sought further clarification and additional detail from the Royal College of Psychiatrists in Scotland as well as examining the arguments posed in relation to a possible exemption by various other respondents to the consultation. After thorough examination, we formed the view that these concerns can be mitigated against and that there are no compelling, fundamental reasons to exempt psychiatric hospitals from the proposed legislation. For example, it was confirmed that there are other ways to de-escalate situations with psychiatric patients and that both nicotine replacement therapy and cessation support was available to support those unable to smoke. Concerns over an increase in aggression, requested discharge or other

	health patients, palliative patients or for those 'where hospitals are considered home'. 1 of the 5 suggested that psychiatric units should be exempt for a limited time to allow them to adapt to the ban with regards to how they work with their patients.		complications have been recorded in psychiatric institutions imposing bans on smoking in the UK and other countries, however these concerns did not materialise when implemented. Moreover providing an exemption for psychiatric units would exacerbate existing health inequalities among this patient group where almost three quarters of those with certain conditions (such as psychosis) smoke. It is also important to note that in the 2016 Act, Chapter 3, section 4B (2) it states that – it is a defence for an accused charged with an offence under this section to prove that the accused did not know, and could not reasonably be expected to have known, that the place in which it is alleged the accused was smoking was within the no-smoking area outside a hospital building. No further mitigating action can be taken in legislation,

			however it is intended that enforcement officers and hospital staff would offer the necessary support to such individuals in the first instance to prevent them from inadvertently committing an offence. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.
	Visual Impairments Another potential impact identified of this policy on those with disabilities is that those who would be unable to read the required signage due to visual impairments may be more likely to inadvertently commit an offence.	Prohibiting smoking outside hospital buildings: consultation analysis, 2020.	No further mitigating action can be taken in legislation, however it is intended that enforcement officers and hospital staff would offer the necessary support to such individuals in the first instance to prevent them from inadvertently committing an offence.
	Smoking & Mental Health Issues 1) People with mental health conditions are more likely to smoke than the general population and there is a positive association between smoking and poorer mental health.	1) Prohibiting smoking outside hospital buildings: consultation analysis, 2020. 2) Change in mental health after smoking cessation: systematic review and meta-analysis, 2014	It is not expected that there are material data gaps with regards to this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.

	2) Stopping smoking is associated with improvements in depression, anxiety, stress, psychological quality of life, and positive affect compared with continuing to smoke.		
	Mobility Smokers in this group who struggle with mobility may find it harder to comply with the smoke-free area rules and may be more tempted to knowingly commit an offence.	Prohibiting smoking outside hospital buildings: consultation analysis, 2020.	No further mitigating action can be taken in legislation, however it is intended that enforcement officers and hospital staff would offer the necessary support to such individuals in the first instance to prevent them from inadvertently committing an offence. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.
	Smoking Prevalence & Health Conditions Smoking rates were higher (26%) among adults living with a limiting long-term health condition compared to those living with no long-term health condition (13%). Adult smokers living with a limiting long-term health condition smoked more cigarettes on average per day (12.7) compared to those living with	Scottish Health Survey (SHeS) 2019, last updated September 2020.	It is not expected that there are material data gaps with regards to this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.

	no long-term health condition (11.7).		
Sex or Gender	**Smoking prevalence does not differ significantly by sex**, with 19% of men and 16% of women identifying themselves as current smokers in 2019. However, on average, men smoked a higher number of cigarettes per day than women (13.1 mean cigarettes per day for men compared with 11.3 for women).	Scottish Health Survey (SHeS) 2019, last updated September 2020.	It is not expected that there are material data gaps with regards to sex or gender and this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.
Pregnancy and Maternity	**Pregnant persons more likely to be hospital patients** and therefore more likely to be exposed to others smoking when entering and then leaving the building. These groups may feel vulnerable to the effects of second hand smoke and may find it harder to move away from groups of smokers which currently congregate near entrances	Prohibiting smoking outside hospital buildings: consultation analysis, 2020.	It is not expected that there are material data gaps with regards to this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.
	Mobility Smokers in this group who struggle with mobility as a result of pregnancy may find it	Prohibiting smoking outside hospital buildings: consultation analysis, 2020.	No further mitigating action can be taken in legislation, however it is intended that enforcement officers and

