Consultation on NICE draft recommendations on quitting smoking in pregnancy and after childbirth

Report to the National Institute for Health and Clinical Excellence

Reference: CL2236

Update information

November 2021: NICE guideline PH26 (June 2010) has been updated and replaced by NG209.

This guideline contains the evidence and committee discussion for recommendations from PH26 dated [2010] and [2010, amended 2021].

See www.nice.org.uk/guidance/NG209 for all the current recommendations and the evidence behind them.

Disclaimer

The views expressed in this document are those of Greenstreet Berman Ltd and its contractors and not necessarily those of NICE.

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- Louise Ross, Leicester City PCT;
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E. Executive Summary

E.1 Introduction

In 2005, 32% of mothers in England smoked before pregnancy. Of these, 49% quit before birth. Although most of those that quit before birth were still not smoking after birth, 30% started again before their child reached its first year.

Smoking can be a particular health risk during and after pregnancy for both mother and child. According to the Royal College of Physicians, risks to the mother include complications during labour and increased risk of miscarriage, premature birth, still birth and sudden unexpected death in infancy. It is also estimated to increase infant mortality by about 40%.

The Department of Health tasked NICE *"To produce public health guidance on smoking cessation in pregnancy and following childbirth."* Draft guidance was produced. As part of the consultation process Greenstreet Berman were contracted by NICE to carry out fieldwork to test the relevance, utility and implementability of the guidance, and in particular the draft recommendations on measures to promote or support cessation of smoking in pregnancy and after birth.

E.2 Method

The fieldwork comprised of three main activities:

1. Eight workshops of three hours were attended by around 15 delegates each from a range of professions. Four were held in London, two in Manchester and two in Birmingham. These sessions were designed to encourage debate and most delegates responded from the perspective of their profession.
2. Six focus groups of around two hours were hosted by PCTs in Bristol, Dudley, Leicester, Liverpool, Manchester and Slough. They were attended by around 5-10 delegates each from within the hosting PCT or linked with the hosting PCT. These sessions were designed to identify current practices, issues particular to local populations and the impact of the recommendations on those specific populations.
3. A content analysis of all sessions to identify and summarise key themes of feedback including differences between focus groups and workshops; and differences by professional type, geographical location and population demographics.

Types of job role included health professionals from stop smoking services, midwives, maternity services, health visitors, representatives from Children‟s Centres, PCT staff, local council service/programme managers, commissioners, Department of Health (DH) representatives, tobacco control advisors, smoking cessation helpline services, school and family nurses, hospital stop smoking specialists, GPs, psychologists, pharmacists, alternative health therapists, researchers and lecturers.

Although representation of job role was broadly obtained, the following professionals were underrepresented: dentists (none), occupational health (OH) professionals (none), pharmacists (two) and commissioners (five). The limitations of underrepresentation of these groups include:

- Not being able to confirm dentist, pharmacist and OH professional willingness to engage with the implementation of Recommendation 2;

- Not being able to confirm commissioner support of the implementation of all the recommendations or their willingness to do so.

All workshops and focus groups took place in December 2009 in order to meet the project schedule.

E.3 Findings

E3.1 Impact on current practice

Most areas make use of a referrals system in relation to offering smoking cessation advice. This is in line with Recommendations 1, 2 and 4 which are concerned with referring women and/or their partners and significant others (if they smoke) to stop smoking services. The exception was Manchester who offer on-the-spot advice. They were concerned that following these recommendations would be less effective and decrease levels of smoking cessation.

Although most areas do offer referrals, this tends to be on an opt-in basis, while the recommendations suggest using an opt-out approach. As this would increase referrals, there were concerns about resourcing this approach and whether it would be cost-effective.

There was much concern about obtaining referrals through pharmacists and GPs (rates of which are reportedly low in the majority of areas) but it was thought that incentives may help. Professionals other than those listed in the recommendations have been found to be invaluable with assisting with supporting smoking cessation among pregnant women, particularly Children‟s Centre staff.

NRT is the most commonly offered treatment, although psychological interventions are also used. No mention of psychological interventions within the guidance may lead to services ceasing to offer them to patients.

There is no consistent collation or monitoring of data which has significant implications for Recommendations 6 and 7 (concerned with the evaluation of incentives schemes and smoking relapse programmes). Changes in data collection would require significant resourcing by services.

E3.2 Usefulness of recommendations

The concept of the recommendations was felt to be useful by most delegates in that they appear to aim to pull together a range of information in one place. Clarity was sought in some specific areas:

- What level to use for CO testing – 10 as recommended by DH, or three or five as currently used within most services;
- How to conduct Cotinine testing, what it involves, timeframes for testing and return of results and when it is appropriate to use the test;
- When to use various psychological interventions such as counselling, CBT and hypnotherapy.

Many participants felt that the recommendations would benefit from some restructuring and further clarification.

E3.3 Language of the recommendations

The language of the recommendations in general was felt to require some amendment and clarification.

E3.4 Practicality and relevance

The following recommendations were thought overall (with redrafting and editing) to be implementable, practical and relevant:

- Recommendations 1 and 2 (concerning referrals of women planning pregnancy, pregnant or with a child up to one year);
- Recommendation 3 (concerning the treatment pathway);
- Recommendation 4 (concerning referring women‟s partners and significant others); and
- Recommendation 5 (concerning training of health professionals).

Recommendations 6 and 7 (concerning evaluation of incentives schemes and smoking relapse programmes) were thought by the majority to be unfeasible. It was thought that implementation would be unlikely, due to a lack of evidence to support incentives schemes; a preference to include relapse with smoking cessation; and a lack of expertise in conducting evaluations.

E3.5 Factors affecting implementation and delivery

There were a range of issues raised that would impact delivery of the recommendations including:

- Level of knowledge among relevant health professionals concerning issues pertaining to smoking cessation, including barriers to quitting, testing and appropriate treatment;
- Which health professional groups would be best to engage with and rely on to deliver smoking cessation referrals and treatment;
- Delivery of smoking cessation services by health professionals that currently smoke;
- Resourcing;
- Support of commissioners – this was felt to be vital to successful implementation;
- Continuity of care of women;
- Whether only NRT is offered or psychological interventions also.

E3.6 How to increase likelihood of effectiveness

To improve effectiveness, links would need to be made with a greater range of programmes, initiatives and professionals for each recommendation. Suggestions were provided in all sessions and for all recommendations, as well as for the guidance as a whole. These are provided in the main body of the report.

It was thought by the majority that if the recommendations were restructured as a whole, merging Recommendations 1 and 2, and possibly 4 (all concerning referrals); and deleting (or merging) 6 and 7 (both concerning evaluation of smoking cessation schemes), that this would increase uptake of the recommendations.

Individual redrafting and editing was also thought to be essential to their clarity and therefore uptake.

E3.7 Gaps in guidance

A significant gap identified in the guidance related to advice on how to reach and communicate with specific vulnerable groups. These included:

- Pregnant teenagers or others with „chaotic" lifestyles;
- Black and Minority Ethnic (BME) groups;
- Those who do not speak English well or at all;
- Disabled groups;
- People on low incomes;
- People with mental health issues;
- People who have other substance misuse problems;
- Those living in rural locations.

In addition to inclusiveness, other gaps identified included:

- How to access partners and significant others;
- How to broach the subject of smoking;
- How to resource changes to current practices;
- How to provide continuity of care;
- Psychological elements of smoking to include addictive behaviour, motivational behaviours and barriers;
- How or whether to train health professionals that currently smoke (i.e. issues with current smokers providing advice on quitting smoking to others);
- Pre-pregnancy advice;
- Use of shisha, chewing tobacco and cannabis users that also use tobacco.

It was felt that there was also a lack of information or actions specific to commissioners, particularly within Recommendations 1-4.

E.4 Conclusions and recommendations to PHIAC

E4.1 Restructuring

Consider creating a single referrals pathway to include content from Recommendations 1 and 2 and possibly also Recommendation 4.

Recommendation 5 was thought to require significant restructuring in terms of making clearer:

- Whether training is to be provided in different levels;
- Who training might be provided to;
- Clarification of what the content of training might be – especially if in different levels.

Consider removing Recommendations 6 and 7. If they are retained, consider merging them into one evaluation recommendation.

E4.2 Inclusion of additional issues

A range of issues were identified as needing greater coverage within the guidance. These included:

- How to obtain the support of commissioners and what role they should play in the implementation of each recommendation;
- How the issue of relapse fits in with each recommendation;
- How and when to utilise psychological interventions for example counselling, CBT and hypnotherapy;
- How to identify and manage psychological elements of smoking i.e. addictive behaviour, motivational behaviour;
- A comprehensive list of health professionals to engage with, how to engage them and what their roles should be;
- How to identify and refer those that use shisha, chewing tobacco and tobacco within cannabis cigarettes;
- How to access hard-to-reach and vulnerable groups.

E4.3 Recommendation-specific suggestions

Although the aim of the recommendations as a whole is good – to pull together and provide clear guidance on how to support women (and significant others in their lives) to quit smoking before, during and after pregnancy – the specific recommendations were felt to require amendments as outlined below.

Recommendation 1: identifying women who smoke and referring them to NHS Stop Smoking Services

- Consider advising a system of combined referrals and on-the-spot treatment where appropriate;
- Provide advice on how to deal with an increased number of referrals through using an opt-out rather than an opt-in system, including how to resource such changes if necessary;
- Consider how to retain trust of women when using an opt-out system e.g. mention that the referral is automatic due to NICE guidance or service protocol;
- Provide more detailed advice on CO testing;
- Provide information on the role of GPs;
- Consider highlighting within Recommendations 1 and 2 the use of local smoking cessation telephone helplines rather than just the national helpline;
- Edit the diagram to include pre-pregnancy smoking and referrals.

Recommendation 2: referring women who smoke to NHS Stop Smoking Services

- Consider removing dentists and pharmacists from „Who should take action?“;
- Consider highlighting within Recommendations 1 and 2 the use of local smoking cessation telephone helplines rather than the national helpline;
- Consider adding other health professionals to „Who should take action?“, for example adoption and fostering services;
- Provide clarification on:

  - When to make referrals;
  - How to find out about smoking status or to sensitively introduce the subject;
  - What the term „notes" refers to, giving some examples;
- Consider providing guidance on psychological elements of why women and/or their partners, families and significant others smoke.

Recommendation 3: NHS specialist pregnancy services and NHS Stop Smoking Services for women who smoke

- Reorder bullets in „What action should they take?" to ensure they are chronological;
- Consider mention of psychological therapies such as counselling, CBT and hypnotherapy;
- Consider mention of psychological barriers and elements to quitting smoking (for example making explicit reference to addictive behaviours) and how to address these;
- Provide more information on what Cotinine testing involves and the timeframes for testing and return of results, or links to such information;
- Offer suggestions on how to identify which women to target;
- Consider splitting this recommendation into two: treatment pathway; and how to involve women in smoking cessation during pregnancy service provision.

Recommendation 4: NHS specialist pregnancy services and NHS Stop Smoking Services for partners and 'significant others'

- Make explicit how to identify and engage with partners and significant others in terms of smoking cessation;
- Clarify whether this recommendation relates to pregnancy-specific or generic smoking cessation advice;
- Provide clarity on the difference between counselling and giving advice;
- Provide more information on provision of NRT, for example cost of NRT, forms of NRT available and when best to use the different forms;
- Provide information on the validity of Cotinine testing and how to administer the test without causing the patient to disengage;
- Clarify the referral and treatment pathway for partners and significant others.

Recommendation 5: training

- Clarify how training would be delivered e.g. via university course or as on the job training;
- Clarify who would buy and deliver the training;
- Clarify the depth and content of training for each professional group;
- Clarify whether smoking status would have an impact on eligibility to receive training;
- Suggest how training might be evaluated e.g. through examination or service provision;
- Provide information on the costs and benefits of training, to encourage commissioners to support this recommendation;

- Include brief interventions and psychological elements of smoking addiction, motivational behaviour and appropriate counselling or therapy techniques.

Recommendation 6: incentives

- Consider deleting the recommendation or merging with Recommendation 7;
- If retained consider significantly editing the recommendation to include:
    - Renaming to „Evaluation of incentives schemes";
    - Providing evidence for incentives schemes and the type of incentive to use;
    - Providing information on ethical considerations with respect to using incentives;
    - How to resource evaluations including changes in data collection practices;
    - How to access expert support and advice with respect to conducting evaluations;
    - How to resource additional data collection;
- Consider funding incentives schemes and their evaluation.

Recommendation 7: preventing a smoking relapse

- Consider deleting the recommendation or merging with Recommendation 6;
- If retained consider significantly editing the recommendation to include:
    - Renaming to „Evaluating programmes to prevent smoking relapse";
    - Information on the difference between relapse and smoking cessation;
    - How to resource evaluations and any changes in data collection practices;
    - How to access expert support and advice with respect to conducting evaluations;
    - How to resource additional data collection;
- Consider funding relapse schemes and their evaluation;
- Consider including issues relating to relapse throughout all recommendations.

E4.4 Use of psychological interventions

Many delegates questioned the apparent omission of psychological interventions such as counselling, CBT and hypnotherapy within the guidance. It was unclear as to whether such approaches are not covered due to a lack of evidence for their effectiveness or because such approaches are not supported by NICE. A small number of individuals reported using such methods at present and therefore requested clarification as to why these are not mentioned within the recommendations. In light of this, it might be useful to consider funding research on counselling and other psychological interventions.

In light of current practices (i.e. use of such interventions) it is important to make explicit within the guidance whether these interventions have been excluded because:

a) There is not enough supporting evidence to include them; or

b) There is enough evidence to suggest they should not be used or considered as treatment.

It might be an option to suggest that these interventions could be considered using professional judgement on a case-by-case basis.

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CONTENTS

1 INTRODUCTION

1.1 Background to the work

1.1.1 Smoking before, during and after pregnancy

In 2005, 32% of mothers in England smoked before pregnancy. Of these, 49% quit before birth. Although most of those that quit before birth were still not smoking after birth, 30% started again before their child reached its first year.[1]

Smoking can be a particular health risk during and after pregnancy for both mother and child. According to the Royal College of Physicians,[2] risks to the mother include complications during labour and increased risk of miscarriage, premature birth, still birth and sudden unexpected death in infancy. It is also estimated to increase infant mortality by about 40%.[3]

Research on the risks to the infant from maternal smoking during pregnancy shows the following:

- Physical and mental retardation in children of seven and 11 years – this deficit was found to increase with the number of cigarettes smoked after the fourth month of pregnancy. Children of mothers who smoked 10 or more cigarettes a day were found to be shorter and between three and five months retarded on reading, mathematics, and general ability than children of non-smokers.[4]
- Lower birth weight and neonatal/perinatal mortality has been linked to smoking after the fourth month of pregnancy, although there is mixed opinion on this.[5] [6] [7]
- Lower functional residual lung capacity in infants.[8]
- Increased risk of asthma in children.[9]
- Increased risk of early adult onset diabetes.[10]

Maternal smoking during pregnancy has also been linked with a range of behavioural outcomes including:

- Higher risk of Attention Deficit Hyperactivity Disorder in those that are genetically predisposed to the Disorder (ADHD);[11] [12]
- Increased risk of male criminal outcomes in adulthood;[13]
- Greater irritability in newly born infants;[14] and
- Possible links with psychopathology in adulthood.[15]

Parental smoking around or in front of a child under 12 years (i.e. causing the child to be a passive smoker) has also been linked with a range of negative health outcomes.

Almost half of all children in the UK are exposed to tobacco smoke at home.[16] Infants of parents who smoke are more likely to suffer from breathing disorders such as bronchitis or asthma. Smoking before and after birth puts babies at three to four times greater risk of Sudden Infant Death Syndrome.[17]

Some studies also suggest that some of these health impacts can be greater with a higher number of cigarettes smoked per day. Additionally, it has been found that stopping smoking after the third month of pregnancy is of greatest importance.[18]

1.1.2 Health inequalities

There is little evidence that education level among white women is a factor in relapse in those that stopped smoking during pregnancy but started again after birth.[19] However, there is evidence to suggest that generally less educated smokers are less likely to quit smoking than more highly educated smokers.[20]

There is evidence to suggest that smoking disproportionately affects lower socio-economic groups: 31% of manual groups smoke, compared with 20% of non-manual groups.[21]

There is also evidence to suggest a link between smoking and age. Mothers under the age of 20 years are five times more likely than those aged over 35 to smoke throughout pregnancy (45% for the under 20s and 9% for the over 35s).[22]

Finally, a 2007 study by Bauld et al[23] concluded that: "NHS Stop Smoking Services have probably made a modest contribution to reducing inequalities in smoking prevalence. To achieve government targets, however, requires both the development of more innovative cessation interventions for the most addicted smokers and action to ensure that other aspects of tobacco control policy make a larger contribution to inequality goals."

1.2 A request for guidance from the Department of Health

The Department of Health tasked NICE *"To produce public health guidance on smoking cessation in pregnancy and following childbirth."*

Draft guidance was produced and as part of the consultation process Greenstreet Berman were contracted by NICE to carry out fieldwork to test the relevance, utility and implementability of the guidance, and in particular the draft recommendations on measures to promote or support cessation of smoking in pregnancy and after birth.

1.3 Target audience and populations covered

This guidance aims to consider all women who smoke who:

- Are planning a pregnancy;
- Are pregnant (from conception to birth);
- Have an infant aged less than 12 months.

It will also consider all women who stop smoking immediately prior to or during their pregnancy.

To address health inequalities, particular emphasis will be given to pregnant women (and women who have recently given birth) from groups where smoking rates are high. This includes those who are:

- Aged 20 or younger;
- In routine and manual occupations;
- Lone parents;
- Unemployed (or with a partner who is unemployed);

- From a BME group;
- Looked after in a care setting;
- Refugees and asylum seekers.

