TACKLING HEALTH INEQUALITIES

TARGETING ROUTINE AND MANUAL SMOKERS IN SUPPORT OF THE PUBLIC SERVICE AGREEMENT SMOKING PREVALENCE AND HEALTH INEQUALITY TARGETS
**DH INFORMATION READER BOX**

<table>
<thead>
<tr>
<th>Policy</th>
<th>Estates</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR/Workforce</td>
<td>Commissioning</td>
</tr>
<tr>
<td>Management</td>
<td>IM &amp; T</td>
</tr>
<tr>
<td>Planning/Performance</td>
<td>Finance</td>
</tr>
<tr>
<td>Clinical</td>
<td>Social care/Partnership working</td>
</tr>
</tbody>
</table>

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**Title**  
Tackling Health Inequalities – Targeting Routine and Manual Smokers in Support of the Public Service Agreement Smoking Prevalence and Health Inequality Targets

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**Description**  
This guidance supports the achievement of the PSA smoking prevalence and health inequality 2010 targets. It provides PCTs and local authorities with a firm rationale as to why targeting routine and manual smokers will in turn help reduce smoking prevalence. Evaluation will occur during National Support Team field visits in addition to feedback from Regional Tobacco Policy Managers who will disseminate the guidance.

**Cross reference**  
NHS Stop Smoking Services: Service and Monitoring Guidance 2009/10

**Superseded documents**  
N/A

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TACKLING HEALTH INEQUALITIES
TARGETING ROUTINE AND MANUAL SMOKERS IN SUPPORT OF THE PUBLIC SERVICE AGREEMENT SMOKING PREVALENCE AND HEALTH INEQUALITY TARGETS
Executive summary

Government policy is committed to reducing health inequalities and has set ambitious Public Service Agreement (PSA) targets to ensure that the gap in health inequalities between the rich and the poorest in our communities does not widen.

National Support Teams are tasked to support the local delivery of PSA targets, working in partnership with local authorities, primary care trusts (PCTs) and NHS trusts. This paper concentrates on the 2010 PSA 18 smoking prevalence targets and provides a firm rationale as to why targeting routine and manual (R&M) smokers to quit will ultimately reduce health inequalities, including infant mortality, contributing positively to the health inequality PSA target.

This paper acknowledges that stop smoking services will play a prominent part in supporting smokers in the R&M group to quit. However, it advocates placing stop smoking services in the correct context as part of an overall approach to tobacco control. In this way R&M smokers will be prompted to quit and channelled to effective evidenced-based support and, because most smokers stem from this group, there is the greatest gain in terms of de-normalising smoking in our communities.

The paper is intended for use at a local level as this is where stop smoking services can engage with R&M smokers more effectively and where PCTs and NHS trusts, in partnership with local authorities, can make a difference. The paper provides clear recommendations for PCT commissioners and providers, local authorities and the third sector, drawing from national policy documents in order to translate government policy into effective local action.
1. Background

1.1 Presently there are two PSA targets that relate to smoking prevalence:

- To reduce prevalence among the general population to 21% or less by 2010.
- To reduce smoking prevalence in the R&M group to 26% or less by 2010.

1.2 In addition, the Government has pledged to reduce health inequalities by tackling the wider determinants of health, such as poverty, poor and educational outcomes. This too is supported by a PSA target:

- To reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

And it is underpinned by two, more detailed, objectives:

- Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the R&M group and the population as a whole.
- Starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

1.3 Smoking remains the leading cause of preventable mortality and morbidity in England, with large numbers of smokers often concentrated in the more deprived communities and exposed to well-established health risks. As such, smoking plays a massive role in health inequalities, accounting for up to half of the entire mortality differential between social classes. It is also a major contributor to infant mortality. Smoking in pregnancy increases infant mortality by approximately 40%, and smoking prevalence is 1.5 times higher in R&M pregnant women than the population as a whole. People from poorer social classes are likely to die early due to a variety of factors that government has acknowledged through the PSA targets, but smoking remains the predominant factor in terms of lifestyle.

