



**T8** Reduce the rate of smoking, contributing to the national target of: reducing the rate in manual groups from 32% in 1998 to 26% by 2010; 800,000 smokers from all groups successfully quitting at the 4 week stage by 2006

The rationale for this target is the link between smoking and cancer mortality. Smoking is also a key factor in health inequalities and a major cause of many other diseases, notably CHD. The target is intended to deliver a challenging but achievable increase in activity in NHS tobacco control and the smoking cessation services programme. Consistent development throughout the target period will be needed to ensure that this target is achieved – the history of tobacco control and smoking cessation services has shown that services need time to develop. Service development on this scale will necessitate the increased involvement of health professionals in a range of disciplines, including GPs who have a key role in offering advice and prescribing pharmacological aids. The need for an adequate supply of smoking cessation advisers should be achievable through recruitment and training of suitable individuals, who may be nurses, pharmacists or other players such as community workers, to provide services to smokers, usually on a sessional basis. Further information is available on <http://www.doh.gov.uk/tobacco>.

We would suggest that local plans and trajectories need to take into account the year on year growth of services which will be needed, and that services will need to be developed from the start of the target period, to ensure local and national targets are met and maintained throughout the period. To illustrate this, an example of a possible national trajectory is included below.

The 800,000 “4 week quitters” are to be drawn from all social groups. However in order to focus on the impact of smoking on the higher mortality and morbidity rates in manual socio-economic groups, the target links cessation activity to the national manual groups prevalence target. If this national target for prevalence of smoking among manual groups is to be achieved, a high proportion of smokers in manual groups must successfully quit. All PCTs will need to meet a challenging target for successful quitters, not least because smokers in manual groups are to be found in all areas. However targets for PCTs in areas of highest deprivation will need to be relatively more demanding. It is planned that allocations will reflect this, and the target envelopes for StHAs (which will be made available shortly on

<http://www.doh.gov.uk/tobacco>) will be calculated accordingly. StHAs will need to set targets for their PCTs on this basis. (The former methodology for distribution of resources will no longer apply.)

PCTs' success in reaching smokers in manual groups and their local contributions to the national manual groups prevalence target will not be monitored centrally. In view of the importance of this area, we suggest that PCTs might wish to include in their local plans a consideration of how they plan to reach disadvantaged smokers through partnership working as part of an overall tobacco control strategy. The drive to tackle smoking in pregnancy will be an important part of this – see under “Reducing Health Inequalities”.

#### Data sources and monitoring

The Department of Health smoking cessation monitoring return will provide the data used for tracking successful four week quitters; this data should be the equivalent of SaFF collection lines 4210 and 4221. The data from the smoking cessation monitoring return are collected, validated and analysed by DH. They are published in a quarterly Statistical Press Notice, and at a more detailed level in an annual bulletin.

Prevalence of smoking among the general adult population of 16 and over is presented in the General Household Survey (<http://www.statistics.gov.uk/lib>). This includes analysis by socio-economic group e.g. manual groups.

T37 Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focussing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between “routine and manual” groups and the population as a whole by 2010, starting with children under one year.

The data to support this target are included in the SaFF. Pregnant smokers who quit at any time before delivery will count towards this target.

Data quality has been compromised in the past due to missing or incomplete data, or distortion of data due to failure to ascertain smoking status. These problems should be addressed following the issue of a Data Set Change Notice (DSCN) in early October which sets out the questions which need to be asked to deliver robust data. The website address for the DSCN is <http://www.nhsia.nhs.uk/dscn> (ref, DSCN 50/2002)

In order to complete the SaFF lines at the year end, data needs to be collected locally throughout the year. When setting the baseline from which to plan their one percentage point reduction, it is suggested that PCTs use the data collected in the first half of the year, that is, between April 2002 and September 2002. If the data has not been reliable to date PCTs will need to make the best estimate possible on which to base their planned trajectories.

The rationale for this target is the clear link between smoking in pregnancy and health inequalities. Prevalence is highest among women who left full-time education at an early age, younger women, single women and those with a partner who smokes. The target therefore specifies a focus on disadvantaged groups as a contribution to the national target to reduce the infant mortality gap by at least 10% by 2010. This aspect

will not be monitored centrally at PCT level. This targeting to disadvantaged groups can be fostered through partnership working (perhaps linked with the targeting of the smoking cessation services programme – see under “Cancer”) and PCTs might wish to plan for this at local level.

A national smoking in pregnancy initiative has been underway since April 2001, under which former HAs received specific funding to appoint a “champion” of services for pregnant smokers, with responsibility for coordinating and developing services to help pregnant smokers to stop. Individuals with this nominated responsibility (who can be contacted via smoking cessation coordinators) should therefore be in place across the country and their role will be key to delivering this target. It will therefore be sensible to include the smoking in pregnancy champions in the process whereby local plans are drawn up. It will be important that health professionals (midwives, practice nurses, health visitors) are involved in reaching pregnant smokers. Effective liaison with the Surestart programme will help to secure mutual success. Further information can be found at [www.doh.gov.uk/tobacco](http://www.doh.gov.uk/tobacco).