The guidance will also consider anyone who smokes and lives in the same dwelling as a woman who is pregnant, planning a pregnancy or has an infant aged less than 12 months (regardless of whether or not the woman smokes).

1.4 The recommendations

Seven recommendations were drafted in total covering the processes of referral and treatment for pregnant women and mothers, and their partners, families and significant others. They also covered training for health professionals and evaluation of programmes concerned with the use of incentives to support smoking cessation, and prevent relapse to smoking.

The full detail and wording of these recommendations can be found in Annex A: Recommendations on page 53.

2 METHOD

2.1 Overview

In total, eight workshops and six focus groups were conducted around England.

The workshops were generally larger (roughly 10 to 20 delegates each) with a range of professional groups from around the country and lasted for three hours each. They aimed to encourage a high level of debate concerning all of the recommendations and professionals tended to respond from the perspective of their profession.

The focus groups tended to be smaller (around five delegates each) and were usually attended by those from a specific PCT or who worked with that PCT. They lasted for around two hours each and aimed to look more at local practice and how all of the recommendations might impact on their practice and local population demographics. The focus groups also gathered information on current practice and local concerns. Delegates invited to the focus groups tended to be from professions that would struggle to attend a half day workshop geographically distant from the location of their work, such as midwives and health visitors.

Workshop locations included:

- Birmingham;
- London;
- Manchester.

Focus group locations included:

- Bristol;
- Dudley;
- Leicester;
- Liverpool;
- Manchester;
- Slough.

Delegates were invited via a range of routes including directly via email, letter and/or telephone; and/or via intermediary organisations to which the possible delegates were members or associated with in some way.

All sessions made use of a topic guide including the draft guidance or proforma pre-agreed with NICE to ensure consistency of approach. These guides were sent out at least three working days in advance (and preferably a week) to provide delegates with time to consider their responses beforehand. All groups discussed the recommendations as a whole and one or more recommendations individually. Each group was attended by a range of professionals to encourage debate and discussion.

The fieldwork covered a five-week period starting 2 December 2009. Due to issues with unavailability in the Christmas period, Greenstreet Berman agreed to aim to conduct all fieldwork in the first two weeks of December and no later than the third week of December to ensure completion by early January. In light of this, as soon as the draft guidance had been approved by NICE (at the end of November) it was sent to delegates such that they would have time to consider it in detail in advance of the workshops and focus groups. For some delegates (particularly those attending the 2 December sessions (Dudley and Manchester focus groups and the first London workshop), this was unfortunately a shorter notice period than would have been ideal.

The workshops were facilitated by two facilitators and the focus groups by one facilitator. All sessions were recorded for research purposes only.

A thematic analysis of all results combined was conducted and the final report is based on a synthesis of all fieldwork. This included assessing differences of opinion by type of professional.

2.2 Development of guides and question sets

Key questions and issues to explore were agreed with NICE at the outset. A workshop topic guide and focus group proforma were drafted to guide the sessions and ensure consistency of approach. Draft versions were commented on and approved with NICE prior to their dissemination. Guides included:

- Introduction and background to the work including information about NICE and its role in developing public health guidance;
- Process of development of recommendations including the role of the review in NICE decision making;
- Aims of the session, feedback and reporting to PHIAC;
- The NICE draft recommendations on quitting smoking during pregnancy and after childbirth;
- Role of delegates, NICE observers (where applicable) and Greenstreet Berman facilitators;
- Housekeeping (for example fire escapes, break times, location of facilities, ground rules);
- Overview of workshop/focus group;
- Session by session guide including questions per session;
- Appendix of background information including some relevant statistical information on this topic area.

In addition to guides, other documentation produced included evaluation sheets and worksheets for sessions so that delegates could also make their own notes. These notes were collected at the end of all sessions.

The proformas and topic guides are provided in the Appendices which are separate to this document.

2.3 Recruitment of delegates

2.3.1 Workshops

The invitation list of contacts was agreed with NICE in advance of the development of the recommendations. This was composed in part from Greenstreet Berman‟s contacts database, partly developed through internet based searching and partly composed of NICE contacts including NICE stakeholders. The list of contacts included people to invite directly to the workshops and intermediary organisations which Greenstreet Berman asked to contact certain groups of professionals on behalf of the researchers and of NICE. These included professionals representing groups such as GPs, nurses, midwives, health visitors, dentists, pharmacists and occupational health professionals.

Invitations were sent initially by email or by post using NICE letter-headed paper where an email address was not available. These were sent six weeks in advance of the workshops.

Where groups were underrepresented, additional „chaser" emails or letters were sent and/or people called directly to discuss whether they would like to attend a workshop. Intermediary organisations were re-contacted to ask if they would be able to send „chaser" emails to their contacts. NICE also contacted some of their contacts directly to ask them to pass on invitations to appropriate professionals. Additional invitations were sent particularly to dentists, pharmacists, occupational health professionals and commissioners. These groups of particularly underrepresented professionals were also invited to focus groups should these have been more convenient to attend.

Workshops were booked for Manchester, London and Birmingham and as such there was a range of geographical locations for delegates to attend.

2.3.2 Focus groups

For the focus groups it was agreed with NICE which geographical locations should be focused on. A Greenstreet Berman consultant then contacted the Primary Care Trusts (PCTs) in those areas directly to identify the Smoking Cessation Manager.

Once the Smoking Cessation Manager had been identified, an email was sent with the background information and what would be required:

- To book a room for two hours on the PCT premises;
- To invite colleagues such as smoking in pregnancy specialists, midwives (both specialist and general), GPs, health visitors, commissioners, Children"s Centre staff;
- To let Greenstreet Berman know who had been invited.

In the main, most PCTs were willing and able to help out in this way, although in one case, telephone chasing of possible delegates was conducted by Greenstreet Berman rather than the PCT.

Once delegates had been confirmed, Greenstreet Berman sent background information including the proforma and draft guidance to the delegates (or via the contact at the PCT where delegate emails had not been provided).

Additional invitations were sent to professionals unable to attend the workshops, where their particular group was underrepresented, for example dentists, pharmacists and commissioners.

Focus groups were run in Bristol, Dudley, Leicester, Liverpool, Manchester and Slough.

2.4 Conducting the workshops

Eight half-day workshops were run in total. Two in Birmingham, two in Manchester and four in London. One London workshop and both Manchester workshops were conducted on NICE premises as this has been found to facilitate greater attendance. The other workshops were conducted at city centre venues.

The workshops were generally attended by approximately 10 to 20 delegates each, with a range of professional groups from around the country. They aimed to encourage a high level of debate concerning the recommendations.

Delegates were invited to arrive at the venue half an hour before the workshop was due to commence. There were two facilitators – one to lead, the other to support the plenary sessions. Both facilitators led the small groups. Some workshops were also attended by NICE observers. All sessions were digitally recorded to ensure accuracy of note taking throughout the session. Recordings were not used to identify any delegate – all sessions were anonymous and confidential.

Overview of recommendations

Following an introduction and overview of the recommendations, the facilitator started with a plenary (all delegate) session. This looked at the recommendations as a whole and sought feedback on perceived:

- Usefulness, practicality, and impact of the recommendations;
- Factors affecting implementation and delivery of the recommendations;
- Gaps in the recommendations; and
- Suggested links with other initiatives.

Recommendation-specific session

Following the plenary session, delegates were split into small groups to discuss one or more specific recommendations. Specific issues, in addition to those listed above, included:

- Wording of the recommendation;
- What would need to be done to make it work, or make it work more effectively;
- The impact on current practice;
- Barriers and facilitators for applying the recommendation;
- Feasibility and practicality of the recommendation.

Post session

Evaluation sheets were issued at the end of each session.

Write ups of all sessions were drafted and circulated among all delegates to each session to allow any additional comments and clarification where information may have been inaccurately captured. The write ups of the sessions were finalised once comments had been received, or the deadline for comment had passed.

2.5 Conducting the focus groups

Six two-hour focus groups were conducted, in or near the PCT premises. Focus groups were run in Bristol, Dudley, Leicester, Liverpool, Manchester and Slough. This was in order to increase geographical representation of delegates and to capture opinion from professionals working in areas serving high levels of vulnerable or hard-to-reach groups.

The focus groups were generally attended by around five delegates each and were usually attended by those from the host PCT and those who worked with that PCT. They aimed to look more at local practice and how the recommendations might impact on their practice and local population demographics. The focus groups also gathered information on current practice and local concerns. Delegates invited to the focus groups tended to be from professions that would struggle to attend a half day workshop geographically distant from the location of their work, such as midwives and health visitors.

One facilitator attended each focus group, as well as (usually) the person responsible for organising the group within the PCT and the delegates. The facilitator acted as a lead facilitator as well as taking notes. All sessions were digitally recorded to ensure accuracy of note taking throughout the session. Recordings were not used to identify any delegate – all sessions were anonymous and confidential. Notes from all delegates were also collated at the end of each session.

Current practice

Prior to the focus groups, delegates were asked to consider information concerning: current practice, key demographic groups and issues particular to their PCT/organisation. They were also asked about their current practices and the kind of advice they offered. Following an introduction and overview of the recommendations, the facilitator started with a plenary (all delegates) session to discuss these issues.

Overview of recommendations

This was followed by a plenary session that looked at the recommendations as a whole and sought feedback on perceived:

- Usefulness, practicality, impact of the recommendations;
- Factors affecting implementation and delivery of the recommendations;
- Gaps in the recommendations; and
- Suggested links with other initiatives.

Recommendation-specific session

Following the plenary session, one or more specific recommendations were discussed individually. Where the focus groups were quite large, delegates were split into smaller groups. For smaller groups, a plenary format was continued. Specific issues, in addition to those listed above, included:

- Wording of the recommendation;
- What would need to be done to make it work, or make it work more effectively;
- The impact on current practice;
- Barriers and facilitators for applying the recommendation;
- Feasibility and practicality of the recommendation.

Post session

Evaluation sheets were issued at the end of each session.

Write ups of all sessions were drafted and circulated among all delegates to each session to allow any additional comments and clarification where information may have been inaccurately captured. The write ups of the session were finalised once comments had been received, or the deadline for comment had passed.

2.6 Analysis and reporting of results

There was one write up per session, written so as to provide anonymised and confidential feedback on the recommendations. These are provided in the separate appendices to this report.

These write ups, along with additional thoughts and recollection of discussions were used in the analysis. All facilitators attended a thematic analysis session whereby the recommendations as a whole and each recommendation, one by one, were discussed in turn.

The results from the focus groups and workshops were compared and any differences and similarities were discussed. Issues specific to certain demographic groups or geographical locations were also discussed, as were any issues specific to health professionals.

Discussion of the recommendations as a whole and then the recommendations one by one, included:

- Key themes surrounding:
    - Practicality;
    - Feasibility;
    - Impact;
    - Effectiveness and usefulness;
    - Inclusiveness e.g. any concerns with increasing health inequalities;
    - Suggested changes including to wording;
    - Gaps;
    - Suggested support for implementation including links with other initiatives or other professional groups;
- Any issues particular to certain demographics, for example areas with high rates of teenage pregnancy, or ethnic minorities;
- Any issues particular to professional groups, for example midwives, commissioners, health visitors, pharmacists, dentists and GPs.

Current referral and advice-giving practices, current issues and any particular concerns with the recommendations based on target audience were also discussed.

3 MAIN FINDINGS

3.1 Profile of delegates

A total of 166 delegates attended the fieldwork sessions from all over England. There was a mixed gender representation, although most delegates were female. The majority of all delegates were white British, although there was representation from black, Asian, mixed race and other white communities.

A range of job types were also represented although notable underrepresentation included dentists, occupational health professionals, pharmacists and commissioners. Opinions were broadly consistent across job type.

Most delegates served areas that included women and families from white British, other white, black, Asian and Eastern European backgrounds, and travelling communities.

Key issues felt to affect the provision of smoking cessation services during and after pregnancy included low socio-economic status of the population, secondhand smoking, drug misuse, teenage pregnancies, rural access difficulties and language barriers.

3.1.1 Delegate profiles

The total number of delegates consulted was 166.

- Workshops were conducted in London, Birmingham and Manchester, with a total of 123 delegates. The majority were female and of white British ethnicity with a small number of black, Asian, mixed race and other white delegates.
- Focus groups were conducted in Leicester, Manchester, Liverpool, Dudley, Bristol and Slough with a total of 43 delegates. The majority were white British and female.

Delegates were drawn from across England, covering all regions, although there was limited representation from the South West and the North East of England.

Types of job role included a range of health professionals within and linked with stop smoking services, midwives, maternity services, health visitors and representatives from Children‟s Centres. Representation was also obtained from PCTs and local council service/programme managers, commissioners, Department of Health representatives, Tobacco Control advisors, Helpline services, school and family nurses, hospital stop smoking specialists, GPs, psychologists, pharmacists, alternative health therapists, researchers and a lecturer. Although representation of job role was broadly obtained, underrepresentation of professional groups included:

- Dentists and occupational health professionals (none attended);
- Pharmacists (two attended);
- Commissioners (five attended).

It should be noted that differences of opinion between professional types were not noted except for the following:

- Commissioners were more concerned with the evidence base and resourcing of the recommendations than most delegates;
- Midwives were concerned about the impact on their time and workload;
- All non-midwives including Heads of Midwifery were concerned about the support of midwives in the implementation of the recommendations.

3.1.2 Profile of area (focus groups only)

On the whole most areas reported populations including white British, black, Asian, other white nationalities (particularly Polish) and those from the travelling community. For example, delegates to the Berkshire East PCT focus group (working in the Slough area) reported a diverse population of approximately 52 nationalities.

There was variance in socio-economic status, although even in more wealthy locations with less evidence of deprivation, areas of low socio-economic status were reported. Stop smoking services were reported to be most often visited by women from lower socio-economic groups, who in some areas were usually unemployed and receiving some form of government benefit. It was also reported that there may also be higher rates of drug use in these areas.

One delegate reported a rise in the uptake of smoking cessation services during and after pregnancy from teenagers. Others reported younger women aged 20-35; migrant groups such as those from Eastern European backgrounds; and traveller communities. Despite some areas being predominantly black or Asian, delegates reported a lower uptake of services by these groups.

3.1.3 Particular concerns for PCT/local areas (focus groups only)

There was concern about the high rates of teenage pregnancies in some areas and higher rates of teenagers who smoke (above the reported national average of 24.5%). Representatives from Dudley PCT in particular reported a rise in smoking-related health problems for teenage mothers, such as premature births.

There was also concern about the effects of secondhand smoke particularly in some areas where smoking rates are high and the woman‟s partner and/or family members may be smokers.

In areas such as Berkshire, Liverpool and Leicester, delegates felt that language barriers prevented a greater uptake of services. They described needing to be creative in the way they communicate with communities with poor levels of English. Delegates reported that women from Eastern Europe are more likely to smoke and hence needed to be targeted; something that is not currently being carried out consistently. Delegates from Liverpool reported having a number of specialist clinics aimed at accessing hard-to-reach groups such as non-English speakers, pregnant teenagers, drug users and obese patients.

Some PCTs reported having problems with the uptake of their smoking cessation services (relating to pregnancy and after childbirth) in general. It was felt that this may be due to:

- Some smoking women denying that they smoke;
- Lack of flexibility of some services such as location and opening hours;
- Lack of specialist staff.

To combat these issues, some areas reported trying to pilot stop smoking services with maternity and antenatal clinics, but again reported that uptake has been poor.

Finally, smoking cessation services (relating to pregnancy) in Leicestershire reported some difficulty providing their services to those in rural areas.

3.2 Current practice

Referrals

In line with Recommendations 1, 2 and 4 (concerning referrals of women, their partners and significant others), most areas make use of a referrals system in relation to offering smoking cessation. The exception was the Manchester area where they made a decision not to refer, but to offer on-the-spot advice. They have found this method to increase smoking cessation among pregnant women. As such they would not wish to change their practices.

There was concern about obtaining referrals through pharmacists and GPs, and it was also felt that Local Authorities (LAs) do not provide enough smoking cessation support to pregnant women. It was thought to be essential to involve professionals working in Children‟s Centres as they are thought to be invaluable in identifying women and helping them to stop smoking. Liverpool delegates reported that Liverpool Women‟s Hospital‟s automatic referrals system works very well.

Advice provided

NRT is the most commonly offered form of treatment although some delegates reported using psychological treatments such as hypnotherapy and counselling and many reported wishing to utilise these methods in combination with NRT to address the psychological elements of smoking.

Data collected

There is no consistent monitoring of data and data collection rarely goes beyond the minimum requirements from the Department of Health. This will have serious implications for the implementation of Recommendations 6 and 7 (concerning evaluation of incentives schemes and smoking relapse programmes).

3.2.1 Referral processes

Referrals

In line with Recommendations 1, 2 and 4 (concerning referrals of women, their partners and significant others), most areas receive referrals to specialist pregnancy stop smoking services through midwifery services and health visitors. It is determined whether the client is a smoker at first book-in, where a brief intervention is carried out and a CO test may be administered. The client can then choose to opt-in and be referred to the relevant PCT where a smoking in pregnancy advisor or specialist stop smoking advisor contacts the client and continues to provide necessary advice and support to stop smoking. The majority of delegates reported there to be a dedicated stop smoking in pregnancy service in their area. Working with midwives was felt to be a key component of current practice.

In one area (Manchester) a different system is in place. Smokers who are pregnant or have small children are given advice by whoever they see first (e.g. PCT staff, Children‟s Centre Staff, midwife). Delegates report that this is a successful model as demonstrated by reduced smoking rates. As such they would be concerned about moving to a referrals-only system.