1.4 Research suggests that no single approach to tackling smoking will be successful in isolation and what is required is sustained and coordinated action at all levels – nationally, regionally and locally. Reducing smoking prevalence rates in the R&M group is no exception. Although stop smoking services are well placed in terms of providing
evidence-based stop smoking support, they will ultimately be more effective and attract more smokers when part of a comprehensive approach to tobacco control.

2. Aims

2.1 THIS PAPER WILL:

- Provide a firm rationale why reducing smoking rates in R&M smokers will contribute to reducing health inequalities as a whole, including the infant mortality element set out in the national health inequalities PSA target.

- Concentrate on smokers in the R&M group. Although there will be an emphasis on improving quit rates in the R&M group and how best to achieve this, the paper will place stop smoking services in the correct context as part of a comprehensive approach to tobacco control. The reason for this is twofold. Improved R&M quit rates will ultimately de-normalise smoking in communities with the highest smoking prevalence (and offers the potential to make further gains in normalising smoke-free lifestyles); and placing smoking cessation services as part of an overall tobacco control approach will ensure that R&M smokers are prompted to quit and channelled appropriately to effective evidence-based support.

- Highlight the importance of targeting smokers in the R&M group as a means of reducing overall health inequalities and achieving the PSA targets highlighted above.

- Apply at a local level. PCTs and local authorities have a good understanding of the health behaviours of their communities and the effects they have on health and well-being. What they require from the centre is a clear rationale that they can disseminate locally why tackling smoking in the R&M group will result in positive health gains. This paper will provide that rationale and make recommendations enabling commissioners to purchase effective interventions that are appropriately developed in line with R&M preferences; ultimately translating government policy into local action.
3. **Audience**
- PCTs – commissioners and providers
- Local authorities
- Third sector organisations

4. **Definition**

4.1 In 2007, there were an estimated 14.9 million people in the R&M group of which 26% smoke, 28% men and 24% women.

4.2 R&M smokers are defined by their occupation (according to the Standard Occupational Classification, or SOC, codes). The SOC codes in terms of R&M groups include occupations such as lower supervisory and technical or routine and semi-routine occupations. As such they account for almost 50% of smokers in England by SOC code, or approximately 4.25 million smokers. The top five R&M occupations for men include HGV drivers, storage handling, sales and retail, van drivers and labourers. The top five R&M occupations for women are sales and retail, carers, cleaners, educational assistants and kitchen and catering assistants.

4.3 There are more people in R&M occupations in the north, north west and north east of England and in Yorkshire and in the Midlands than in the rest of the country.

4.4 Forty-two per cent in the R&M group are aged 25 to 45, compared with 35% in the general population. In addition, R&M workers are more likely to have children aged under five (39% compared with 35% of the general population).

4.5 In terms of smoking, smokers in the R&M group are more likely to have started smoking before they reached the age of 16 (48% compared with 33% for managerial and professional groups). They are also more likely to be heavily addicted to smoking: 37% of male heavy-smoking R&M workers report having their first cigarette within five minutes of waking, which is a measure of heavily addicted smokers.

4.6 Although R&M smokers are defined by their occupation, most non-employed people (eg the unemployed, the retired, those looking after a home, those on government employment or training schemes, the sick and people with disabilities) are classified according to their last main job. The exceptions to this rule are full-time students and those who have never worked or are long-term unemployed. These groups are excluded from the classification and are not included in the R&M group.
4.7 A third of R&M smokers live in the most deprived 20% of areas. Over a third (37%) of this group smoke, compared with only 22% of those in managerial and professional occupations living in the same areas.

5. Marketing insights into R&M smokers

5.1 R&M workers tend to establish standard routines in which smoking is entrenched.

5.2 The family and local community are very important to R&M smokers and many live in close proximity and socialise regularly. Quitting smoking can be isolating to R&M smokers as they are surrounded in their communities and social groups by other smokers, and this often leads to relapse.

5.3 R&M smokers may be daunted by the prospect of quitting; they know from personal experience, and from others, that it is hard and painful, and feel that it is likely to end in failure. The short-term benefits of quitting are perceived as minimal when compared against the pain of quitting and the fact that the long-term benefits will not be felt for some time.