	harder to comply with the smoke-free area rules and may be more tempted to knowingly commit an offence.		hospital staff would offer the necessary support to such individuals in the first instance to prevent them from inadvertently committing an offence. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.
	Second Hand Smoke is a serious health threat to mothers and babies 1) Maternal exposure to second hand smoke has adverse health effects for the mother and the foetus and exposure to second hand smoke is a serious health threat to infants. 2) The introduction of national, comprehensive smoke-free legislation in Scotland was associated with significant reductions in preterm delivery and babies being born small for gestational age. These findings are plausible and add to the growing evidence of the wide-ranging health benefits of smoke-free legislation, and support the adoption of such	1) Tobacco Advisory Group of the Royal College of Physicians report, 2010. 2) Impact of Scotland's Smoke-Free Legislation on Pregnancy Complications: Retrospective Cohort Study, 2012 3) Maternal smoking in pregnancy and birth defects: a systematic review based on 173 687 malformed cases and 11.7 million controls	It is not expected that there are material data gaps with regards to this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.

	legislation in other countries that have yet to implement smoking bans. 3) Birth defects are positively associated with maternal smoking and should be included in public health education/messaging.		
Gender Reassignment	Research by ASH Scotland indicates that smoking prevalence is higher among transgender people.	Stop-smoking service provision for Lesbian, Gay, Bisexual and Transgender (LGBT) communities in Scotland.	It is not expected that there are material data gaps with regards to gender identity and this policy. We will continue to monitor any trends that arise as it is not currently included within the SHeS and from our stakeholders.
Sexual Orientation	**Those identifying as LGBT+ smoke more** In 2019, adults identifying as LGB & Other reported a higher smoking rate (24.9%) than those identifying as Heterosexual (17.2%).	Scottish Health Survey (SHeS) 2019, last updated September 2020.	It is not expected that there are material data gaps with regards to sexual orientation and this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.
Race	**White: Scottish and White: Polish more likely to smoke** In 2019, adults whose ethnicity was White: Other British (12.8%), Asian (6.9%) or All other ethnic groups (14.5%) reported a lower	Scottish Survey Core Questions 2019, last updated January 2021.	It is not expected that there are material data gaps with regards to race and this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.

	smoking prevalence than the White: Scottish group (18.4%). The White: Polish group had the highest smoking rate at 30.1%		
Geographical location (In particular remote/rural and island communities)	1) An atlas of Tobacco Smoking in Scotland, showed that smoking rates were slightly lower in island communities than in the central belt. Orkney had rates of 21.7% of the adult population while in Greater Glasgow and Clyde that figure was 29.8% for example. 2) Smoking rates across Scotland are analysed through the Scottish Health Survey, and have been falling since the Health Survey began to 19% for men and 16% for women.	1) Tobacco Smoking in Scotland, An Atlas, 2007 2) Scottish Health Survey (SHeS) 2019, last updated September 2020.	It is not expected that there are material data gaps with regards to geographical location and this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.
Religion or Belief	**Those with no religion more likely to smoke** Smoking rates were lower for adults who identified as Muslim (8.1%), Other Christian (11.6%), Church of Scotland (12.0%), Other religion (15.4%) and Roman	Scottish Survey Core Questions 2019, last updated January 2021.	It is not expected that there are material data gaps with regards to religion or belief and this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.