Referrals through specific routes were also mentioned:

- **Local helplines:** some delegates represented local helplines who pass on relevant information to a PCT – the helpline contact the relevant smoking cessation services to deliver stop smoking advice.
- **GPs:** although most delegates reported a low referral rate from GPs, Dudley delegates reported that 92% of GPs in Dudley provide an in-house stop smoking service; and Bristol delegates reported successful smoking cessation services commissioned via GP practices.

Some delegates felt under pressure from targets aimed at monitoring quit rates. A few described being forced to go for „easy wins‟ at the expense of those clients that may need more time and attention and are less likely to end in referral.

Opt-in versus opt-out

The recommendations suggest an opt-out system is adopted. Reports on current practice suggest that few areas employ an opt-out system at this time, due to a lack of resource.

3.2.2 Advice provided

Delegates most commonly reported using the following to assist pregnant women to quit smoking:

- NRT;
- Some counselling;
- Some quitting advice;
- Home visits;
- Specialist advisors to support and add to generic services.

A small minority of delegates also referred to the use of alternative methods such as hypnotherapy, which prompted further discussion as to whether they should or should not be used as a common means to assist pregnant women with their smoking cessation.

No delegates reported advising pregnant women to cut down. It was felt that the definition of „quit‟ does not account for those who have significantly reduced their intake. For example from 20 a day to two a day.

Very few delegates provided examples of more holistic advice that tackle more generic issues – any examples that were given were usually confined to localised short-term schemes and pilots. Some delegates in London reported use of hypnotherapists and acupuncturists.

Delegates wished to be able to provide more advice on smoking as an addictive behaviour; and greater levels of psychological support.

Many delegates were not comfortable with how to engage vulnerable groups and as such requested additional advice and support through the recommendations on how to access ethnic minorities or those not speaking English as their first (or in some cases even second) language e.g. Polish. There were also reported high rates of teenage pregnancy; and it was suggested that secondhand smoking is more common among black and Asian populations.

3.2.3 Other health professionals (focus groups only)

Overall, it was reported that fewer referrals are provided by healthcare professionals from non-clinical backgrounds and delegates reported challenges in persuading other health professionals to understand the importance of referrals.

It was felt that Children‟s Centres played a key role in the referral process and that this should be reflected in the recommendations.

Delegates reported a low referral rate from pharmacists and suggested that, along with GPs, they may need to be incentivised to refer. Delegates also felt that Local Authorities do not do enough in providing smoking cessation services to pregnant women.

Other referrals were reported from hospitals. For example Liverpool Women‟s Hospital operates an automatic referral system which was felt to be very effective.

3.2.4 Data collected (focus groups only)

There is no consistent monitoring of data. This would have serious implications on Recommendations 6 and 7 (concerning evaluation of incentives schemes and smoking relapse programmes). Delegates suggested their removal from the guidance, or alternatively significant editing of them.

PCTs reported that they comply with Department of Health requirements for data collection and rarely collect anything beyond this. Delegates involved in local initiatives or pilot schemes may collect data to assess the effectiveness of a programme but not much is done with the data in terms of sharing the findings with other services.

Some areas have bespoke databases that carry data specific to pregnant women, for example Dudley‟s Smoking and Pregnancy Database and Bristol‟s Stork Database.

3.3 Feedback on recommendations as a whole

The concept of the recommendations as a whole was felt to be useful in that they seem to aim to pull together a range of information in one place. There were however some concerns with them including:

- Confusion over CO testing and which level to use to trigger referral or advice – most delegates reported using three or five, while the recommendations suggest using seven, in contrast with the level of 10 recommended by the Department of Health;
- Confusion with how to conduct Cotinine testing, what it involves, timeframes for testing and return of results, and when is appropriate to use the test;

- Incomplete or partial mention of current practices with respect to treatment – key elements of some practices that are not covered within the recommendations included psychological interventions such as counselling, CBT and hypnotherapy;
- No mention within the recommendations of:
    - How to access vulnerable or hard-to-reach groups;
    - How to access partners and significant others;
    - How to broach the subject of smoking;
    - How to resource changes to current practices;
    - How to provide continuity of care;
    - Psychological elements of smoking including addictive behaviour, motivational behaviours and barriers to quitting;
    - How or whether to train health professionals that currently smoke (i.e. should current smokers be providing advice on quitting smoking to other people);
    - Pre-pregnancy advice;
    - Use of shisha, chewing tobacco and cannabis users that also use tobacco;
    - Issues such as other substance misuse and mental health problems;
- Limited information specific to commissioners;
- Incomplete links with initiatives and programmes – need to include greater range within the recommendations (see Section 3.3.5 for examples).
- Unclear and confusing structure of the recommendations – suggestions for change included:
    - Merging Recommendations 1, 2 and 4;
    - Redrafting the treatment pathway laid out in Recommendation 3;
    - Deleting Recommendations 6 and 7 or editing and merging them.

3.3.1 Usefulness of the recommendations

The concept of the recommendations was felt to be useful in that they seemed to aim to collate much information in one place. It was not thought that they added anything per se, but it was felt that they had the potential to clarify the current situation and current expected practice. The recommendations were reported to conflict with some current practice which was of concern to those working in those areas (i.e. Manchester). It was felt that it might be useful to allow both a referrals system and a point of contact advice mechanism where deemed appropriate.

Delegates felt that the tone of the recommendations was more about „what to do“ as opposed to „how to do“. They wanted more directive language and specific guidance on how to achieve the various actions.

The order of the recommendations was found to be confusing and delegates felt that those dealing with referrals should be combined into one recommendation; and any dealing with treatment should be in another single recommendation.

It was felt that information or guidance on partners and relapse should be incorporated throughout the recommendations, as opposed to being in distinct and separate recommendations of their own.

3.3.2 Factors affecting implementation and delivery

Knowledge and expertise

There are implicit assumptions that may affect the delivery of the recommendations including:

- That healthcare professionals know how to refer;
- That they know how to help people stop smoking;
- That midwives are all able to carry out interventions;
- That specialists are all able to carry out interventions.

There needs to be greater clarity on what the interventions are, how they take place and the order in which they should happen.

Attitude of health professionals

It was felt that the recommendations need to promote the importance of the stop smoking agenda amongst healthcare professionals. For example, there were queries concerning whether an adequate stop smoking service can be provided by health professionals who currently smoke.

Resourcing

Numerous resource issues were raised around dealing with the increased number of referrals from an opt-out system, more specifically:

- Volume of calls and staff time taken to make those calls;
- Calls resulting in no referrals (due to incorrect contact information provided by the individual);CO and Cotinine testing and the training required for their use;
- Training of specialist smoking cessation staff;
- Provision of free NRT;
- Evaluation and monitoring work;
- Provision of incentives (to clients/patients and health professionals).

There was also much confusion around whether Recommendation 3 promoted home visits and if so, there was concern about the heavy cost implications arising from this approach.

Support of commissioners

As a result of these resource issues, it will be vital to obtain the support of commissioners. As such it was felt essential that there is more frequent reference to the part commissioners must play in the implementation of each recommendation as their involvement and support will be key to successful implementation. Currently there is little mention of commissioners and few actions aimed at commissioners within the recommendations as a whole.

3.3.3 Barriers to implementation

Language

There is no reference within the recommendations to language and translation issues particularly with reference to:

- Providing printed materials such as leaflets and letters;
- Translation issues when calling, conducting home visits or providing videos.

Changes to current practice

Delegates referred to conflicting guidance and were concerned this may affect implementation. For example they were not sure which reading level to adhere to with respect to CO testing: the Department of Health guidelines state 10 but practitioners tend to use a reading of three to seven.

Continuity of care

There is no reference to continuity of care and how important it is to maintain rapport with the client throughout their pregnancy and beyond. In particular, delegates felt that highlighting four week quits within the recommendation was not helpful and that the timeframe should be extended.

A lack of awareness of how to easily transfer information between professionals was also felt to present a barrier to successful treatment.

Treatment offered

It was felt that the availability and promotion of NRT through prescription only would present as a barrier. It was suggested that there could be some reference to NRT available over the counter.

There were also great concerns that the recommendations only partially reflect current practice. There was strong support for psychological interventions to be used in conjunction with NRT. Delegates were not happy that psychological interventions were not mentioned in the guidance.

Testing

Some delegates felt that the methods for CO and Cotinine testing as laid out in Recommendations 1 and 3 were not clear. There was concern that the tests might cause patients to feel scolded which could present a barrier of guilt, as opposed to patients feeling reassured that there is evidence they have cut down or quit.

3.3.4 How to increase likelihood of effectiveness

There was concern that the recommendations would not be effective because they are not mandatory.

Links with programmes, guidance and professionals

There needs to be clearer information on how to link with other programmes, existing guidance and other professionals such as Children‟s Centres – this includes promoting best practice and knowledge sharing. The guidance also needs a more comprehensive list of links.

There needs to be a wider referral route to include professionals such as Youth Offending Teams; and clarification of who refers and who offers the treatment. Examples of which other professionals could be included are in Section 3.3.5 below.

Treatment

Although some delegates called for the recommendations to incorporate a wider range of health care professionals, others felt that what is actually needed is more clarity on the specific role of specific healthcare professionals and non-professionals. For example, what is the role of GPs, how do pharmacists refer, what do midwives need to be saying? Who needs to engage with treatment?

It was also suggested that there needs to be consistent monitoring and intervention at every visit as opposed to just at the first book-in.

3.3.5 Links with other initiatives, guidance and professionals

A range of initiatives and other guidance was mentioned throughout the workshops and focus groups and as such it was felt that the guidance as a whole should make clearer links with them. These include:

- Smokefree Homes and Cars;
- Children‟s Centre guidelines and practice;
- Every Child Matters;
- Healthy Child Programme;
- Maternity Matters;
- National Pregnancy Helpline;
- National (and local) Stop Smoking Helpline;
- Tobacco Control Alliance;
- Midwives Toolkit.

Other professionals to involve included:

- Counsellors and trainers in the area of smoking cessation;
- Children‟s Centre staff;
- Schools and school nurses;
- Partnership Forums;
- Prison staff;
- Health visitors;
- Commissioners;

- Health and family co-ordinators;
- Obstetricians;
- Maternity service managers;
- Connections staff;
- Sonographers.

3.3.6 Gaps in guidance

It was felt that there is no real differentiation between guidance for the practitioner and guidance for the commissioner. Delegates felt there was little or no reference to the cost-benefit of actions within all the recommendations and this needed to be made clearer if commissioners are to fund this work.

There is little or no reference to pre-pregnancy and the early stages of pregnancy.

The recommendations are centred on the smoking of cigarettes with no reference to other products such as chewing tobacco, shisha and the use of cannabis cigarettes that contain tobacco.

There is no acknowledgement that CO readings could be affected by other factors such as faulty boilers or exposure to exhaust fumes for those living in urban areas.

Overall the treatment strategy is centred around proactive treatment rather than preventative psychological approaches. Smoking as an addictive behaviour is not highlighted in the recommendations hence there are no actions concerning the psychological aspects of smoking as an addiction and the reasons why people may choose to smoke. It was suggested that tackling these areas (for example mental health issues, domestic abuse, alcoholism and drug taking) help to tackle smoking cessation and as such should be included.

There are also no references to research around addiction, psychology and smoking.

Inclusiveness

Delegates reported that smoking rates are often higher for migrant groups and felt that this is not reflected in the guidance and neither is there any advice on how to combat this issue.

There were many concerns raised that there is little (if anything) in the guidance that advises on how to reach vulnerable groups that may also be at greater risk of smoking during pregnancy:

- Pregnant teenagers;
- BME groups;
- Disabled groups;
- People on low incomes;
- People with mental health issues;
- People who have other substance misuse problems.

There is no information on how to access these groups and what their particular issues or sensitivities may be.

3.4 Recommendation-specific feedback

3.4.1 Recommendation 1: identifying women who smoke and referring them to NHS Stop Smoking Services

Recommendation 1 overview

This recommendation is relevant to professionals who have a lot of contact with pregnant women and mothers such as midwives and health visitors.

This recommendation is concerned with making referrals to smoking cessation services. It lays out a referrals pathway.

The detail of this recommendation can be found in „Annex A: Recommendations“ which begins on page 53.

Overview of key points for Recommendation 1

There was overall support for Recommendation 1 but more clarity was needed around the following:

- CO testing – when to administer, how to administer, interpretation of readings, guidance on foetal CO testing;
- Role of GPs;
- What is meant by „the notes“;
- How to deal with a possible increase in the number of referrals from the opt-out system suggested in the recommendation;
- How to access hard-to-reach groups;
- How to deal with use of shisha, chewing tobacco and cannabis (where used with tobacco).

There were also suggestions that Recommendations 2 and 4 (both concerning referrals) could be merged with this recommendation.

Would it work in practice?

Overall, it was thought that Recommendation 1 would have high impact and high feasibility. However, there would need to be changes made based on delegate feedback, particularly for stop smoking services that currently offer on-the-spot advice.

What impact might it have on current practice?

There were concerns that Recommendation 1 would result in an increased number of referrals and this would have resource implications for areas that may not have the capacity to handle a greater influx of cases. There would be an obvious impact on areas such as Manchester where current practice of on-the-spot advice differs from a referrals process, as outlined in Recommendation 1.

Current CO testing practices would be affected for the following reasons:

- Delegates do not adhere to the same standard CO reading (where someone is considered to be a smoker);

- The Department of Health suggest a reading of 10 as indicative of a need for concern, however delegates reported using readings of three, five or seven as their markers – one individual cited research that links a figure of five with decreased foetal growth[1];
- There are differences in when the test is administered – some ask whether the woman smokes then test her, others test then ask if she is a smoker if there is a high reading.

What are barriers and facilitators?

Attitudes of professionals

There were concerns about the attitudes of health professionals such as midwives who are themselves smokers. It was felt they would not be able to effectively promote stop smoking issues if this is not something that they believe in or practice themselves.

Resourcing

There are obvious resourcing barriers and some areas may simply not have the budgets to be able to train all those who come into contact with a pregnant woman, to either refer or to provide smoking cessation advice. Major resourcing issues were also reported around being able to provide home visits and delegates felt this should not be the preferred option. It was suggested that other flexible options should be promoted such as letters and mobile telephone texting.

Role of GPs

There were questions about the role of GPs including whether they should be administering CO tests and delivering smoking cessation advice, or whether they should just be involved in referrals.

CO tests

Specific barriers concerned with CO testing to identify smoking status were reported in some areas, mainly relating to the level of CO to use. Concerns around the accuracy of CO tests were also reported, particularly with reference to secondhand smokers or those who have not smoked two days prior to testing. It was also suggested that results could be affected by using alcohol swabs.

Some delegates received training on the use of CO monitors, but reported that their PCT did not have monitors for them to use.

Delegates also queried where to record CO test results.

Finally, there was confusion about the wording of „parts per million". Some suggested that the correct measurement for CO testing is „parts per millimo".

[1] Gomez C, Berlin I, Marquis P and Delcroix M (2005) *Expired air carbon monoxide concentration in mothers and their spouses above 5 ppm is associated with decreased fetal growth,* Preventive Medicine, 40 (2005) 10-15.

The 'notes'

There was confusion around what was meant by „the notes". Delegates felt there needed to be clarity on exactly which notes the recommendation was referring to. It was suggested that there should be a central point or set of „notes", where all information is recorded and that all relevant health professionals have access to.

How to increase effectiveness?

Referral points

Delegates felt that Recommendation 1 should promote a local helpline number as opposed to the national number which has low usage rates. For example, some delegates reported receiving no referrals at all from the national helpline.

Delegates agreed that as well as needing a greater range of healthcare professionals and non-professionals to refer pregnant women who smoke, there also needs to be a greater number of specialist staff, clinics and non-healthcare agencies to refer women to. Examples are provided below in the „Links" section.

Opt-out system

Delegates agreed that Recommendation 1 would be more effective using an opt-out system, whereby referrals are made as a matter of course in the first instance i.e. more people would be referred. However, there was not much support for using an opt-out system per se. There were concerns about losing the trust of some women if an opt-out system were to be adopted; and the cost implications of adopting such an approach.

Amendments to the referral pathway diagram

The guidance is intended to reflect support to those women planning a pregnancy, those who are pregnant and following childbirth. The referrals diagram however includes no reference to pre-pregnancy and it was felt that this needed to be amended to match the scope of the guidance.

Links with existing guidance, professionals and organisations

It was suggested that this recommendation should link with tobacco control (e.g. the Tobacco Control Alliance) and current databases and IT systems such as the Stork database.

Professionals to link with included:

- Voluntary advocates with previous smoking experience to reach the community;
- Provider leads, policy makers, practice-based PCT commissioners, commissioners of NHS Pregnancy Services Acute Trusts, Heads of Midwifery, and Heads of Health Visiting;
- Outreach youth workers, school and college contacts, social services, teenage pregnancy services;
- Sonographers for referrals;
- Pharmacists;
- Sexual health services;
- Practice nurses;
- Nurseries;
- Obstetricians;
- Breastfeeding teams;
- Antenatal and neonatal services;
- Senior nurses;

- Social marketing teams;
- Employers and the workplace.

Gaps in recommendation

A small number of delegates felt that there needed to be something explicit within Recommendation 1 about the role of or advice on foetal CO monitors. In relation to Cotinine testing questions were raised as to whether it is necessary or should just be used in specific circumstances, for example where there are concerns that a woman is not being entirely open about her smoking status.

Specific guidance was also sought on how to access hard-to-reach groups, in particular:

- Better language provision;
- Information on cultural differences of various BME groups;
- A joined-up approach to addressing drug users and smoking;
- Targeted services for pregnant teenagers and others with „chaotic" lifestyles, for example use of texting or access via amusement arcades or shopping centres.

Some delegates felt there needed to be explicit mention of breastfeeding and promoting smoking cessation in the breastfeeding agenda. More clarification was also requested on smoking and fertility treatment and how smoking may reduce chances of becoming pregnant.