5.4 R&M smokers can see smoking as integral to who they are rather than something they do. Smoking may fulfil many needs: it is a fix, it is a coping mechanism, it fills a gap, helps them to relax and have some ‘me’ time, or it can act as a reward. As such, attempting to become a non-smoker or even an ex-smoker may not only seem daunting but out of character.

6. Rationale for targeting R&M smokers

6.1 The Department of Health paper *Health Inequalities: Progress and Next Steps* (2008) advocates scaling-up activity that will achieve the 2010 health inequality PSA target. In addition to the work currently being delivered by the National Support Team (NST) for health inequalities, other NSTs, particularly for tobacco control, are being asked to re-focus efforts to improve services for R&M workers, working in partnership with the NST for health inequalities.

6.2 As smoking is responsible for one-sixth of all deaths in the UK, it is the area where behaviour change would make the greatest impact on health inequalities.

6.3 The greatest volume of smokers is to be found in the R&M socio-economic group. It therefore follows that the greatest volume of
smoking-related health inequalities stems from this group, as does the greatest gain if smokers can be effectively supported to quit.

6.4 Research suggests that, while R&M smokers may find it harder to convert into non-smokers, they are not ‘hard to reach’ in terms of wanting to quit.

6.5 Approaching the ‘hardest to reach’ in an unfocused manner does not have as clear an evidence base as targeting R&M smokers. In addition, because the volume of such smokers is small, it will be harder to drive down smoking prevalence and, in turn, reduce health inequalities.

6.6 In comparison, a coordinated focus on reducing smoking in the R&M group will reduce health inequalities more significantly, as it targets smokers where there is the greatest volume, who we know are not hard to reach and who want to quit, and where there is now a clear evidence base on how to engage and support them.

6.7 Reducing smoking prevalence in R&M smokers has further health gains in that it de-normalises smoking in communities where other hard to reach, niche smokers reside, making it easier for them to quit once specific campaigns for them are developed and implemented.

7. Impact of the wider tobacco control strategy on the R&M group and health inequalities

7.1 Stop smoking services, even those services targeting R&M smokers, should not operate in isolation, as this approach will not maximise their potential reach and efforts in R&M communities.

7.2 The NST for tobacco control has developed a comprehensive tobacco control approach. A model has been developed as a basic framework for building and assessing a local strategic approach to tobacco control and is based on international experience, including the World Health Organization MPOWER model and the Department of Health national six-strand approach as outlined in Smoking Kills (1998). Although it includes stop smoking services, it is not limited to that one element. The approach consists of three core elements (that could be utilised by other NSTs in terms of tackling health behaviours that result in illness and disease and limit life expectancy), which are:

☐ planning and commissioning
☐ developing multi-agency partnership working
☐ monitoring, evaluation and response
These three elements are crucial as they ensure that effective tobacco control programmes are supported by a strong central spine which individual operational strands and work streams link into.

7.3 Operational work streams include:
- making it easier to stop smoking
- tackling cheap and illicit tobacco
- normalising smoke-free lifestyles
- communication

7.4 As each work stream feeds into and includes the core elements, their activities are coordinated. Locally, this could operate using the following examples:

- Local commissioners for tobacco control may advocate that all partners, signed up to deliver local tobacco control programmes, utilise the national SmokeFree branding. The communication arm of the programme will ensure that any local communication includes the national branding, and a service level agreement ensures its adoption by the stop smoking service and other programme work streams. By working in this manner, a media response concerning any element of tobacco control will be appropriately branded and will direct the R&M smoker to the local stop smoking service for advice, as it supports the national stop smoking campaigns developed in line with R&M group insights.

- Research shows that price is still the leading trigger for smokers to quit. And, although tackling cheap and illicit tobacco supply will not in isolation reduce health inequalities, this supply threatens to undermine other effective tobacco control interventions if not minimised and controlled. Evidence suggests that places of work may also be the very places where cheap and illicit tobacco is accessed, therefore local action could include a variety of responses in terms of R&M smokers, including intelligence gathering and sharing, information events for both employers and employees and an introduction to the local stop smoking service.

