ASH and CIEH Briefing Note

Local Area Agreements: Why they should include reduced smoking prevalence as a stretch target

Implications for Public Health

Smoking prevalence is a key indicator not just for smoking-related diseases but also for health inequalities. Reduced smoking prevalence is as important a target for Local Authorities (LAs) as it is for Primary Care Trusts (PCTs), to help focus their attention on a key determinant of health inequalities and threat to wellbeing. Smoking prevalence is a more relevant indicator than increasing life expectancy at birth because, unlike the latter which is calculated on the basis of current mortality data, smoking prevalence is a major factor in future disease and premature death. It is also closely correlated with lower socioeconomic status. Even LAs with relatively low overall smoking prevalence compared to national averages will have pockets of deprivation which need addressing, and continuing to drive down smoking prevalence will be a good indicator of their effectiveness in achieving this.

Reduced smoking prevalence is associated with increased life expectancy and reduction of a wide range of diseases both chronic and acute. Smoking causes a third of all cancers, 1 in 5 cases of cardiovascular disease and the majority of bronchitis and emphysema. Smoking in pregnant women and exposure to secondhand smoke is now thought to be the major cause of sudden infant death syndrome (SIDS) and is strongly linked to increased risk of pneumonia and bronchitis, asthma attacks and middle ear disease in children.

Reducing smoking prevalence can also have a strongly positive impact on the local economy. Research in the West Midlands found that the total cost of treating smokers and the effects of premature death, ill health and loss of productivity due to smoking amounted to more than £1.25bn in 2001 alone. This economic planning tool is now available to calculate the costs of smoking on any local economy.[1]

Health inequalities

Smoking is the individual health behaviour most strongly linked to health inequalities. The odds of being a smoker are increased in routine and manual workers, and substantially increased in the most disadvantaged for example those living in rented housing, without access to a car, live in crowded accommodation, who are unemployed, single parents on benefit, or have mental health problems.[2] To quote Professor Martin Jarvis, Emeritus Professor at University College London Health Behaviour Unit, *"any marker of disadvantage that can be envisaged and measured, whether personal, material or cultural, is likely to have an independent association with cigarette smoking."* The PSA target from which the indicator is derived includes a

specific target for routine and manual workers and so remains a matter for concern even for areas of low overall smoking prevalence.

What needs to happen

- Local Strategic Partnerships need to be encouraged to adopt smoking prevalence as one of the stretch targets in their Local Area Agreements.

- Local Strategic Partnerships need to ensure that work is undertaken with their local public health agencies and Government Office to determine the basis for calculating smoking prevalence in their area and for determining the appropriate targets.

- Public Health professionals also need to work with their Local Strategic Partnership to help develop Local Area Agreement action plans. These should include the following locally relevant elements of a comprehensive tobacco control strategy, reflecting the Department of Health six strands approach:
  - Helping smokers to give up
  - Protection from secondhand smoke
  - Education and media
  - Reducing tobacco promotion
  - Regulatory enforcement (including under-age sales, smokefree legislation and the advertising ban)
  - Tackling smuggling (in collaboration with HM Revenue and Customs)

Measurement of smoking prevalence

Currently the smoking-related indicator being used by PCTs is 4 week quit rates through the Stop Smoking Services and this will continue to be needed to enable effective performance measurement of the services. The NHS Stop Smoking Services will continue to be vital, will be performance managed and should be delivered in accordance with DH Service and Monitoring Guidance.[3]

However, it is anticipated that smoking prevalence will become the key national smoking-related indicator for PCTs from April 2008. PCTs will be negotiating appropriate local targets for smoking prevalence, which need to be based on current local area smoking prevalence. It is critical that the data being used are consistent, reliable and comparable across different areas and that the PCT and LA use the same data.

The Department of Health is working with the Office for National Statistics to include questions on smoking in the core of the new Integrated Household Survey for 2008/09 and beyond. This survey will have a sample size of around 300,000. It is expected that this will yield prevalence data that can be used at PCT and Local Authority levels and that it will provide a reliable marker of progress for all but the very smallest areas.

However, the data from 2008/09 will not be available until the end of 2009 and so an interim measure will be needed from which to develop initial targets. This could be model-based ("synthetic") estimates or proxy measures, or, where available, a booster of the Health Survey for England. Work is ongoing to review current practice with regard to local prevalence estimation at Strategic Health Authority and PCT levels and to develop recommendations for best practice until national data becomes available.

Timetable

December 2007 All Local Authorities consulting on new Local Area Agreement outcomes frameworks, funding plans and performance arrangements; Government Offices and central departments review of proposed priorities.

January 2008 Negotiation of priorities based on departmental and Government Office discussions and Local Authority/Local Authority Partnership consultations

March 2008 Continuing negotiation on priorities

April 2008 LAs submit revised outcomes framework to Government Offices which will include proposed improvement targets

May 2008 Continuing negotiation of improvement targets

June 2008 Government Office Regional Directors make recommendations to central Government. Ministerial sign off.

Resources

Using Local Area Agreements to reduce health inequalities
http://www.renewal.net/Documents/RNET/Solving%20the%20Problem/Usinglocalarea.doc

Negotiating new Local Area Agreements
http://www.communities.gov.uk/documents/localgovernment/pdf/476151

The New Performance Framework for Local Authorities & Local Authority Partnerships
http://www.communities.gov.uk/documents/localgovernment/pdf/505713

ASH mapping project giving synthetic smoking prevalence by ward
http://oldash.org.uk/html/mappingproject/mappingproject.html

ASH factsheets on smoking and health
http://www.newash.org.uk/ash_f5izj246.htm

References

[1] http://www.smokingcosts.org.uk/
[2] Jarvis, M. and Wardle, J. Social patterning of individual health behaviours: the case of cigarette smoking. In: Marmot M, Wilkinson RG (Eds) Social Determinants of Health, 2nd Edition OUP 2005
[3] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079644