Delegates felt that there needed to be greater reference to the costs and benefits of actions within Recommendation 1 if commissioners are to take it seriously.

It was also suggested that there needs to be more information about existing barriers and the sharing of best practice.

Finally there was no reference to shisha, chewing tobacco or cannabis smokers (most cannabis cigarettes, it was reported, usually include a small amount of tobacco) and this was thought to be essential.

3.4.2 Recommendation 2: referring women who smoke to NHS Stop Smoking Services

Recommendation 2 overview

This recommendation is relevant to professionals who have less contact with pregnant women and mothers such as dentists and community pharmacists.

This recommendation is concerned with making referrals to smoking cessation services.

The detail of this recommendation can be found in „Annex A: Recommendations" which begins on page 53.

Overview of key points for Recommendation 2

There was a strong feeling that this recommendation should be combined with Recommendation 1. There were also suggestions that Recommendation 4 could be merged with this recommendation.

Delegates felt that the list in „Who should take action?" should include a wider range of healthcare professionals, although there was some debate on how useful dentists and/or pharmacists would be in making referrals.

There were concerns relating to when to make referrals, how to find out about smoking status, and how to take account of other forms of tobacco use such as shisha users, cannabis users who also include tobacco in their cannabis cigarettes and those who chew tobacco.

Would it work in practice?

Overall delegates felt Recommendation 2 had high impact and high feasibility but felt it would be more effective and relevant if combined with Recommendation 1; and linked to the referral pathway diagram from Recommendation 1.

What impact might it have on current practice?

As with Recommendation 1, delegates were concerned that the increased number of referrals would put a strain on existing resources.

There was a feeling among healthcare professionals that it would be difficult to encourage pharmacists and dentists to make referrals, however there was no specific feedback from pharmacists who attended the workshops to support this.

It should be noted that there was a low response to the research from pharmacists (two) and dentists (none) and so their own opinions have not been represented in this fieldwork. Their absence from the fieldwork sessions may or may not be indicative of how relevant the subject matter is to their key work. They were invited at a later stage, after key professionals such as midwives and health visitors, so had a shorter notice period for attendance at sessions – this may have impacted their capacity to respond and/or attend. Their absence could also be related to high levels of workload prior to the Christmas period. This may need to be explored further.

What are barriers and facilitators?

Identifying a woman"s smoking status was felt to be problematic due to:

- Reliance on the individual accurately reporting their smoking status;
- Concerns regarding the accuracy of CO testing, which was thought to be influenced by other variables (passive smoking, chewing tobacco, faulty boilers);
- The point at which to administer a CO test (so as not to offend women or infer that the information they have given is not true).

This was felt to be particularly pertinent where the woman is attending a centre or clinic for other purposes, e.g. dental treatment.

It was clear that these „other" professionals would need more information and clear guidance on how to actually refer women to specialist services for smoking cessation during and after pregnancy. Examples included suggested ways to introduce the subject and things to look out for such as staining of the teeth (with respect to dentists).

How to increase effectiveness?

A number of suggestions were raised as to how to increase effectiveness. These included:

- Extending the target population to partners, significant others and families.
- Including a wider range of health professionals under „Who should take action?", for example adoption and fostering services; and consider removing other professionals e.g. dentists.
    - Considering training needs of these professionals;
    - Considering how to encourage their support, for example some pharmacists and GPs are incentivised to conduct referrals through targets linked to pay;
- Promoting a local helpline number as opposed to the national number.
- Providing clarity on the term „notes" – what it may include.
- Consider replacing the term „smoke" with „tobacco", to capture other users including those who use shisha, cannabis cigarettes (containing tobacco) and chewing tobacco.

Links with existing guidance and professionals

Links with the following were suggested: the National NHS Training Centre, National Pharmacy Association (NPA), the Royal Pharmaceutical Society of Great Britain (RPSGB) and pharmacy multiples, Every Child Matters, Maternity Matters, and the Department of Health Service and Monitoring Guidance.

Gaps in recommendation

Delegates felt that questions around whether the woman smokes should not be confined to first book-in but should be asked at every visit, throughout the pregnancy.

There was concern that Recommendation 2 does not explicitly state that women should be asked about exposure to secondhand smoke. As such women who are exposed to secondhand smoke may not be so comprehensively captured.

There was concern that there appears to be no information on how to identify or determine why a woman smokes within Recommendation 2. This was felt to be important in order to provide more relevant and specific advice.

Delegates suggested that there could be a leaflet containing all the information needed about smoking cessation services provided in order to increase successful referrals.

3.4.3 Recommendation 3: NHS specialist pregnancy services and NHS Stop Smoking Services for women who smoke

Recommendation 3 overview

This recommendation is concerned with specialist services for smoking cessation during and after pregnancy and how they deal with referrals for example whether they are visited only, or whether they also conduct home visits.

This recommendation lays out a treatment pathway. It also suggests the involvement of women in such service provision.

The detail of this recommendation can be found in „Annex A: Recommendations" which begins on page 53.

Overview of key points for Recommendation 3

Overall it was thought to be very helpful to have a recommendation outlining the treatment pathway. However Recommendation 3 was thought to increase confusion rather than provide clarity, mainly due to the ordering of the bullets and specific areas of wording.

Another key issue was that this recommendation only partially covers current practice, most notably omitting psychological interventions. Other issues included:

- No information on how to access hard-to-reach groups;
- Mixed perception of validity of Cotinine testing;
- Awareness of Cotinine testing only in terms of research rather than medical treatment;
- Need to be more holistic and link with other services;
- Need to include those planning a pregnancy;
- Need to consider how best to contact women;
- How to identify who to target;
- Possibly need to split the recommendation into treatment pathway; and how to involve women in the provision of services for smoking cessation during and after pregnancy.

Would it work in practice?

It was suggested that Recommendation 3 broadly reflects current practice and as such could work, however the treatment pathway laid out was felt to be confusing. In its current format it was felt it would have low feasibility and impact. There were also a number of key concerns with the suggested treatment plan. For example it was thought that the bullet points were not in chronological sequence of treatment and that an incomplete protocol was presented.

What impact might it have on current practice?

A number of concerns were raised relating to resourcing for Cotinine testing and for home visits.

The recommendation was also thought to only partially reflect current practice and so be less effective than the current situation. For example, there is no explicit reference to psychological interventions, and the psychological issues and barriers relating to stopping smoking.

What are barriers and facilitators?

Resources

Although home visits were felt to be essential in order to make the services for smoking cessation during and after pregnancy available to all groups of women, much concern was raised about offering home visits as a matter of course due to the resource (time and cost) implications. It was felt that it might be more appropriate to offer home visits only for „good reasons", for example to those on low incomes who cannot afford to travel, and those with more than one child under five who would find it difficult to travel etc.

If only a small number of individuals within PCTs were able to offer services for smoking cessation during and after pregnancy, and related advice, there was concern that continuity of service provision may be at risk due to staff turnover.

Contacting women

There were some concerns that cultural issues could pose barriers. There were also concerns about contacting woman who do not speak English very well or at all. Particular concerns related to the first bullet point under „What action should they take?" regarding telephoning all women. It was noted that this may not always be appropriate. Specific issues and suggestions included:

- Considering sending a letter prior to telephoning in the first instance;
- Offering texting as an option – this is currently utilised successfully by some PCTs;
- Some cultural groups may react more strongly to a pregnant women or mother smoking and family members may not know that the mother smokes;
- Participants highlighted the differences in cultural attitudes towards smoking, as this is reportedly frowned upon in some BME cultures, particularly among women. It was thought that this may cause difficulties should it not be widely known that the woman is a smoker.
- Calls made from the NHS usually come up as withheld – in light of this many women, particularly teenagers, may not pick up if they are using a mobile;

In light of these issues it was suggested that in order to avoid possible domestic abuse, consent to contact by either telephone or letter should be obtained prior to any contact being made concerning smoking cessation.

With reference to bullet point nine in the „What action should they take?" section, there was concern that it would not be possible to contact women at a 12-month follow-up either by telephone or by post (with a low return rate for postal questionnaires). There were also concerns about the financial/resource implications of a 12-month follow-up.

Wording and presentation

It was felt that the wording and presentation of Recommendation 3 confuses rather than aids understanding. This will cause barriers to implementation if left in its current format.

CO testing

A key barrier relates to CO testing in that there were mixed views on the correct CO reading to measure against. This is covered in detail under Recommendation 1 feedback in Section 3.4.1.

Cotinine testing

There were also concerns about the use of Cotinine testing. Key points include:

- The test can be invalid if the individual uses NRT patches and lives with a smoker;
- Mixed perception of accuracy and consistency of Cotinine versus CO testing;
- The test is time-consuming taking up to half an hour;
- The return time for results is lengthy;
- Use of the test is expensive.

Other delegates had queries concerning:

- Who would be responsible for conducting the Cotinine test;
- Whether it is a saliva, blood or urine test.

It should be noted that a minority of delegates did not know what a Cotinine test is – these were mainly service providers at management level, although a handful of midwives were not aware.

How to increase effectiveness?

Support from other professionals

In order to implement Recommendation 3, there would need to be high level support from commissioners and Directors of Public Health – it was felt that this is not addressed in Recommendation 3.

It was also suggested that practice nurses should be included in Recommendation 3 as people to take action.

Cotinine testing

Some suggested that the Cotinine test should only be used with discretion rather than in all cases, for example in cases where it is thought the patient is not being wholly open concerning their smoking status.

Wording and structure

In the first section on „target population", it was suggested that the age of the infant should be raised from 12 months to five years to align it with other guidance and initiatives such as the Every Child Matters framework.

It was thought that the last sentence of bullet one in the „What action should they take?" section, „Invite them to the clinic", should be made the first sentence of bullet point two which would therefore read „Invite them to the clinic. If they are not able to attend specialist services for smoking cessation during and after pregnancy, consider visiting them in an alternative venue or offering a home visit."

Under the „What action should they take?‟ section, bullets four and five were thought to be the wrong way around. It was suggested that they be swapped around. This would mean that first would be “During the first face-to-face meeting, discuss how much and how frequently…” followed by “Address the factors which prevent these women…”.

There were concerns about the wording relating to discussion of how much and how often the woman smokes. It was suggested that this should not just be about the number of cigarettes, but also include issues such as whether they are pre-rolled or self-rolled, whether filters are used in self-rolled cigarettes, and whether low or high tar tobacco is smoked.

It was felt that Bullet point seven in the same section should be moved from Recommendation 3 to Recommendation 4. It was also thought to be unclear who would undertake this action: health visitors, tobacco control or the women themselves? It was suggested that if this were to be amended so that it suggests the health professional asks the women to encourage their partners to quit, then it could remain within Recommendation 3.

With respect to bullet point ten, it was suggested that the phrase „professional judgement‟ was not appropriate and that clear guidance and guidelines would be needed on the prescription of NRT. With respect to bullet 12, it was noted that not all NRT is offered via prescription and as such it might be more appropriate to remove any reference to prescription. It was also suggested that “Normally this will be 2 weeks of NRT therapy” and the surrounding sentences may need amendment or removal as it was unclear as to what was being offered: two weeks of advice and discussion, followed by two weeks of NRT therapy; or four weeks of NRT therapy.

Finally it was suggested that the last two bullets should be removed and perhaps incorporated into one or more of Recommendations 1, 2 and 4.

With respect to the penultimate bullet, it was felt that more information was needed on targeting of women i.e. why target, who should be targeted, likely costs of targeting. It was also felt that it would be great to involve women in service provision, but that this should not be part of Recommendation 3. It was suggested that a separate recommendation could be created to cover how to involve women in service provision.

Links with existing guidance and professionals

Links suggested for inclusion within the guidance included with:

- Alternative health services such as hypnotherapy;
- National Pregnancy Helpline;
- National (and local) Stop Smoking Helpline;
- Midwives Toolkit;
- Smokefree resources;
- Children‟s Centre guidance.

Professionals included:

- Midwives;
- Health visitors;
- Family support workers;
- Teenage pregnancy co-ordinators;
- Commissioners;
- Midwifery staff;
- Children‟s Centre staff;
- Parenting groups;
- Local charity staff;
- Workplace staff;

- Refuge centre staff.

Gaps in recommendation

Gaps included:

- A lack of evidence underpinning existing strategies, such as the national stop smoking helpline, as reference is made to this within the recommendations, and stop smoking campaigns. Delegates requested further detail regarding the success of these strategies if they are to promote them (as suggested within the guidance); No reference to how to use CO testing, for example it was suggested that there has been a change of approach from "Look your reading has dropped, well done!" to "So you are lying – you have not given up at all!" – there was concern that this current negative approach to CO testing was not addressed within the recommendations other than to say that it must be conducted with „sensitivity";
- No mention of addictive behaviours or addiction and how to cope with this;
- No mention of counselling or types of counselling to use (despite this being briefly mentioned in Recommendation 4) for example, CBT, longer term therapy;
- No discussion of the model to use for example, Trans-theoretical Model (TTM);
- No mention of other professionals to involve, for example, psychologists and hypnotherapists, nor hospital staff (in relation to pregnant in-patients who are in hospital for reasons other than their pregnancy);
- No mention of alternative settings or mechanisms to access hard-to-reach groups, for example:
    - One delegate noted how she contacts pregnant teenagers who smoke via advertisements in amusement arcades to offer them a non-judgemental cut-rate hypnotherapy session to stop smoking;
    - Stop smoking advice offered following baby massage sessions in Children"s Centres;
- No clear definition of what constitutes a relapse.

3.4.4 Recommendation 4: NHS specialist pregnancy services and NHS Stop Smoking Services for partners and 'significant others'

Recommendation 4 overview

This recommendation is relevant to partners, families and „significant" others who might smoke. It suggests which services and provisions are available to them, and how to identify them.

The detail of this recommendation can be found in „Annex A: Recommendations" which begins on page 53.

Overview of key points for Recommendation 4

It was felt that Recommendation 4 should be combined with Recommendations 1 and 2. As it stands further clarification is needed on:

- Free NRT;
- Cotinine testing;
- Awareness of how information is sent (bearing in mind language and cultural barriers);
- Information on the difference between providing advice and counselling;
- Referral pathway for partners/significant others.

Would it work in practice?

There was a sense that Recommendation 4 would have a higher impact and higher feasibility if combined with Recommendations 1 and 2. It is unclear to delegates whether Recommendation 4 is about prevention or treatment. Some felt that this recommendation was not entirely relevant or specific enough to the „pregnant women" scenario and read as general smoking cessation guidance. This was felt to be inappropriate.

What impact might it have on current practice?

Delegates queried the use of the term „free NRT" and wanted clarification on the prescription of NRT. Some delegates felt it conflicted with current practice.

Some delegates felt offering home visits would have a negative impact on resources and felt other methods should be promoted. However those who currently offer home visits find them to be very successful in facilitating smoking cessation.

What are barriers and facilitators?

Delegates wanted information on how useful video and print materials are, with specific examples of materials that are most effective. They felt that it would help if there were means to share best practice.

There was concern that there are no references to language barriers.

Dissemination of print based resources to those who opt out could be problematic and delegates felt that this should be handled with reference to informed consent. Specific confidentiality issues were raised over sending information to women whose families/partners may not know they smoke, or sensitivity issues to do with cultural barriers and domestic abuse.

Delegates questioned the use of Cotinine testing; how viable it was economically, what exactly the test entailed and how to administer the test as an assurance as opposed to making the client feel like they are being „told off".

It was noted that referred sessions are often during the day and that partners may not be able to attend due to work commitments.

How to increase effectiveness?

Delegates felt that reference to partners within Recommendation 4 would be better placed within Recommendation(s) 1 and/or 2.

There needs to be more detail in the pathway on how partners are brought into smoking cessation services i.e. their permission is required. More information is also needed on what to do if a multi-component intervention takes place.

There were specific wording issues raised:

- „Free NRT patches": remove the word „patches" as this is not the only NRT therapy;
- Delegates were wary of the word „counselling", because many people involved in smoking cessation services are not trained counsellors.

Links with existing guidance

Delegates felt it was important to make reference to Smokefree Homes and Cars within Recommendation 4.

Gaps in recommendation

There is no information on referral processes for partners (and others) in Recommendation 4.

Significant others may not live in the same household and delegates felt there should be clarification on how they would be accessed.

Delegates felt that Recommendation 4 needs to make clear whether partners of pregnant women who smoke will be referred to the generic smoking cessation services or to smoking and pregnancy specialists.

Reference to the role of commissioners was felt to be essential within Recommendation 4.

3.4.5 Recommendation 5: training

Recommendation 5 overview

This recommendation is concerned with the provision of training for professionals working with pregnant women and mothers such that they have a greater understanding of issues relevant to smoking cessation and services/support available. This relates to training for referrals, provision of information, identification of smokers and treatment of smokers.

The detail of this recommendation can be found in „Annex A: Recommendations" which begins on page 53.

Overview of key points for Recommendation 5

Overall this was thought to be a good recommendation. However there were some issues that were felt to need greater clarity, including:

- Who would be responsible for buying and delivering the training;
- Which health professionals would receive the training;
- Whether there would be different levels of training and if so, what these levels might encompass;
- Whether the training would be on graduate or diploma university courses, or „on the job".

There were also concerns linked with resourcing, both in terms of cost of training and the cost of covering for staff released to undertake training.

It was also not clear whether the training would cover issues perceived as essential, such as:

- How to access hard-to-reach groups;
- Brief interventions as well as intensive interventions;
- Psychological aspects of smoking;
- Use of psychological therapies and when different therapies might be most appropriate.

Finally, there were concerns about the effectiveness of delivering the training to health professionals that smoke. It was strongly felt that those health professionals that provide smoking cessation services should only be non-smokers or ex-smokers. A comparison was made with substance misuse centres where those who provide advice are all ex-users and not current users.

Would it work in practice?