	Catholic (20.0%) than the No religion (20.3%) reference group. The No religion group had the highest smoking rate at 20.3%.		
Low Income	**More likely to smoke if in most deprived quintile** 1) Adults living in more deprived areas were more likely to smoke in 2019. 32% among those who lived in the most deprived quintile with step-decreases across the intermediate quintiles to 6% in the least deprived quintile. A similar overall pattern by area deprivation was recorded for the mean number of cigarettes smoked per day. In 2019, the mean number of cigarettes smoked per day among current smokers that lived in the most deprived areas (13.1 cigarettes) was higher than that among current smokers in the least deprived areas (10.2 cigarettes). 2) Smoking prevalence is higher among disadvantaged groups, and disadvantaged	1) Scottish Health Survey (SHeS) 2019, last updated September 2020. 2) Socioeconomic status and smoking: a review, 2017 3) Socioeconomic Status, Social Context, and Smoking Lapse During a Quit Attempt: An Ecological Momentary Assessment Study, 2020	It is not expected that there are material data gaps with regards to this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.

	smokers may face higher exposure to tobacco's harms. Uptake may also be higher among those with low socioeconomic status (SES), and quit attempts are less likely to be successful. 3) Smokers from lower socio-economic backgrounds attempting to quit experienced greater pro-smoking social contexts that affected subsequent risk for lapse.		
	A class identifier Some views expressed in the 2019 consultation highlighted a concern that the those from lower socio-economic communities may be impacted by this policy, due to the perceived identification of 'being working class' if smoking as a result of smoking being perceived as more common in working class communities. It was suggested that a ban could be perceived as targeting them based on their class.	Prohibiting smoking outside hospital buildings: consultation analysis, 2020.	It is not expected that there are material data gaps with regards to this policy. We will continue to monitor any trends that arise through the SHeS and from our stakeholders.

Marriage and civil partnership	The Scottish Government does not require assessment against this protected characteristic unless the policy or practice relates to work, for example HR policies and practices. This policy does not relate to work therefore we have not considered it for this EQIA.	N/A	N/A

Stage 3: Assessing the quality of the impacts and identifying opportunities to promote equality

At this stage of the equality impact assessment, the qualitative scoring of the potential impacts (negative, positive and neutral) have been considered for each of the protected characteristics and the other specified characteristics already listed in this EQIA. This qualitative scoring has been undertaken using the data and evidence available and gathered to date.

Do you think that the policy impacts on people because of their age?

Age	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	An enforceable smoke-free perimeter of 15m would not create unlawful discrimination related to age, as this would be enforceable for all.
Advancing equality of opportunity	**X**	**X**		Elderly persons are more likely to be hospital patients and are exposed to others smoking when entering and then leaving the building. These groups may feel

				vulnerable to the effects of second hand smoke and may find it harder to move away from groups of smokers which currently congregate near entrances so this policy would positively impact them. However, some may experience negative impacts by being more at risk of committing an offence. Those struggling with mobility may find it harder to comply with the smoke-free area rules and may be more tempted to knowingly commit an offence. Smokers who do not have the capacity to fully understand the policy may inadvertently commit an offence by smoking within the perimeter. Those who would be unable to read the required signage due to visual impairments may be more likely to inadvertently commit an offence. Signage is expected to feature the international no-smoking symbol which should mitigate the impact on the latter group to a degree although they may still not understand that there is a smoke-free perimeter in place. No further mitigating action can be taken in legislation, however it is intended that enforcement officers and hospital staff would offer the necessary support to such individuals in the first instance to prevent them from inadvertently committing an offence. It is also important to note that in the 2016 Act, Chapter 3, section 4B (2) it states that – it is a defence for an accused charged with an offence under this section to prove that the accused did not know, and could not reasonably be expected to have known, that the place in which it is alleged the accused

				was smoking was within the no-smoking area outside a hospital building. The policy would also be beneficial for smokers in this group who have been advised to give up or cut down on smoking during their treatment or to support the maintenance of good health in their later years. Increased exposure to smoking cues (including seeing other people smoke) can reduce the likelihood of a quit attempt being successful, so this policy may support people in this group in attempts to quit smoking. It is more important than ever to introduce measures that de-normalise smoking and support cessation, in addition to reducing exposure to second hand smoke for non-smokers in the current context and risk of COVID-19, especially for the elderly who are more at risk. The continued progress re. de-normalisation of smoking is necessary to ensure that young people do not pick up the habit, with it being out of sight and out of mind so that Scotland can reach the 2034 target of 5% or less of the population smoking. Smoking contributes to significant negative outcomes and age-related cognitive decline can be accelerated by smoking. We believe that the negative impacts of introducing a 15m perimeter ban would therefore be offset by population health benefits in addition to benefits to elderly smokers who should be supported to quit for their own health.