7.5 The examples above represent only two ways in which a coordinated, comprehensive tobacco control approach could be utilised to engage with and support R&M smokers to quit. Their aim is to reinforce the message that all elements, when commissioned and delivered
appropriately, funnel R&M smokers effectively to the local stop smoking service.

8. Recommendations

8.1 PCT COMMISSIONERS

☐ Tobacco control at a local level has the potential to be strengthened through joint commissioning and by deploying World Class Commissioning criteria. Commissioning stop smoking services is often a very useful starting point as it provides commissioners with the opportunity to get it right. For example, PCT commissioners can look to local authorities to co-own four-week quit targets and ensure that stop smoking services target R&M smokers utilising local public health data and social marketing insights. In addition, service level agreements can be developed to ensure that stop smoking services are underpinned by current evidence-based practice, for example utilisation of the national Tobacco Control Marketing and Communications Strategy (2008–2010), the NHS Stop Smoking Service and Monitoring Guidance (2009/10), and the Tobacco Control 10 High Impact Changes document (which advocates applying an integrated framework to the delivery of stop smoking support). All three documents recommend supporting R&M smokers to quit and the marketing strategy provides a comprehensive programme of tasks to be implemented nationally and adopted locally over the next two years.

☐ Commissioners should explore how focusing on the R&M group has the potential to contribute positively on other key targets. For example, research suggests that targeting pregnant smokers in the R&M group is the most effective way that PCTs and local authorities can ensure a greater reduction in the percentage of women continuing to smoke during pregnancy, which in turn impacts on infant mortality rates as smoking in pregnancy increases infant mortality by 40%.

8.2 PCT PROVIDERS

☐ Provide stop smoking support to R&M smokers through an integrated framework model. This will ensure that all providers of local stop smoking services are trained and supported to deliver high-quality interventions, providing a wide reach in a variety of settings.

☐ Utilise national branding linking local targeted stop smoking support to national campaigns aimed at R&M smokers.
Implement national marketing strategy programmes as and when they are fully developed for local use. For example, work in partnership with ‘face to face’ field marketers who communicate direct with local R&M smokers, implement the healthcare professionals’ programme and the employers’ programme and raise awareness of local services through mass action events such as No Smoking Day.

Gather and share local R&M smoking insights with PCT commissioners to inform the development of future service level agreements.

Gather and share other tobacco-related intelligence, eg on cheap and illicit tobacco, and feedback to strategic partners (such as Trading Standards) to reduce the negative effect that access to cheap tobacco has on engaging R&M smokers.

8.3 LOCAL AUTHORITIES

Seek to ensure that prevalence targets are included in local area agreements and their importance is communicated to key partners.

Support the development and maintenance of a local Tobacco Control Alliance that is funded, adequately resourced, has high-level strategic support and is accountable to the Local Strategic Partnership.

Coordinate and monitor activity of the Tobacco Control Alliance, eg enforcement of smoke-free legislation and reduction of cheap and illicit tobacco. These particular work streams are crucial to reducing smoking prevalence due to their influence on de-normalising smoking in communities and R&M workplaces with high smoking rates and prompting attempts to quit due to the continuation of high tobacco prices.

8.4 THIRD SECTOR

The third sector is well placed to influence R&M smokers within their communities. The National Marketing Strategy advocates community activation as a way of generating quit attempts among R&M smokers and calls for third party ‘influencers’ to implement national activation programmes.
As community is important to R&M smokers, third sector community organisations are able to provide local insights to stop smoking service providers and PCT commissioners. They can, following training, provide community-based stop smoking advice and support through contractual arrangements with specialist provider stop smoking services, channelling complex R&M smokers to the specialist service.

9. Conclusion

This paper has drawn from national policy documentation that supports targeting R&M smokers to quit as a crucial way of reducing health inequalities and smoking prevalence. Those documents include:


This paper advocates supporting R&M smokers to quit through a comprehensive programme of tobacco control that is underpinned by the following principles: effective multi-agency partnerships, planning and commissioning, and monitoring and evaluation. In this way, stop smoking services are maximised both in reach and quality.
9.3 In addition to providing a firm rationale for targeting R&M smokers, this paper offers practical recommendations for commissioners, providers and key partners in order to translate government policy into effective local action.

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