It was felt that this recommendation could work in practice; however greater clarity would be needed in specific areas as outlined below.

What impact might it have on current practice?

Some delegates felt that there would be no impact on current practice, as training programmes are already in place. Other delegates however had concerns about the resource implications on current practice, especially for those working in a rural location, for example how much time off work would be required, where the training would be held.

If the suggested training were to be taken up by the relevant professionals, it was felt that the training would help to ensure a consistent approach across different professional groups and thus be more likely to help women quit smoking.

It was also felt that Recommendation 5 would only be effective, and therefore have an impact, if it was supported by commissioners. They would need to agree to provide financial resourcing and to release staff to undertake any training if required.

What are barriers and facilitators?

There were concerns that there may be issues with retraining existing staff such as midwives. Particular concerns were raised in relation to training health professionals who are smokers themselves. The example was given of drug programmes being conducted by former drug users, rather than current users.

The resource implication for smoking cessation services was also suggested as a barrier – it would be important to obtain commissioner support for Recommendation 5 in light of this.

Finally, there was some confusion with the structuring of Recommendation 5 as it seemed to suggest, but not make explicit, different levels of training. It was also not clear what each level of training might involve and who it might be relevant to.

How to increase effectiveness?

It was thought that in order to increase effectiveness:

- The training needed to be mandatory and standardised;
- Recommendation 5 needs to:
    - Use more prescriptive wording i.e. clearer, more defined actions;
    - Use stronger wording – „You should" rather than „You could consider".

It was not clear whether this training would be delivered via universities or as „on the job" training. It was suggested however that it would be important to ensure that training is provided as a core module embedded in the training of midwives, GPs and pharmacists as it is not currently a priority issue for all groups.

Wording

It was suggested that the wording of Recommendation 5 hints at there being a range of levels of training. For example:

- Level 1: how to make effective referrals;
- Level 2: understanding the impact of smoking and exposure to secondhand smoke;
- Level 3: how to encourage pregnant smokers to quit;
- Level 4: ensuring that training meets national standards;
- Level 5: providing interventions e.g. levels of NRT, how to undertake CO testing.

If this is correct, this needs to be clarified and made explicit. If this is not correct, then Recommendation 5 needs to be redrafted. It was also felt that Recommendation 5 needs to be clearer as to which professionals would be delivering and receiving the different levels of training.

It was also felt that there needed to be greater clarity on which level of training the last two bullets in „What action should they take?" were applicable to. It was not clear who would receive this training. Additionally, it was not clear what the „perceived barriers" (in the penultimate bullet in this section) referred to. It was thought that training should explicitly include psychological elements of smoking-addiction and how these might be overcome.

Clarification is also required on what the term „healthcare professionals" encompasses. For example, does this include Children"s Centre staff, nursery staff and/or any other types of workers?

Role clarity

Under the „Who should take action?" section, it was not clear which of those professionals in the list were intended to buy, deliver or receive the training. This would need to be clarified.

Measuring effectiveness of training

There were queries concerning how it would be possible to measure professional knowledge and understanding (with reference to bullet two in „What action should they take?") unless exams are to be undertaken at the end of training.

Links with existing guidance

Training is currently thought to be offered as an „add-on" and it was felt that it should be an integral part of the early training of professionals such as GPs, nurses and midwives.

Links with guidance on issues such as weight management and breastfeeding was thought to be essential.

Gaps in recommendation

It was suggested that there ought to be specific training available on how to access various hard-to-reach groups.

It was also felt that only intensive interventions were included in this recommendation and brief interventions were not (for example, suggesting to pregnant smokers that they ought not to smoke).

Finally, it was felt to be essential that psychological elements of smoking-addiction are included, as should information on motivational behaviour and counselling, particularly guidance on the most effective forms of counselling.

Reference to the role of service managers was also thought to be important.

3.4.6 Recommendation 6: incentives

Recommendation 6 overview

This recommendation is concerned with the evaluation of incentives programmes relating to smoking cessation e.g. financial, provision of food vouchers. It outlines data collation and the evaluation of programmes.

It also covers research and data collection by services, PCTs and/or academic institutions.

The detail of this recommendation can be found in „Annex A: Recommendations" which begins on page 53.

Overview of key points for Recommendation 6

There was little support for Recommendation 6 and overall it was felt that its removal from the guidance would be the most appropriate course of action.

Most delegates found this recommendation difficult to understand and thought they were being asked to put in place new incentives programmes, rather than to evaluate existing programmes.

There was great concern about the use of incentives programmes due to a range of factors including ethics, the lack of evidence base and resourcing.

If Recommendation 6 were to be retained within the guidance, key suggestions for amendment included:

- Rewording and renaming to „Evaluating existing incentives programmes";
- Providing evidence for such programmes including the type of incentive;
- Providing clarity on what is meant by „quitter";
- Providing information on ethical considerations with respect to using incentives;
- Providing information and guidance on how to resource such evaluations;
- Suggesting ways in which to access expert support and advice in conducting evaluations;
- Considering merging with Recommendation 7.

Would it work in practice?

This recommendation was thought to be the weakest and there was much negative feedback. It was thought that it would have low impact and low feasibility.

However it should be noted that most delegates found this recommendation difficult to understand and thought they were being asked to put in place new incentives programmes, rather than evaluate existing programmes.

What impact might it have on current practice?

There were concerns that the suggested data to be used is not currently collected. As such the resource impact to start the collation of this data would be great and as such would be unlikely to happen.

What are barriers and facilitators?

There was a lack of willingness to implement incentives programmes for the following reasons:

- All the evidence for their effectiveness is from the United States and felt to be inapplicable to the UK;
- There was concern about resourcing such programmes and particularly resourcing such a detailed evaluation;
- There were concerns relating to a lack of knowledge and expertise within smoking cessation services in conducting such evaluations;
- There was concern from commissioners about supporting and resourcing such incentives programmes without clear evidence of their effectiveness;

- Ethical concerns were raised about the impact of the use of incentives e.g. would women be encouraged to continue smoking into pregnancy such that they would be eligible to receive incentives to stop smoking during or after pregnancy.

In light of concerns about implementing such programmes in the first place, the overwhelming opinion was that evaluation of such programmes would be rare.

For those who do already run such programmes, it was felt that such an evaluation, such as that outlined within Recommendation 6, would be too complex to conduct without the use of outside expertise and not possible to fund.

How to increase effectiveness?

In order to clarify the purpose of this recommendation, it was felt that the title should be changed to „Evaluating existing incentives programmes" or something similar.

In order to encourage implementation of such programmes and therefore their evaluation, it was suggested that:

- The government could provide support for pilot schemes to be conducted;
- More resource would need to be made available (staff, time and money);
- Evidence of effectiveness, including the type of incentive, would be essential.

It was additionally suggested that where programmes are already in place, the following guidance would be needed to encourage evaluation:

- How to conduct an effective evaluation;
- How to resource such evaluations;
- Information on how to access expert advice and support to conduct such complex evaluations.

It was also felt that small scale programmes may not be comparable across the country. As such it would be necessary to provide a template for programmes and for their evaluation to ensure consistency of approach and applicability of results across the UK.

Links with existing guidance, initiatives and organisations

It was suggested that Recommendation 6 might be linked with Recommendation 7 if it is retained.

Additionally the following links were suggested with:

- Smokefree North West who are introducing shopping vouchers;
- Children and Young People"s plans to see what needs to be done on a local level;
- Academic guidance on evaluations;
- Obesity programmes;
- The National Tobacco Control Strategy.

It was also suggested that some organisations might want to invest in such programmes and as such could be referred to within the guidance. The only example provided by delegates was that of SANDS (Stillbirth and Neonatal Death Society).

Gaps in recommendation

It was felt that the definition of „quitter" needed to be clear. For example, it was stated that the Department of Health suggests a four-week quit time, however most delegates felt that this ought to be increased.

3.4.7 Recommendation 7: preventing smoking relapse

Recommendation 7 overview

This recommendation is about the evaluation of programmes concerned with smoking relapse prevention. It outlines data collation and the evaluation of programmes. It also covers research and data collection by services, PCTs and/or academic institutions.

The detail of this recommendation can be found in „Annex A: Recommendations" which begins on page 53.

Overview of key points for Recommendation 7

There was little support for this recommendation. Overall it was felt that money would be better invested in smoking prevention than in prevention of relapse and as such the opinion was that it might be best to remove this recommendation.

Most delegates found this recommendation difficult to understand and thought they were being asked to put in place new relapse programmes, rather than evaluate existing programmes.

It was also felt that the issue of relapse should be included throughout the recommendations, rather than as an „add-on" at the end.

If it were to be implemented, suggestions included:

- Rewording and renaming to „Evaluating programmes to prevent smoking relapse";
- Providing evidence for such programmes;
- Providing clarity on what is meant by relapse;
- Providing information and guidance on how to resource such evaluations;
- Providing guidance on how to access expert support and advice in conducting evaluations;
- Considering merging with Recommendation 6.

Would it work in practice?

It was thought that Recommendation 7 would have low impact and low feasibility.

However it should be noted that most delegates found this recommendation difficult to understand and thought they were being asked to put in place new relapse programmes, rather than evaluate existing programmes.

What impact might it have on current practice?

As with Recommendation 6, there were concerns that the suggested data to be used is not currently collected. As such the resource impact to collate this data would be great and probably not possible.

What are barriers and facilitators?

There was confusion on the difference between a „relapse" programme and a „quit smoking" programme as it was felt that they should address identical issues.

As with Recommendation 6, there was a lack of willingness to implement relapse programmes for the following reasons:

- Cost of resourcing such programmes and particularly resourcing such a detailed evaluation;
- Lack of knowledge and expertise within smoking cessation services in conducting such evaluations;
- Concern from commissioners about supporting and resourcing such programmes without clear evidence of their effectiveness.

In light of concerns about implementing such programmes in the first place, the overwhelming opinion was that evaluation would be rare. It was also felt that such an evaluation would be too complex to conduct without the use of outside expertise and impossible to fund.

How to increase effectiveness?

Wording

In order to clarify the purpose of this recommendation, it was felt that the title should be changed to „Evaluating programmes to prevent smoking relapse" or similar.

It was also suggested that the target of helping women with children up to 12 months should be increased to five years in line with the Every Child Matters framework.

Support

As with Recommendation 6, guidance on the following was thought to be necessary:

- How to conduct an effective evaluation;
- How to resource complex evaluations;
- How to access expert advice and support.

Again, it was felt that small scale programmes may not be comparable across the country. As such it would be necessary to provide a template for programmes and for their evaluation to ensure consistency of approach and applicability of results across the UK.

Links with existing guidance, initiatives and organisations

It was suggested that Recommendation 7 might be linked with Recommendation 6.

Additionally the following links were suggested for inclusion within Recommendation 7:

- Johnson and Johnson;
- Pharmaceutical research organisations;
- Substance misuse services;

- Academic guidance on evaluations.

Gaps in recommendation

It was felt that the definition of „quitter" needed to be clear. For example, it was stated that the Department of Health suggests a four-week quit time, however most delegates felt that this ought to be increased.

It was felt that a definition of „relapse" was also required as there was no common consensus on what this was. For example:

- „Relapse is defined as a commencement of smoking in months two and three after the official quit date" or „Relapse is defined as recommencing smoking following childbirth".

Information and support on how to monitor and track a relapse was also felt to be missing from Recommendation 7.

4 DISCUSSION AND RECOMMENDATIONS

Overall, the concept of the recommendations was felt to be good, in that they seem to aim to pull together a range of information and advice to support those working with pregnant women and their families/significant others to reduce smoking and secondhand smoking before, during and after pregnancy.

However, participants felt that the recommendations would benefit from further clarity and restructuring. They also expressed concern in some cases that the recommendations may be difficult to implement.

Key suggestions included creating a single „referrals" recommendation by merging Recommendations 1, 2 and 4; and deleting or significantly amending Recommendations 6 and 7.

Recommendation 3 was felt to require significant restructuring and greater clarity; and Recommendation 5 required some editing.

A range of links with other professionals, initiatives, programmes and organisations were suggested. Specific conclusions and suggestions are outlined in the sections that follow.

4.1 Current practices

Key points to consider within recommendations relating to current practices

- The majority supported a referrals system, but resistance is likely in some areas. For example, Manchester focus group delegates felt there would be resource implications if they were to change their current practice of offering on-the-spot advice, as well as a decrease in the effectiveness of smoking cessation service provision among pregnant women, mothers and their significant others. Consider how to overcome this issue, perhaps through recommending a system that combines referrals and point of contact advice as appropriate.
- Need to make explicit within the recommendations how to identify and engage with partners and significant others in terms of smoking cessation.
- Need to consider how to encourage GPs and pharmacists to engage in referrals, perhaps through the use of incentives.
- Need to mention Children"s Centres and hospitals as sources of referral and support within the recommendations.
- Consider highlighting within the recommendations the use of local smoking cessation telephone helplines rather than (or as well as) the national helpline – some delegates reported no referrals at all from the national helpline.
- Consider mentioning psychological interventions such as counselling, CBT and hypnotherapy within the guidance and/or recommendations.
- Consider guidance on how to provide smoking cessation support from the perspective of managing addictive behaviours, rather than supporting only the physical addiction.
- Lack of consistent collection or monitoring of data will have serious implications for Recommendations 6 and 7 and would support their removal from the guidance.

4.2 Inclusiveness

The populations served by the delegates included white British, black, Asian, Eastern European, travellers and other white nationalities. Key reported issues for service provision for smoking cessation during and after pregnancy included:

- Low socio-economic status of the population;
- Secondhand smoking;
- Drug misuse;
- Teenage pregnancies;
- Rural access difficulties;
- Language barriers;
- Women denying they smoke;
- Availability/flexibility of services e.g. location or opening hours.

Key points to consider within recommendations relating to inclusiveness

In light of these points, it is particularly important that the recommendations and guidance address more clearly and provide clear supporting guidelines on issues around:

- Accessing and supporting vulnerable and hard-to-reach groups;
- Secondhand smoking, for example whether it is acceptable for partners and significant others to smoke outside or whether they must also quit;
- Providing clearer guidelines on how to access and refer „others";
- Information on psychological barriers to, and elements of, quitting smoking.

4.3 Overview of recommendations

Overall the recommendations were felt to be useful in that they collated much information in one place. There were, however, a number of concerns raised with them. Key suggestions for amendment to the recommendations as a whole are provided in the table below.

Key points to consider within the recommendations as a whole

Key suggestions for amendments included:

- Re-structuring of the recommendations:
  - Merge 1, 2 and possibly also 4;
  - Delete or significantly amend 6 and 7;
  - Clarify and restructure 3;
- Information and guidance on:
  - How to access vulnerable or hard-to-reach groups;
  - How to resource changes to current practices;
  - How to provide continuity of care;
  - What constitutes a relapse;
  - Include „relapse" as part of smoking cessation throughout the recommendations;
- Inclusion throughout the guidance and recommendations of issues such as:
  - Psychological elements of smoking to include addictive behaviour, mental health problems, motivational behaviours and barriers;
  - Pre-pregnancy advice;
  - Use of shisha, chewing tobacco and cannabis users that also use tobacco;
- Greater information and guidelines specific to commissioners" roles;
- Links with a greater range of initiatives and programmes.

4.4 Recommendation-specific conclusions

4.4.1 Recommendation 1: identifying women who smoke and referring them to NHS Stop Smoking Services

Recommendation 1 overview

This recommendation is relevant to professionals who have a lot of contact with pregnant women and mothers such as midwives and health visitors.

This recommendation is concerned with making referrals to smoking cessation services. It lays out a referrals pathway.

The detail of this recommendation can be found in „Annex A: Recommendations" which begins on page 53.

There was overall support for this recommendation; however there were minor points of clarification required, which are provided below.

Recommendation 1 – points to consider

It is suggested that this recommendation is redrafted or that supporting guidance is provided to cover issues relating to:

- CO testing – when to administer, how to administer, interpretation of readings (i.e. evidence to support the suggested reading of 10), guidance on foetal CO testing (even if it is to state that there is little evidence to support its use);
- The role of GPs;
- What is meant by „the notes" and provide examples if appropriate;
- How to deal with the increased number of referrals from the opt-out system promoted in the recommendation;
- How to retain the trust of women when using an opt-out system e.g. mention that a referral will be made as a matter of course due to service protocol or NICE guidance;
- How to access and communicate with hard-to-reach groups including BME and those with more „chaotic" lifestyles such as teenage mothers;
- How to manage the use of shisha, chewing tobacco and cannabis (if tobacco is also used);
- Additional information relevant to commissioners including mention of evidence to support the recommendation.

It was also suggested that the referrals diagram is edited to include a section before the current diagram on pre-pregnancy smoking and referrals. Finally, merging of Recommendations 1, 2 and 4 could be considered to provide a single „referrals" recommendation.

4.4.2 Recommendation 2: referring women who smoke to NHS Stop Smoking Services

Recommendation 2 overview

This recommendation is relevant to professionals who have less contact with pregnant women and mothers such as dentists and community pharmacists.

This recommendation is concerned with making referrals to smoking cessation services.

The detail of this recommendation can be found in „Annex A: Recommendations" which begins on page 53.

Again, this recommendation was supported. There were some suggestions for amendment which are provided below.

It was suggested that dentists might not find it very easy to engage with the referrals process and that if they were to be required to do this they would need clear guidance on how to introduce the subject of smoking with their clients, for example with reference to staining on teeth.