				Children and young people are more likely to take up smoking if their environment normalises it – the de-normalisation of smoking as an inherent aim of this policy will benefit children and young people by putting tobacco out of sight and out of mind. It will further protect them from any potential risk of second-hand smoke and the damage it can have, to which children are in particular more vulnerable.
Promoting good relations among and between different age groups			**X**	The introduction of a 15m smoke-free perimeter is unlikely to impact on the promotion of good relations between age groups.

Do you think that the policy impacts people with disabilities?

People with disabilities	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	An enforceable smoke-free perimeter of 15m would not create unlawful discrimination related to disability. Hospital grounds already have smoke-free policies; this would just enforce this policy for 15m outside of a hospital building.
Advancing equality of opportunity	**X**	**X**		There could potentially be positive and negative impacts on people with disabilities. Those with disabilities or mental health conditions are more likely to be hospital patients and are exposed to others smoking when entering and the leaving the building. These groups may feel vulnerable to the effects of second-hand smoke and may find it more difficult to move away from groups of smokers which currently congregate near entrances at many hospital sites so this policy would be positive for them. The policy would also be beneficial for smokers in this group who have been advised to give up or cut down on smoking to positively impact upon their condition where applicable. Increased exposure to smoking cues (including seeing other people smoke) can reduce the likelihood of a quit attempt being successful, so this policy may support people in these groups in attempts to quit smoking which could support their health more widely. We also know that people with mental health

				conditions are more likely to smoke than the general population. However, some people in these equality groups may experience negative impacts by being more at risk of committing an offence. Smokers in these groups who struggle with mobility may find it harder to comply with the smoke-free area rules and may be more tempted to knowingly commit an offence. Smokers who do not have capacity to fully understand the policy may inadvertently commit an offence by smoking within the perimeter. Another potential impact of this policy on those with disabilities is that those who would be unable to read the required signage due to visual impairments may be more likely to inadvertently commit an offence. No further mitigating action can be taken in legislation, however it is intended that enforcement officers and hospital staff would offer the necessary support to such individuals in the first instance to prevent them from inadvertently committing an offence. The significant majority of health boards felt strongly in 2017 that all hospitals should be included in the proposed new legislation to ensure equity across the NHS estate as well as consistency for staff, patients and members of the public. Following consultation with the Royal College of Psychiatrists; NHS Health Boards; Mental Health Network of Glasgow; SPECTRUM; Cancer Research UK; Scottish Coalition on Tobacco and Glasgow City Council, it is believed that for equality

				and consistency, the Regulations should be applied to all hospitals and that psychiatric hospitals should not be exempt. To exempt certain types of hospitals creates an 'us vs them' and results in the health protections from environmental tobacco smoke being applied unevenly to patients, staff and visitors across Scotland, which in itself is an inequalities issue. To exempt mental health facilities is to continue to widen the inequalities by permitting health damaging behaviours to continue to disproportionately affect very vulnerable patients, whilst not permitting that behaviour at general hospital sites. Alternatives to smoking should be provided as should cessation support, as with any other addictive substance. To exempt these hospitals would also widen inequalities for other patients around the smoker and for staff working within these facilities who would be exposed to smoking cues, normalisation or the risk of second-hand smoke should they work in these facilities that they would not be elsewhere in the NHS. There is also precedent for this – a full smoking ban (both internally and externally on hospital grounds) is already in place at The State Hospital, Carstair, a forensic mental health hospital. It is also important to note that in the 2016 Act, Chapter 3, section 4B (2) it states that – it is a defence for an accused charged with an offence under this section to prove that the accused did not know, and could not reasonably be expected to have known, that the place in