Recommendation 2 – points to consider

- Whether to merge with Recommendation(s) 1 and possibly 4 to create a single „referrals‟ recommendation;
- Consider providing advice on how to manage a possible increase in referrals if services switch from opt-in to opt-out;
- Whether any amendments should be made to the list of „Who should take action?‟ for example, add other health professionals such as adoption and fostering services and remove dentists and/or pharmacists;
- Clarification on:
  - When to make referrals;
  - How to find out about smoking status or to sensitively introduce the subject;
  - How to take account of other forms of tobacco use such as shisha, cannabis users who also include tobacco in their cannabis cigarettes and those who chew tobacco;
  - What the term „notes‟ refers to.
- The need to provide supporting guidance on psychological elements of why women and/or their partners/families/significant others smoke.

4.4.3 Recommendation 3: NHS specialist pregnancy services and NHS Stop Smoking Services for women who smoke

Recommendation 3 overview

This recommendation is concerned with specialist smoking cessation during pregnancy services and how they deal with referrals, for example whether they are visited only, or whether they also conduct home visits.

This recommendation lays out a treatment pathway. It also suggests the involvement of women in smoking cessation during pregnancy service provision.

The detail of this recommendation can be found in „Annex A: Recommendations‟ which begins on page 53.

Although a treatment pathway was thought to be of great use, Recommendation 3 was felt to be poorly presented. It was also noted that it only partially reflects current practice as it refers only to the use of NRT.

Recommendation 3 – points to consider

Key issues to address included:

- Reordering of the bullets in „What action should they take?" such that they are in chronological order;
- Redrafting of wording to aid clarity;
- Inclusion of psychological therapies and support such as counselling, Cognitive Behavioural Therapy (CBT) or hypnotherapy, and where their use might be appropriate;
- Inclusion of psychological barriers and elements to quitting smoking (for example making explicit reference to addictive behaviours) and how to address these;
- Make reference to models of behaviour change such as the Trans-theoretical Model (TTM);
- Provision of additional information and guidance on:
    - How to engage with vulnerable and hard-to-reach groups such as BME groups and teenage parents;
    - How to make contact with individuals from different cultural backgrounds;
    - What Cotinine testing is and how and when is best to utilise it;
    - How to resource increased numbers of home visits or provide clarity on when home visits should be offered;
    - How the use of mass media may be of help in smoking prevention or cessation;
    - What constitutes a relapse;
    - How to identify which women to target;
- Include more information on the need for support from commissioners;
- Split the recommendation to cover two key areas, perhaps creating an additional recommendation:
    - Treatment pathway (the majority of the current recommendation);
    - How to involve women in smoking cessation service provision.

4.4.4 Recommendation 4: NHS specialist pregnancy services and NHS Stop Smoking Services for partners and 'significant others'

Recommendation 4 overview

This recommendation is relevant to partners, families and „significant" others who might smoke. It suggests which services and provisions are available to them, and how to identify them.

The detail of this recommendation can be found in „Annex A: Recommendations" which begins on page 53.

There were a number of concerns raised with this recommendation and overall it was felt best to merge it with Recommendation(s) 1 and/or 2 to create a single referrals recommendation.

Recommendation 4 – points to consider

A key consideration would be merging this recommendation with Recommendations 1 and 2.

Further clarification could be provided either within the recommendation or as supporting guidance on:

- Whether this recommendation is pregnancy-specific or whether „others" would be treated via generic smoking cessation services;
- The prescription and cost-free provision of NRT, plus the various types of NRT available, and when each type would be most appropriate;
- Validity of Cotinine testing and what the test entails including timeframes for completion of test and for return of results;
- How to administer Cotinine testing without causing the patient to disengage;
- How to resource increased numbers of home visits or provide clarity on when home visits should be offered;
- How information on smoking cessation should be provided to smokers (bearing in mind language and cultural barriers) e.g. leaflet, letter, telephone call, text, DVD, face-to-face etc;
- The difference between providing advice and counselling;
- The referral and treatment pathways for partners/significant others;
- Reference to the role of commissioners in the implementation of this recommendation.

4.4.5 Recommendation 5: training

Recommendation 5 overview

This recommendation is concerned with the provision of training for professionals working with pregnant women and mothers such that they have a greater understanding of issues relevant to smoking cessation and services/support available. This relates to training for referrals, provision of information, identification of smokers and treatment of smokers.

The detail of this recommendation can be found in „Annex A: Recommendations“ which begins on page 53.

Overall this was felt to be a good recommendation. Key concerns related to resourcing the training both in terms of the cost of training itself and the cost of releasing staff to undertake training. As such it would be particularly important to ensure that commissioners are engaged and supportive of this recommendation to ensure its successful implementation. There was also much confusion about what the training would actually entail; and who would buy, deliver and receive the training.

Recommendation 5 – points to consider

Key points to address could include clarifying:

- How the training would be delivered for example via university courses or as on the job training;
- The depth and content of training for each professional type;
- Whether the training is to be offered via a range of „levels“ of knowledge e.g. referrals, impact of smoking, understanding psychological elements of smoking, providing interventions etc;
- How training might be evaluated, for example through examination or improved smoking cessation during pregnancy service provision;
- Whether smoking status of the professional would have an impact on their eligibility for training and service delivery, or the content of any training programme;
- Cost-benefit information to encourage commissioners to support this recommendation.

It was also suggested that the recommendation should cover brief interventions (for example “You should stop smoking”) and psychological elements of smoking-addiction, motivational behaviour and appropriate counselling techniques.

4.4.6 Recommendation 6: incentives

Recommendation 6 overview

This recommendation is concerned with the evaluation of incentives programmes relating to smoking cessation, for example financial or provision of food vouchers. It outlines suggested data collation and how to evaluate such programmes. It provides guidance on research and data collection by services, PCTs and/or academic institutions.

The detail of this recommendation can be found in „Annex A: Recommendations“ which begins on page 53.

There was little support for this recommendation. This was due to two key issues (a) lack of evidence to support running incentives schemes and (b) lack of infrastructure, data collection, knowledge and expertise to conduct such in-depth evaluations.

Three possible options have been identified.

Recommendation 6 – options

- Removing the recommendation;
- Merging with Recommendation 7;
- Significantly editing the recommendation regardless of whether it is merged.

If the recommendation were to be retained and edited, thought needs to be given to how to resource such programmes and how to provide enough evidence to persuade commissioners to run incentives schemes. Other key points to consider if editing the recommendation are outlined below.

Recommendation 6 – points to consider if retaining

- Rewording and renaming to „Evaluation of incentives schemes“;
- Providing evidence for incentives programmes and the type of incentive to use;
- Providing information on ethical considerations with respect to using incentives;
- Information and guidance on how to resource evaluations;
- Information and guidance on how to access expert support and advice in conducting evaluations;
- How to provide resourcing to change current data collection;
- Reference to the need for commissioner support to implement this recommendation.

The table below offers thoughts to consider if the recommendation is removed.

Recommendation 6 – points to consider if removing

If the recommendation were to be removed, NICE could consider funding research programmes to set up and evaluate incentives schemes in the UK on a large enough scale to ensure applicability of outcomes across the UK.

Once evidence to support the use of incentives schemes in the UK is more widely available, more PCTs and other smoking cessation services may be amenable to resourcing their implementation. With adequate access to expertise, these programmes could then be evaluated to add to the existing evidence base.

4.4.7 Recommendation 7: preventing a smoking relapse

Recommendation 7 overview

This recommendation is concerned with evaluation of programmes concerned with smoking relapse prevention. It outlines data collation and evaluation of programmes. It also provides information on research and data collection by services, PCTs and/or academic institutions.

The detail of this recommendation can be found in „Annex A: Recommendations“ which begins on page 53.

As with Recommendation 6, there was little support for this recommendation. This was due to two key issues (a) lack of understanding of the difference between relapse and smoking cessation advice and (b) lack of infrastructure, data collection, knowledge and expertise to conduct such in-depth evaluations.

Overall it was felt that money would be better invested in smoking prevention than in relapse prevention.

Three possible options have been identified.

Recommendation 7 – options

- Removing the recommendation;
- Merging with Recommendation 6;
- Significantly editing the recommendation regardless of whether it is merged or not.

If the recommendation were to be retained, there are some key issues that would need to be attended to. These are outlined below.

Recommendation 7 – points to consider if retaining

- Rewording and renaming to „Evaluating programmes to prevent smoking relapse";
- Providing information on the difference between relapse and smoking cessation;
- Information and guidance on how to resource evaluations;
- Information and guidance on how to access expert support and advice in conducting evaluations;
- Reference to the need for commissioner support to implement this recommendation;
- How to provide resourcing to change current data collection.

4.5 Other points to consider

4.5.1 Use of psychological interventions

Research

It is the authors" understanding that there is not enough evidence on psychological interventions such as counselling, CBT and hypnotherapy to recommend them within the guidance or recommendations. In light of this, it might be useful to consider funding research on counselling and other psychological interventions.

Inclusion in guidance

In light of current practices (i.e. use of such interventions) it is important to make explicit within the guidance whether these interventions have been excluded because:

a) There is *not* enough supporting evidence to include them; or

b) There *is* enough evidence to suggest they should *not* be used or considered as treatment.

It might be an option to suggest that these interventions could be considered using professional judgement on a case-by-case basis.

ANNEXES

ANNEX A: RECOMMENDATIONS

Recommendation 1: identifying women who smoke and referring them to NHS Stop Smoking Services

Who is the target population?

Women who smoke and are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

Those responsible for providing health and support services for the women listed above and their partners. This includes:

- midwives (at first booking), GPs and health visitors
- those working in fertility clinics.

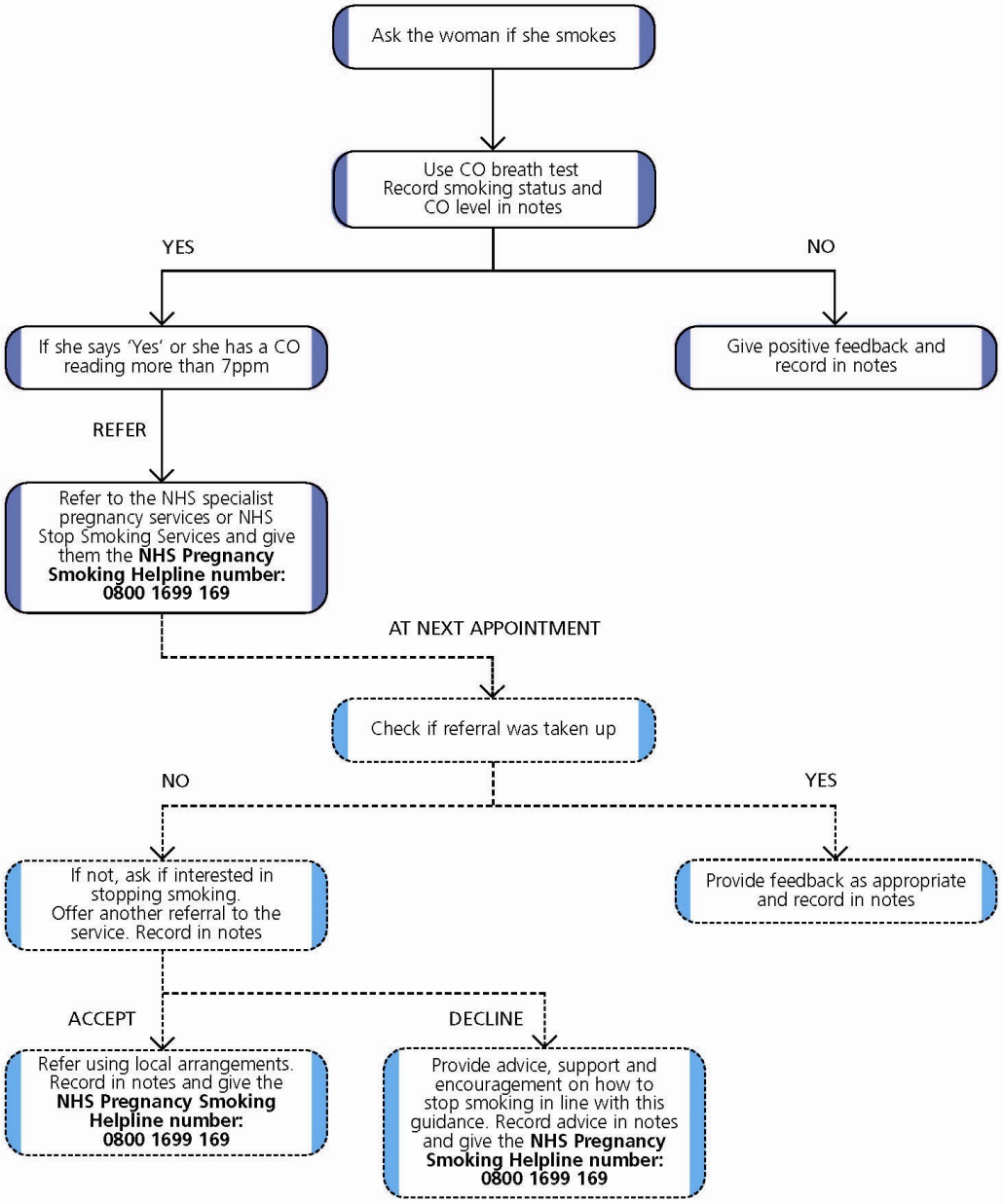
What action should they take?

- Ask the woman if she smokes. Use the carbon monoxide (CO) breath test to overcome under- and misreporting and to aid discussion.
- Record smoking status and CO level in the notes.
- Refer all those who smoke, even those unwilling to consider quitting or with a CO reading of more than 7 parts per million, to a specialist pregnancy or intensive NHS Stop Smoking Service. Explain that this is part of normal practice and that a specialist midwife or adviser will phone to talk about smoking. (See also, recommendation 3.) (Note: during the initial telephone conversation with the specialist, women who decide that they do not wish to quit should be sent information about smoking and pregnancy and on how to get help later if they so wish.) Record outcome in the notes.
- Use local arrangements to make an appointment and give the NHS Pregnancy Smoking Helpline number: 0800 1699 169.
- At the next appointment, check if the referral was taken up. If not, ask if they are interested in stopping smoking. Offer another referral to the service and record this offer in the notes.
- If the referral is declined, accept the answer non-judgmentally, leave the offer of help open, record in notes and review at a later appointment.
- Offer smoking cessation services in a sensitive, non-judgmental manner.
- Highlight the flexibility of many NHS Stop Smoking Services for pregnant women (for example, some offer home visits).
- Provide information (for example, leaflets) about the risks of smoking for the unborn child and the hazards of exposure to secondhand smoke for the mother and baby.

Details of other ways of identifying people who smoke, improving services for them and retaining them can be found in "Identifying and supporting people most at risk of dying prematurely" NICE public health guidance 15 (available at www.nice.org.uk/PH15).

Referral pathway

Provide all women with information (for example, a leaflet) about the risks of smoking to her and the unborn child, including smoking by partners or family members. Address any concerns she, her partner or family may have about stopping smoking. Tell partners and family members about NHS Stop Smoking Services.



Recommendation 2: referring women who smoke to NHS Stop Smoking Services

Who is the target population?

Women who smoke and are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

Those responsible for providing health and support services for the women listed above and their partners. This includes:

- dentists, occupational health professionals and hospital and community pharmacists
- those working in Children‟s Centres and voluntary organisations.

What action should they take?

- Ask the woman if she smokes. If she does, explain how NHS specialist pregnancy services and intensive NHS Stop Smoking Services can help people to quit.
- Give the NHS Pregnancy Smoking Helpline number: 0800 1699 169. In addition, those with specialist training in smoking cessation for pregnant women should provide information (for example, leaflets) about the risks that smoking poses to the unborn child and the hazards of exposure to secondhand smoke for the mother and baby.
- Refer using local arrangements. Record in notes.

Recommendation 3: NHS specialist pregnancy services and NHS Stop Smoking Services for women who smoke

Who is the target population?

Women who smoke who are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

- NHS specialist pregnancy services and NHS Stop Smoking Services.
- Other providers of intensive interventions to help people quit smoking.

What action should they take?

- Telephone all women who have been referred for help. Discuss smoking and pregnancy with them and the issues they face in a non-judgemental manner (that is, adopt a client-centred approach). Invite them to the clinic.
- Consider offering to visit women at home or at another venue if it is difficult for them to attend specialist services.
- Send information on smoking and pregnancy to those who opt out during the initial telephone call. This should include details on how to get help to quit at a later date, if they so wish.

- Address the factors which prevent these women from using smoking cessation services. This could include a lack of confidence in their ability to quit, lack of knowledge about the services on offer – or difficulty accessing them. It could also include a fear of failure and concerns about being stigmatised.
- During the first face-to-face meeting, discuss how much and how frequently she smokes and ask if anyone else in the household smokes (this includes her partner if she has one). Provide information about the risks of smoking to the unborn child and the hazards of exposure to secondhand smoke. Address any concerns she and her partner or family may have about stopping smoking+.
- Offer personalised information, advice and support on how to stop smoking*.
- Encourage partners and other family members who smoke to quit.
- Provide intensive and ongoing support (brief interventions alone are unlikely to be sufficient) throughout pregnancy and beyond. This includes monitoring smoking status regularly using CO tests. Biochemically validate self-reported quitting at quit date and 4 weeks after. Cotinine tests are preferable for validating quit attempts as they can confirm that someone has abstained from smoking for approximately 7 days (as opposed to 24 hours using CO readings).
- Record the method used to quit smoking, including whether or not women received help and support. Follow up 12 months after the date they set to quit.
- Discuss the risks and benefits of nicotine replacement therapy (NRT) with pregnant women who smoke, particularly those who do not wish to accept the offer of help from NHS Stop Smoking Services. If a woman expresses a clear wish to receive NRT, use professional judgement when deciding whether to offer a prescription*.
- Advise pregnant women using nicotine patches to remove them before going to bed.
- NRT should be prescribed as part of an abstinent-contingent treatment in which the woman who smokes makes a commitment to stop on or before a particular date (target stop date). The prescription of NRT should be sufficient to last only until 2 weeks after the target stop date. Normally this will be after 2 weeks of NRT therapy. Subsequent prescriptions should be given only to women who have demonstrated, on re-assessment, that their quit attempt is continuing+.
- Neither varenicline or bupropion should be offered to pregnant or breastfeeding women*.
- Establish links with contraceptive services, fertility clinics and ante- and postnatal services. Ensure everyone working for these services knows how to refer people to local NHS Stop Smoking Services and NHS specialist pregnancy services. Ensure they understand what these specialist services offer.
- Involve the women being targeted (see above) in the planning and development of services.
- Details of other methods for identifying people who smoke and improving the services on offer to them can be found in „Identifying and supporting people most at risk of dying prematurely" NICE public health guidance 15 (available at www.nice.org.uk/PH15).

** This is an extract from a recommendation in „Smoking cessation services" NICE public health guidance 10.*

+ This is an edited version of a recommendation that appears in „Smoking cessation services" NICE public health guidance 10. It does not constitute a change to the original recommendation.

Recommendation 4: NHS specialist pregnancy services and NHS Stop Smoking Services for partners and 'significant others'

Who is the target population?

Partners and others who smoke and live in the same household as a woman who is pregnant, planning a pregnancy or who has an infant aged under 12 months (regardless of whether or not the woman smokes).

Who should take action?

- NHS specialist pregnancy services and NHS Stop Smoking Services.
- Other organisations providing intensive interventions to help people quit smoking.

What action should they take?

- Offer a multi-component intervention. Two packages which have been found to be effective comprise:
    - free NRT patches combined with smoking cessation resources and multiple telephone counselling sessions
    - video and print materials on smoking cessation combined with multiple contacts with the smoking cessation adviser.

When deciding which interventions to use and in which order, discuss the options with the client and take into account[2]:

- whether a first offer of referral to the NHS Stop Smoking Services has been made
- contra-indications and the potential for adverse effects
- the client"s personal preferences
- the availability of appropriate counselling or support
- the likelihood that the client will follow the course of treatment
- their previous experience of smoking cessation aids.

Do not favour one medication over another. The practitioner and client should choose the one that seems most likely to succeed taking into account the above[3].

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2 This is an extract from „Smoking cessation services" (NICE public health guidance 10).

3 This is a edited version of a recommendation that appears in „Smoking cessation services" NICE public health guidance 10. It does not constitute a change to the original recommendation.

Recommendation 5: training

Who is the target population?

Healthcare professionals who come into contact with women who smoke who are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

- Commissioners of NHS specialist pregnancy services and NHS Stop Smoking Services.
- Maternity services.
- Professional bodies and organisations.
- NHS Centre for Smoking Cessation and Training.

What action should they take?

- Ensure all healthcare professionals know how to refer the women being targeted (see above) to local NHS Stop Smoking Services and NHS specialist pregnancy services. They should also know what these services offer.
- Ensure all midwives, health visitors, doctors, nurses, pharmacists and other healthcare professionals understand the impact of smoking and exposure to secondhand smoke on women and their unborn children. Ensure these healthcare professionals are also trained in the dangers of exposing pregnant women and their unborn child to secondhand smoke.
- Train all midwives in how to encourage women who are pregnant and smoke to quit.
- Ensure NHS Stop Smoking Services staff are trained to the minimum national standard, or on the basis of forthcoming updates from the NHS Centre for Smoking Cessation and Training. For the minimum national standard see „Standard for training in smoking cessation treatments" (www.nice.org.uk/page.aspx?o=502591).
- Provide additional specialised training for NHS Stop Smoking Services staff who are working with pregnant women who smoke.
- Ensure training addresses the perceived barriers to tackling smoking with someone who is pregnant. This may include practitioners" concerns that it might damage their relationship with the pregnant woman, the belief that current information and advice is insufficient or inadequate, limited skills and lack of knowledge of the types of intervention available.
- Ensure training addresses the important role that partners and „significant others" can play in helping a woman who is pregnant or has recently given birth to quit smoking. This includes the need to consider quitting themselves if they smoke.

Recommendation 6: incentives

Who is the target population?

Women who smoke who are planning a pregnancy, are pregnant or who have an infant aged under 12 months.

Who should take action?

- Smoking cessation Commissioners and practitioners.
- Policy makers.

What action should they take?

- Practitioners, policy makers and Commissioners should only endorse incentive schemes to encourage people to quit smoking if they are evaluated.
- An evaluation should:
    - biochemically validate smoking status before and after treatment
    - specify the content of the intervention and how it is delivered
    - investigate any unintended consequences (for example, misreporting of smoking status, or someone deliberately delaying their quit attempt until an incentive is available)
    - measure the impact of incentives on smoking cessation services: recruitment, retention (for example, attendance at appointments) and outcomes (effectiveness)
    - use appropriate process and outcome measures (for example, to determine intermediate outcomes such as knowledge, attitudes and skills, as well as effectiveness, acceptability, feasibility, equity and safety)
    - include a range of indicators to evaluate not only what works, but in what context, as well as the experiences of those involved
    - collect data on costs: staff time, training and overheads (premises, power, equipment), products (for example, incentives, pharmaceutical treatments, leaflets) and the client‟s own expenses.
- PCTs should consult with other trusts and local universities if they want to get involved in research to assess the effectiveness of incentive schemes. Such research should meet the minimum criteria recommended by NICE (see sections 3 and 5 in ‟Methods for the development of NICE public health guidance‟ [Second edition 2009]).

Recommendation 7: preventing a smoking relapse

Who is the target population?

Women who have given up smoking in the 12 months before pregnancy, during pregnancy or who have an infant aged under 12 months.

Who should take action?

- Practitioners providing support to help women stop smoking or to prevent a return to smoking (relapse).
- Commissioners of smoking cessation services.

What action should they take?

- Practitioners and Commissioners should only endorse schemes to prevent a smoking relapse if they are evaluated.
- An evaluation should:
  - biochemically validate smoking status before and after treatment
  - specify the content of the intervention and how it is delivered
  - investigate any unintended consequences
  - measure the impact of relapse prevention on smoking cessation services: recruitment, retention (for example, attendance at appointments) and outcomes (effectiveness)
  - use appropriate process and outcome measures (for example, to determine intermediate outcomes such as knowledge, attitudes and skills, as well as effectiveness, acceptability, feasibility, equity and safety)
  - include a range of indicators to evaluate not only what works, but in what context, as well as the experiences of those involved
  - collect data on costs: staff time, training and overheads (premises, power, equipment), products (for example, incentives, pharmaceutical treatments, leaflets) and the client‟s own expenses.
- PCTs should consult with other trusts and local universities if they want to get involved in research to assess the effectiveness of relapse prevention schemes. Such research should meet the minimum criteria recommended by NICE (see sections 3 and 5 in ‟Methods for the development of NICE public health guidance‟ [Second edition 2009]).

ANNEX B: LIST OF CONTRIBUTORS

The following list of individuals contributed to the workshops and focus groups and stated that they wished their contribution to be acknowledged. NICE and the authors of this report would like to thank everyone listed here and those who wished to remain anonymous for their valuable and helpful input to the fieldwork.

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Janine Brook
Janet Brown
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Faye Carol
Carol Carter
Rishpal Chana
Jenny Chen
Selina Cole
Alison Cutler
Sonia Dore
Hannah Dorling
Rhonda Douglas
Amanda Elsworth
Amy Endacott
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ANNEX C: WORKSHOP TOPIC GUIDE

NICE DRAFT RECOMMENDATIONS ON QUITTING SMOKING IN PREGNANCY AND FOLLOWING CHILDBIRTH: WORKSHOP GROUP TOPIC GUIDE

Introduction

I am [name] and I am the lead facilitator for today. My colleague [name] is the second facilitator who will help scribe the main sessions and facilitate one of the sub-groups. We have a NICE observer today who is [name].

Thank you very much for attending this workshop today run by Greenstreet Berman Ltd on behalf of the National Institute for Health and Clinical Excellence (NICE). NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill-health. NICE guidance is developed using the expertise of those working in different sectors- health care, local government, the voluntary sector and the academic world.

Although the methods for developing the various forms of guidance differ, all the development processes are underpinned by the key NICE principles of basing recommendations on the best available evidence and involving all stakeholders in a transparent and collaborative manner. For more information, visit www.nice.org.uk.

NICE is primarily interested in testing the relevance, utility and implementability of the draft guidance recommendations among professionals working with women who are pregnant, planning a pregnancy or who have an infant aged up to 12 months. This includes midwives, health visitors, professionals in antenatal care services, general practitioners, smoking cessation specialists commissioners, and managers working in the NHS, Local Authorities and wider public, private and community sectors, to test their likelihood of success.

The findings will be used by PHIAC to refine and prioritise draft recommendations in March 2010 and will inform the final guidance to be issued in **June 2010**.

This workshops aims to get your opinion on the draft recommendations on quitting smoking in pregnancy and following childbirth, particularly:

- What are your views of the relevance and usefulness of the recommendations?
- What impact might the recommendations have on policy, service provision and practice?
- What factors could impact implementation of the recommendations?
- How well do the recommendations match with your experience?

Background

The background to this work is provided as an Annex to this document.

Development of recommendations

The guidance was developed through a five-phased process. This included:

1. Drafting of a scope to identify the remit of the work.
2. Consultation to ensure relevance and usefulness of the scope.
3. Reviews of the relevant literature.
4. Consultation on the reviews to identify any missing evidence.
5. PHIAC review of the evidence and drafting of the recommendations.

Stakeholder consultation to evaluate the relevance, usefulness and implementability of the recommendations. This workshop today forms part of this stage.

The recommendations

There are **seven** recommendations which are outlined below.

Recommendation 1: identifying women who smoke and referring them to NHS Stop Smoking Services

Who is the target population?

Women who smoke and are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

Those responsible for providing health and support services for the women listed above and their partners. This includes:

- midwives (at first booking), GPs and health visitors
- those working in fertility clinics.

What action should they take?

- Ask the woman if she smokes. Use the carbon monoxide (CO) breath test to overcome under- and misreporting and to aid discussion.
- Record smoking status and CO level in the notes.
- Refer all those who smoke, even those unwilling to consider quitting or with a CO reading of more than 7 parts per million, to a specialist pregnancy or intensive NHS Stop Smoking Service. Explain that this is part of normal practice and that a specialist midwife or adviser will phone to talk about smoking. (See also, recommendation 3.) (Note: during the initial telephone conversation with the specialist, women who decide that they do not wish to quit should be sent information about smoking and pregnancy and on how to get help later if they so wish.) Record outcome in the notes.

- Use local arrangements to make an appointment and give the NHS Pregnancy Smoking Helpline number: 0800 1699 169.
- At the next appointment, check if the referral was taken up. If not, ask if they are interested in stopping smoking. Offer another referral to the service and record this offer in the notes.
- If the referral is declined, accept the answer non-judgmentally, leave the offer of help open, record in notes and review at a later appointment.
- Offer smoking cessation services in a sensitive, non-judgmental manner.
- Highlight the flexibility of many NHS Stop Smoking Services for pregnant women (for example, some offer home visits).
- Provide information (for example, leaflets) about the risks of smoking for the unborn child and the hazards of exposure to secondhand smoke for the mother and baby.

Details of other ways of identifying people who smoke, improving services for them and retaining them can be found in "Identifying and supporting people most at risk of dying prematurely" NICE public health guidance 15 (available at www.nice.org.uk/PH15).

[Please refer to PowerPoint diagram]

Recommendation 2: referring women who smoke to NHS Stop Smoking Services

Who is the target population?

Women who smoke and are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

Those responsible for providing health and support services for the women listed above and their partners. This includes:

- dentists, occupational health professionals and hospital and community pharmacists
- those working in children"s centres and voluntary organisations.

What action should they take?

- Ask the woman if she smokes. If she does, explain how NHS specialist pregnancy services and intensive NHS Stop Smoking Services can help people to quit.
- Give the NHS Pregnancy Smoking Helpline number: 0800 1699 169. In addition, those with specialist training in smoking cessation for pregnant women should provide information (for example, leaflets) about the risks that smoking poses to the unborn child and the hazards of exposure to secondhand smoke for the mother and baby.
- Refer using local arrangements. Record in notes.

Recommendation 3: NHS specialist pregnancy services and NHS Stop Smoking Services for women who smoke

Who is the target population?

Women who smoke who are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

- NHS specialist pregnancy services and NHS Stop Smoking Services.
- Other providers of intensive interventions to help people quit smoking.

What action should they take?

- Telephone all women who have been referred for help. Discuss smoking and pregnancy with them and the issues they face in a non-judgemental manner (that is, adopt a client-centred approach). Invite them to the clinic.
- Consider offering to visit women at home or at another venue if it is difficult for them to attend specialist services.
- Send information on smoking and pregnancy to those who opt out during the initial telephone call. This should include details on how to get help to quit at a later date, if they so wish.
- Address the factors which prevent these women from using smoking cessation services. This could include a lack of confidence in their ability to quit, lack of knowledge about the services on offer – or difficulty accessing them. It could also include a fear of failure and concerns about being stigmatised.
- During the first face-to-face meeting, discuss how much and how frequently she smokes and ask if anyone else in the household smokes (this includes her partner if she has one). Provide information about the risks of smoking to the unborn child and the hazards of exposure to secondhand smoke. Address any concerns she and her partner or family may have about stopping smoking[4].
- Offer personalised information, advice and support on how to stop smoking[5].
- Encourage partners and other family members who smoke to quit.
- Provide intensive and ongoing support (brief interventions alone are unlikely to be sufficient) throughout pregnancy and beyond. This includes monitoring smoking status regularly using CO tests. Biochemically validate self-reported quitting at quit date and 4 weeks after. Cotinine tests are preferable for validating quit attempts as they can confirm that someone has abstained from smoking for approximately 7 days (as opposed to 24 hours using CO readings).

4 This is an edited version of a recommendation that appears in „Smoking cessation services" NICE public health guidance 10. It does not constitute a change to the original recommendation.

5 This is an extract from a recommendation in „Smoking cessation services" NICE public health guidance 10.

- Record the method used to quit smoking, including whether or not women received help and support. Follow up 12 months after the date they set to quit.
- Discuss the risks and benefits of nicotine replacement therapy (NRT) with pregnant women who smoke, particularly those who do not wish to accept the offer of help from NHS Stop Smoking Services. If a woman expresses a clear wish to receive NRT, use professional judgement when deciding whether to offer a prescription[6].
- Advise pregnant women using nicotine patches to remove them before going to bed3.
- NRT should be prescribed as part of an abstinent-contingent treatment in which the woman who smokes makes a commitment to stop on or before a particular date (target stop date). The prescription of NRT should be sufficient to last only until 2 weeks after the target stop date. Normally this will be after 2 weeks of NRT therapy. Subsequent prescriptions should be given only to women who have demonstrated, on re-assessment, that their quit attempt is continuing[7].
- Neither varenicline or bupropion should be offered to pregnant or breastfeeding women[8].
- Establish links with contraceptive services, fertility clinics and ante- and postnatal services. Ensure everyone working for these services knows how to refer people to local NHS Stop Smoking Services and NHS specialist pregnancy services. Ensure they understand what these specialist services offer.
- Involve the women being targeted (see above) in the planning and development of services.
- Details of other methods for identifying people who smoke and improving the services on offer to them can be found in „Identifying and supporting people most at risk of dying prematurely" NICE public health guidance 15 (available at www.nice.org.uk/PH15).

Recommendation 4: NHS specialist pregnancy services and NHS Stop Smoking Services for partners and 'significant others'

Who is the target population?

Partners and others who smoke and live in the same household as a woman who is pregnant, planning a pregnancy or who has an infant aged under 12 months (regardless of whether or not the woman smokes).

Who should take action?

- NHS specialist pregnancy services and NHS Stop Smoking Services.
- Other organisations providing intensive interventions to help people quit smoking.

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6 This is an extract from a recommendation in „Smoking cessation services" NICE public health guidance 10.

7 This is an edited version of a recommendation that appears in „Smoking cessation services" NICE public health guidance 10. It does not constitute a change to the original recommendation.

8 This is an extract from a recommendation in „Smoking cessation services" NICE public health guidance 10.

What action should they take?

- Offer a multi-component intervention. Two packages which have been found to be effective comprise:
    - free NRT patches combined with smoking cessation resources and multiple telephone counselling sessions
    - video and print materials on smoking cessation combined with multiple contacts with the smoking cessation adviser.

When deciding which interventions to use and in which order, discuss the options with the client and take into account[9]:

- whether a first offer of referral to the NHS Stop Smoking Services has been made
- contra-indications and the potential for adverse effects
- the client‟s personal preferences
- the availability of appropriate counselling or support
- the likelihood that the client will follow the course of treatment
- their previous experience of smoking cessation aids.

Do not favour one medication over another. The practitioner and client should choose the one that seems most likely to succeed taking into account the above[10].

Recommendation 5: training

Who is the target population?

Healthcare professionals who come into contact with women who smoke who are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

- Commissioners of NHS specialist pregnancy services and NHS Stop Smoking Services.
- Maternity services.
- Professional bodies and organisations.
- NHS Centre for Smoking Cessation and Training.

9 This is an extract from „Smoking cessation services‟ (NICE public health guidance 10).

10 This is a edited version of a recommendation that appears in „Smoking cessation services‟ NICE public health guidance 10. It does not constitute a change to the original recommendation.

What action should they take?