				which it is alleged the accused was smoking was within the no-smoking area outside a hospital building. Smoking contributes to significant negative outcomes for all that engage in it. We believe that the negative impacts of introducing a 15m perimeter ban would therefore be offset by the denormalisation of smoking and the resulting population health benefits in addition to benefits to smokers with disabilities or mental health conditions themselves who should be supported to quit for their own health.
Promoting good relations among and between disabled and non-disabled people			**X**	The introduction of an enforceable 15m smoke-free perimeter is unlikely to impact on the promotion of good relations between disabled and non-disabled people.

Do you think that the policy impacts on men and women in different ways?

Sex/Gender	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	An enforceable smoke-free perimeter of 15m would not create unlawful discrimination related to gender as it is not expected that there are significant differences between the genders and smoking prevalence.

Advancing equality of opportunity			**X**	An enforceable smoke-free perimeter of 15m would not affect equality of opportunity related to gender as it would impact all in the same way. There is little difference in the number of men and women who smoke.
Promoting good relations between men and women			**X**	The introduction of an enforceable 15m smoke-free perimeter is unlikely to impact on the promotion of good relations between men and women.

Do you think that the policy impacts on women because of pregnancy and maternity (including those experiencing pregnancy that do not identify as women)?

Pregnancy and Maternity	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	An enforceable smoke-free perimeter of 15m would not create unlawful discrimination related to pregnancy or maternity.
Advancing equality of opportunity	**X**	**X**		Those that are experiencing pregnancy and maternity are more likely to be hospital patients and are exposed to others smoking when entering and the leaving the building. This group may feel vulnerable to the effects of second-hand smoke and may find it more difficult to move away from groups of smokers which currently congregate near entrances at many hospital sites so this policy would be positive for them. The policy would also be beneficial for smokers in this group who have been advised to give up or cut down on smoking during their treatment (for example, a very high proportion of pregnant smokers are referred for cessation support). Increased exposure to smoking cues (including seeing other people smoke) can reduce the likelihood of a quit attempt being successful, so this policy may support people in this group in attempts to quit smoking. Successful cessations also positively impact the unborn child.

				Some people in this group may experience negative impacts by being more at risk of committing an offence. Smokers in this group who struggle with mobility as a result of pregnancy may find it harder to comply with the smoke-free area rules and may be more tempted to knowingly commit an offence. However, smoking contributes to significant negative outcomes for all that engage in it. We believe that the possible negative impacts of introducing a 15m perimeter ban would therefore be offset by the de-normalisation of smoking and the resulting population health benefits in addition to benefits to pregnant people who should be supported to quit for their own and their baby's health.
Promoting good relations			**X**	The introduction of an enforceable 15m smoke-free perimeter is unlikely to impact on those experiencing pregnancy and maternity and the promotion of good relations to others.

Do you think that the policy impacts on transgender people?

Gender reassignment	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	An enforceable smoke-free perimeter of 15m would not create unlawful discrimination related to gender identity.
Advancing equality of opportunity			**X**	An enforceable smoke-free perimeter of 15m would not affect equality of opportunity related to gender identity.
Promoting good relations			**X**	The introduction of an enforceable 15m smoke-free perimeter is unlikely to impact on the promotion of good relations between transgender, non-binary or cisgender people.

Do you think that the policy impacts on people because of their sexual orientation?

Sexual orientation	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	An enforceable smoke-free perimeter of 15m would not create unlawful discrimination related to sexual orientation.
Advancing equality of opportunity			**X**	An enforceable smoke-free perimeter of 15m would not affect equality of opportunity related to sexual orientation.
Promoting good relations			**X**	The introduction of an enforceable 15m smoke-free perimeter is unlikely to impact on the promotion of good relations between those of the LGBTQIA+ community and others.

Do you think that the policy impacts on people on the grounds of their race?

Race	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	An enforceable smoke-free perimeter of 15m would not create unlawful discrimination related to race.
Advancing equality of opportunity			**X**	An enforceable smoke-free perimeter of 15m would not affect equality of opportunity related to race. Although there are differences in the smoking prevalence rates regarding ethnicity, cessation services are available to all as is any documentation that may need to be translated.
Promoting good relations			**X**	The introduction of an enforceable 15m smoke-free perimeter is unlikely to impact on the promotion of good relations between those of different races.

Do you think that the policy impacts on people because of their religion or belief?

Religion or belief	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	An enforceable smoke-free perimeter of 15m would not create unlawful discrimination related to religion or belief.
Advancing equality of opportunity			**X**	An enforceable smoke-free perimeter of 15m would not affect equality of opportunity related to religion or belief.
Promoting good relations			**X**	The introduction of an enforceable 15m smoke-free perimeter is unlikely to impact on the promotion of good relations between those with different religions or beliefs.

Do you think that the policy impacts on people living on low income or living in poverty?

Living on Low Income/ Living in Poverty	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	An enforceable smoke-free perimeter of 15m would not create unlawful discrimination related to socio-economic background. Although people living in socio-economic disadvantaged are statistically more likely to smoke, services are currently targeted on reducing prevalence in these areas. The enforceable ban would just be an extension of what this group is already being asked to do on hospital grounds like any other, which is to not smoke.
Advancing equality of opportunity			**X**	An enforceable smoke-free perimeter of 15m would not affect equality of opportunity related to socio-economic background. Although smoking is more prevalent in lower income groups, the implications for smokers from different socio-economic backgrounds would be the same as those smokers in higher income groups. It is not apparent that there are negative outcomes or health risks from smoking 15 metres further away from hospital buildings. It is noted that the greater prevalence of smoking in deprived areas acts as a strong component of identity and so restrictions on smoking may be viewed by low income smokers as targeting people from their background. However, everyone, including those from low income groups, will benefit from less exposure to

				second hand smoke and it is expected to outweigh any impacts or inconvenience for low income smokers. Barriers to quitting have been reported for those from lower socio-economic backgrounds. This policy supports those visiting for cessation treatment, who have given up or who have reduced their smoking, and who might find it difficult to pass through areas close to entrances where people have congregated to smoke. Social acceptability has a strong bearing on health behaviours and evidence shows that quitting is made more difficult if a smoker's social environment is filled with smoking cues and this policy aims to support the de-normalisation of smoking. It is believed that this policy therefore will not have significant impacts on the inequalities associated with socio-economic disadvantage.
Promoting good relations		**X**		The introduction of an enforceable 15m smoke-free perimeter could impact relations between those on a low income or living in poverty and others. With the acknowledged differences in smoking prevalence between those in SIMD1 vs SIMD5 groups where those on a lower income or living in poverty more likely to smoke, smoking is starting to become a class signifier. Members of this group may feel targeted by this action, however this is just an enforcement of a 15m ban on grounds where they have already been asked to not smoke.

Do you think that the policy impacts on people living in remote rural/ island communities?

Living in remote rural/ island communities	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			**X**	An enforceable smoke-free perimeter of 15m would not create unlawful discrimination related to those living in remote rural areas and islands. It is believed that there will be no impact on island communities that is significantly different from the effect on other communities.
Advancing equality of opportunity			**X**	An enforceable smoke-free perimeter of 15m would not affect equality of opportunity related to those living in remote rural areas and islands.
Promoting good relations			**X**	The introduction of an enforceable 15m smoke-free perimeter is unlikely to impact on the promotion of good relations between people living in remote rural areas and islands with those living on the mainland.

Stage 4: Decision making and monitoring (Identifying and establishing any required mitigation action)

Have positive or negative impacts been identified for any of the equality groups?	Potential impacts have been considered for each of the protected characteristics and the other specified characteristics as listed in this EQIA. Creating a designated smoke-free area in NHS hospital grounds will impact protected characteristic groups who work in or use hospitals as patients, staff and visitors. The elderly, those with disabilities and pregnant persons were identified as potentially being impacted by this policy decision. However, a strong public health rationale and the positive outcomes they will deliver outweigh any disproportionate impacts on protected characteristic groups. The legislation is designed to promote positive behaviour change and is not intended to be punitive. This facilitates educational opportunities which could further assist boards in promoting free stop-smoking services. Various options have been considered, including NHS hospitals continuing to implement workplace policies, legislating to implement grounds-wide bans or introducing smoke-free areas. The best way to achieve this policy aim of de-normalising smoking, reducing second hand smoke exposure and ensuring that the NHS is an exemplar of positive health behaviours while taking equality impacts into consideration is therefore to implement a smoke-free area around the buildings themselves. It is more reasonable and compassionate to expect people to leave a 15m perimeter than to completely leave hospital grounds. NHS staff will continue to offer cessation support to patients. It is also easier to enforce a prohibition backed by the criminal law near buildings given that some hospital grounds are vast in size. Another potential impact of this policy on equality groups is that those who would be unable to read the required signage due to visual impairments or because they do not read English well may be more likely to inadvertently commit an offence. The fact that the intention is for the signage to feature the international no-smoking symbol should mitigate the impact on the latter group to a degree although they may still not understand that there is a smoke-free perimeter in place. Proposed wording was

	discussed with the Smoking Co-ordinators Network – with representatives from each health board – as well as the Promoting Health Service National Network, representative bodies of Environmental Health Officers in Scotland, with SG Marketing and Communications teams and their corresponding specialist colleagues in NHS Scotland in 2017. No further mitigating action can be taken in legislation, however it is intended that enforcement officers and hospital staff would offer the necessary support to such individuals in the first instance to prevent them from inadvertently committing an offence. These proposals will have the positive impact of improving health for these groups by supporting the de-normalisation of smoking on hospital grounds in order to help reduce the use of tobacco across the population of which they are a part of. This no-smoking policy is intended to beneficial to all – whether or not the people are more likely to smoke. It will also help to prevent and reduce exposure to second-hand smoke by these groups in NHS hospital grounds, at entrances and near windows/vents to buildings, protecting them from the health harms of second hand smoke.
Is the policy directly or indirectly discriminatory under the Equality Act 2010?	There is no evidence, so far within this EQIA that the policy is directly or indirectly discriminatory under the Equality Act 2010.
If the policy is indirectly discriminatory, how is it justified under the relevant legislation?	N/A
If not justified, what mitigating action will be undertaken?	N/A

How has the Equality Impact analysis shaped the policy making process so far?

Equality issues were considered during the policy development process and the proposals were not considered to give rise to the possibility of those affected being treated less favourably due to any of the protected characteristics overall. This policy has a strong public health rationale and the positive outcomes they are expected to deliver should have particular benefits for all of those with protected characteristics who smoke. Disproportionate negative impacts on individuals within protected characteristic groups will be outweighed by the policy's positive health benefits at a population level. This no-smoking policy is intended to beneficial to all – whether or not the people are more likely to smoke. The legislation is designed to promote positive behaviour change and is not intended to be punitive, this facilitates educational opportunities which could further assist boards in promoting free stop-smoking services.

It was therefore considered that a relatively limited Equality Impact Assessment (EQIA) would be appropriate. The focus of the data gathering and consideration was on determining whether there may be any inadvertent effects on different groups by examining the populations likely to be affected by the proposals.

Monitoring and Review

No changes to the policy were considered necessary following the EQIA. However, the Scottish Government will continue to work with stakeholders to ensure full account is taken of equality issues. Data on smoking prevalence rates among protected characteristic groups will continue to be monitored as it becomes available.

Stage 5: Authorisation of EQIA

Declaration I am satisfied with the equality impact assessment that has been undertaken for the The Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022 and give my authorisation for the results of this assessment to be published on the Scottish Government's website.

Name: Karen MacNee

Position: Deputy Director

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