- Ensure all healthcare professionals know how to refer the women being targeted (see above) to local NHS Stop Smoking Services and NHS specialist pregnancy services. They should also know what these services offer.
- Ensure all midwives, health visitors, doctors, nurses, pharmacists and other healthcare professionals understand the impact of smoking and exposure to secondhand smoke on women and their unborn children. Ensure these healthcare professionals are also trained in the dangers of exposing pregnant women and their unborn child to secondhand smoke.
- Train all midwives in how to encourage women who are pregnant and smoke to quit.
- Ensure NHS Stop Smoking Services staff are trained to the minimum national standard, or on the basis of forthcoming updates from the NHS Centre for Smoking Cessation and Training. For the minimum national standard see „Standard for training in smoking cessation treatments" (www.nice.org.uk/page.aspx?o=502591).
- Provide additional specialised training for NHS Stop Smoking Services staff who are working with pregnant women who smoke.
- Ensure training addresses the perceived barriers to tackling smoking with someone who is pregnant. This may include practitioners" concerns that it might damage their relationship with the pregnant woman, the belief that current information and advice is insufficient or inadequate, limited skills and lack of knowledge of the types of intervention available.
- Ensure training addresses the important role that partners and „significant others" can play in helping a woman who is pregnant or has recently given birth to quit smoking. This includes the need to consider quitting themselves if they smoke.

Recommendation 6: incentives

Who is the target population?

Women who smoke who are planning a pregnancy, are pregnant or who have an infant aged under 12 months.

Who should take action?

- Smoking cessation commissioners and practitioners.
- Policy makers.

What action should they take?

- Practitioners, policy makers and commissioners should only endorse incentive schemes to encourage people to quit smoking if they are evaluated.
- An evaluation should:
  - biochemically validate smoking status before and after treatment
  - specify the content of the intervention and how it is delivered

  - investigate any unintended consequences (for example, misreporting of smoking status, or someone deliberately delaying their quit attempt until an incentive is available)
  - measure the impact of incentives on smoking cessation services: recruitment, retention (for example, attendance at appointments) and outcomes (effectiveness)
  - use appropriate process and outcome measures (for example, to determine intermediate outcomes such as knowledge, attitudes and skills, as well as effectiveness, acceptability, feasibility, equity and safety)
  - include a range of indicators to evaluate not only what works, but in what context, as well as the experiences of those involved
  - collect data on costs: staff time, training and overheads (premises, power, equipment), products (for example, incentives, pharmaceutical treatments, leaflets) and the client‟s own expenses.

- PCTs should consult with other trusts and local universities if they want to get involved in research to assess the effectiveness of incentive schemes. Such research should meet the minimum criteria recommended by NICE (see sections 3 and 5 in "Methods for the development of NICE public health guidance" [Second edition 2009]).

Recommendation 7: preventing a smoking relapse

Who is the target population?

Women who have given up smoking in the 12 months before pregnancy, during pregnancy or who have an infant aged under 12 months.

Who should take action?

- Practitioners providing support to help women stop smoking or to prevent a return to smoking (relapse).
- Commissioners of smoking cessation services.

What action should they take?

- Practitioners and commissioners should only endorse schemes to prevent a smoking relapse if they are evaluated.
- An evaluation should:
  - biochemically validate smoking status before and after treatment
  - specify the content of the intervention and how it is delivered
  - investigate any unintended consequences

- measure the impact of relapse prevention on smoking cessation services: recruitment, retention (for example, attendance at appointments) and outcomes (effectiveness)
- use appropriate process and outcome measures (for example, to determine intermediate outcomes such as knowledge, attitudes and skills, as well as effectiveness, acceptability, feasibility, equity and safety)
- include a range of indicators to evaluate not only what works, but in what context, as well as the experiences of those involved
- collect data on costs: staff time, training and overheads (premises, power, equipment), products (for example, incentives, pharmaceutical treatments, leaflets) and the client‟s own expenses.

- PCTs should consult with other trusts and local universities if they want to get involved in research to assess the effectiveness of relapse prevention schemes. Such research should meet the minimum criteria recommended by NICE (see sections 3 and 5 in “Methods for the development of NICE public health guidance” [Second edition 2009]).

Your role

We have identified all delegates present today as working directly with women who are planning to become pregnant, who are pregnant or who have recently given birth, and their families or partners; or those that are representing an organisation that is involved in supporting women and their families at these life stages.

The role of each of you is to provide feedback that can be used by NICE to review and refine the recommendations to ensure that they are useful, implementable and relevant. We are also looking for case study examples of situations where the recommendations may and may not work, and will be asking for these in the second part of this workshop.

This workshop

This workshop will last for approximately three hours and will consist of the following sessions:

- Pre-session questions about current practice – 15 minutes;
- General review of the guidance – 45 minutes;
- Tea break – 15 minutes;
- Recommendation-specific review in which we will break into smaller groups – one hour;
- Plenary appraisal – 30 minutes; and
- Your individual evaluation of today – five minutes.

Please be aware that we are recording today‟s discussion using a digital voice recorder. The recording will be kept in an archive by NICE. We will not identify any individual by name or incidentally in our report. The recording will only be used to check the summary of the discussion. Please advise us if you object to being recorded.

Housekeeping

Before we start today I will just run through a few housekeeping issues:

- Fire escape and location of toilets;
- There is no right or wrong answer today, we value your opinion for this fieldwork;
- Ground rules – only one person to talk at one time, value each other‟s contributions, be supportive etc;
- Everything you say is confidential – the reporting of proceedings will be anonymised;
- [name] will be making some notes throughout as well;
- We will produce a written summary of your feedback; and
- In a week or two we will send you the summary for your comment before we finalise it.

Pre-session questions about current practice (15 minutes)

1. What is your current referral process?
    - Do you currently refer smoking pregnant women and mothers to stop smoking services?
    - If yes,
        i. Where to?
        ii. How is this conducted – are all women offered referrals, or is there an „opt-in“ and „opt-out“ option?
        iii. Do you offer alternatives to women who are not able to attend clinics?
    - How do you identify smokers and/or partners/families that smoke?

2. What advice do you provide?
    - Do you recommend NRT (Nicotine Replacement Therapy) to all smokers, or just those that ask?
    - What (if any) other products do you advise?
    - Do you advise cutting down and if so under what circumstances?
    - What other advice do you provide?

3. Are non-healthcare professionals working with these women aware of stop smoking services?
    - How do they find out about them?

4. What data do you currently collect on smoking cessation e.g. use of incentives, relapse prevention etc?
    - How do you evaluate the effectiveness of any programmes that you conduct?

Session 1 – General review of the guidance (45 minutes)

We would first like to explore your thoughts on the recommendations, specifically considering the relevance, utility and implementability of the recommendations. You should have received the draft recommendations in your delegates pack. If you have not had the opportunity to read the recommendations if I could ask you to read through them now – we have copies of the recommendations if anyone needs a spare.

< Facilitator to run through an overview of the Recommendations >

Please be aware that we will talk through each specific recommendation in the next session, this section is to explore the recommendations as a whole.

1. How useful do you think the recommendations would be? For example:

   Do practitioners from their experience perceive that the recommendations would address the issue of smoking cessation in pregnancy, while planning pregnancy and after childbirth?

2. Would the recommendations work (in specific settings and specific groups)? For example:
   - Would PCTs have the resources to implement the recommendations at a local level?
     - What kinds of resources might these be e.g. staff, funding, „outside" help etc?
   - What might the practical barriers be to accessing and communicating with various groups such as:
     - Ethnic minority groups;
     - Young mothers (under 20 years) and their partners or families;
     - Unsupported mothers;
     - Low income mothers and their partners and families;
     - Mothers who are or who had been looked after children or in care settings; and
     - Refugees and asylum seekers etc?

3. What factors could affect the implementation and delivery of the recommendations? What are the barriers to successful delivery? For example:
   - Are there any groups that might not be covered by the recommendations?
   - What might the impact on health inequalities be?
   - Are there any groups that might be harder to access?

- How might the recommendations be received by women who are planning a pregnancy, are pregnant or who have recently given birth?
- How might the recommendations be received by their partners or by significant others/families?
- Will those responsible for implementing the recommendations have adequate resources, knowledge and understanding to do so?
    - If not, what might be needed e.g. funding, staff, „outside" help, knowledge etc?

4. If the recommendations would not work, why not and what should be done?
    - E.g. need training, not enough resource, lack of access to external organisation or specialist knowledge etc.

<Tea Break – 15 minutes>

Session 2 – Group-based assessment of each recommendation (one hour)

< Group divided into sub groups>

The aim of this section is to formulate a group based appraisal of each of the recommendations. We will talk through each recommendation in turn. We would like you to consider one to start with, but would like you to move on to others as time allows. In addition to discussing each recommendation as a group, we would ask that each of you make notes on the appraisal form and hand them back at the end of this session.

Your views should be based on the current Recommendations, not how they could be if they were changed. You can come back to the rating at the end of the exercise if you feel you need to discuss first.

[NOTE TO FACILITATOR: run through rationale for Recommendations 6 and 7 if necessary i.e. background to the research about incentives and relapse programmes. Delegates can also find more information in the guidance – especially Appendix C on evidence]

Recommendation XX

EXERCISE (10 MINS)

	High impact	
1		**2**
Low feasibility		High feasibility
3		**4**
	Low impact	

1. What would need to be done to make this recommendation work?
   - What do we need to do next to ensure that this topic receives appropriate support to facilitate implementation?
   - Who needs to be involved in this?

2. What are the barriers to and facilitators for applying the recommendation?

3. Are there opportunities to link with or support existing or forthcoming national initiatives? Are there any existing resources or support that we could signpost people to?

4. Are there any gaps in the recommendations that you feel need to be filled?

<REPEAT QUESTIONS ABOVE FOR THE NEXT RECOMMENDATION PROVIDED BY THE FACILITATOR>

Session 3 – Plenary session (half an hour)

Feedback to main group

Feedback from a representative of each of the groups. General discussion of findings.

Workshop evaluation

Hand out the evaluation sheets and collect all papers from meeting attendees.

Thank you for attending this workshop – your contribution and support is welcomed and appreciated.

[Please note that an appendix was attached to the end of this topic guide to provide background information to the work. To save duplication in this report, this appendix has been saved as an annex at Annex E: Background to the work.]

ANNEX D: FOCUS GROUP PROFORMA

NICE DRAFT RECOMMENDATIONS ON QUITTING SMOKING IN PREGNANCY AND FOLLOWING CHILDBIRTH: SMALL GROUP GUIDE

Introduction

I am [name] and I am the facilitator for today.

Thank you very much for attending this small group today run by Greenstreet Berman Ltd on behalf of the National Institute for Health and Clinical Excellence (NICE). NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill-health. NICE guidance is developed using the expertise of those working in different sectors- health care, local government, the voluntary sector and the academic world.

Although the methods for developing the various forms of guidance differ, all the development processes are underpinned by the key NICE principles of basing recommendations on the best available evidence and involving all stakeholders in a transparent and collaborative manner. For more information, visit www.nice.org.uk.

NICE is primarily interested in the testing the relevance, utility and implementability of the draft guidance recommendations that have been developed among professionals working with women who are pregnant, planning a pregnancy or who have an infant aged up to 12 months, or partners of pregnant women e.g. midwives, health visitors, professionals in antenatal care services, smoking cessation specialists, general practitioners, commissioners, and managers working in the NHS, Local Authorities and wider public, private and community sectors, to test their likelihood of success.

The findings will be used by the Public Health Interventions Advisory Committee (PHIAC) to refine and prioritise draft recommendations in March 2010 and will inform the final guidance to be issued in **June 2010**.

This group session aims to get your opinion on the draft recommendations on quitting smoking in pregnancy and after childbirth recommendations.

- What are your views of the relevance and usefulness of the recommendations?
- What impact might the recommendations have on policy, service provision and practice?
- What factors could impact implementation of the recommendations?
- How well do the recommendations match with your experience?

Background

The background to this work is provided as an Annex to this document.

Development of recommendations

The guidance was developed through a five-phased process. This included:

1. Drafting of a scope to identify the remit of the work.
2. Consultation to ensure relevance and usefulness of the scope.
3. Reviews of the relevant literature.
4. Consultation on the reviews to identify any missing evidence.
5. PHIAC review of the evidence and drafting of the recommendations.

Stakeholder consultation to evaluate the relevance, usefulness and implementability of the recommendations. This workshop today forms part of this stage.

The recommendations

There are **seven** recommendations which are outlined below.

Recommendation 1: identifying women who smoke and referring them to NHS Stop Smoking Services

Who is the target population?

Women who smoke and are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

Those responsible for providing health and support services for the women listed above and their partners. This includes:

- midwives (at first booking), GPs and health visitors
- those working in fertility clinics.

What action should they take?

- Ask the woman if she smokes. Use the carbon monoxide (CO) breath test to overcome under- and misreporting and to aid discussion.
- Record smoking status and CO level in the notes.
- Refer all those who smoke, even those unwilling to consider quitting or with a CO reading of more than 7 parts per million, to a specialist pregnancy or intensive NHS Stop Smoking Service. Explain that this is part of normal practice and that a specialist midwife or adviser will phone to talk about smoking. (See also, recommendation 3.) (Note: during the initial telephone conversation with the specialist, women who decide that they do not wish to quit should be sent information about smoking and pregnancy and on how to get help later if they so wish.) Record outcome in the notes.
- Use local arrangements to make an appointment and give the NHS Pregnancy Smoking Helpline number: 0800 1699 169.

- At the next appointment, check if the referral was taken up. If not, ask if they are interested in stopping smoking. Offer another referral to the service and record this offer in the notes.
- If the referral is declined, accept the answer non-judgmentally, leave the offer of help open, record in notes and review at a later appointment.
- Offer smoking cessation services in a sensitive, non-judgmental manner.
- Highlight the flexibility of many NHS Stop Smoking Services for pregnant women (for example, some offer home visits).
- Provide information (for example, leaflets) about the risks of smoking for the unborn child and the hazards of exposure to secondhand smoke for the mother and baby.

Details of other ways of identifying people who smoke, improving services for them and retaining them can be found in "Identifying and supporting people most at risk of dying prematurely" NICE public health guidance 15 (available at www.nice.org.uk/PH15).

[Please refer to PowerPoint diagram]

Recommendation 2: referring women who smoke to NHS Stop Smoking Services

Who is the target population?

Women who smoke and are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

Those responsible for providing health and support services for the women listed above and their partners. This includes:

- dentists, occupational health professionals and hospital and community pharmacists
- those working in children"s centres and voluntary organisations.

What action should they take?

- Ask the woman if she smokes. If she does, explain how NHS specialist pregnancy services and intensive NHS Stop Smoking Services can help people to quit.
- Give the NHS Pregnancy Smoking Helpline number: 0800 1699 169. In addition, those with specialist training in smoking cessation for pregnant women should provide information (for example, leaflets) about the risks that smoking poses to the unborn child and the hazards of exposure to secondhand smoke for the mother and baby.
- Refer using local arrangements. Record in notes.

Recommendation 3: NHS specialist pregnancy services and NHS Stop Smoking Services for women who smoke

Who is the target population?

Women who smoke who are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

- NHS specialist pregnancy services and NHS Stop Smoking Services.
- Other providers of intensive interventions to help people quit smoking.

What action should they take?

- Telephone all women who have been referred for help. Discuss smoking and pregnancy with them and the issues they face in a non-judgemental manner (that is, adopt a client-centred approach). Invite them to the clinic.
- Consider offering to visit women at home or at another venue if it is difficult for them to attend specialist services.
- Send information on smoking and pregnancy to those who opt out during the initial telephone call. This should include details on how to get help to quit at a later date, if they so wish.
- Address the factors which prevent these women from using smoking cessation services. This could include a lack of confidence in their ability to quit, lack of knowledge about the services on offer – or difficulty accessing them. It could also include a fear of failure and concerns about being stigmatised.
- During the first face-to-face meeting, discuss how much and how frequently she smokes and ask if anyone else in the household smokes (this includes her partner if she has one). Provide information about the risks of smoking to the unborn child and the hazards of exposure to secondhand smoke. Address any concerns she and her partner or family may have about stopping smoking[11].
- Offer personalised information, advice and support on how to stop smoking[12].
- Encourage partners and other family members who smoke to quit.
- Provide intensive and ongoing support (brief interventions alone are unlikely to be sufficient) throughout pregnancy and beyond. This includes monitoring smoking status regularly using CO tests. Biochemically validate self-reported quitting at quit date and 4 weeks after. Cotinine tests are preferable for validating quit attempts as they can confirm that someone has abstained from smoking for approximately 7 days (as opposed to 24 hours using CO readings).

11 This is an edited version of a recommendation that appears in „Smoking cessation services" NICE public health guidance 10. It does not constitute a change to the original recommendation.

12 This is an extract from a recommendation in „Smoking cessation services" NICE public health guidance 10.

- Record the method used to quit smoking, including whether or not women received help and support. Follow up 12 months after the date they set to quit.
- Discuss the risks and benefits of nicotine replacement therapy (NRT) with pregnant women who smoke, particularly those who do not wish to accept the offer of help from NHS Stop Smoking Services. If a woman expresses a clear wish to receive NRT, use professional judgement when deciding whether to offer a prescription[13].
- Advise pregnant women using nicotine patches to remove them before going to bed3.
- NRT should be prescribed as part of an abstinent-contingent treatment in which the woman who smokes makes a commitment to stop on or before a particular date (target stop date). The prescription of NRT should be sufficient to last only until 2 weeks after the target stop date. Normally this will be after 2 weeks of NRT therapy. Subsequent prescriptions should be given only to women who have demonstrated, on re-assessment, that their quit attempt is continuing[14].
- Neither varenicline or bupropion should be offered to pregnant or breastfeeding women[15].
- Establish links with contraceptive services, fertility clinics and ante- and postnatal services. Ensure everyone working for these services knows how to refer people to local NHS Stop Smoking Services and NHS specialist pregnancy services. Ensure they understand what these specialist services offer.
- Involve the women being targeted (see above) in the planning and development of services.
- Details of other methods for identifying people who smoke and improving the services on offer to them can be found in „Identifying and supporting people most at risk of dying prematurely" NICE public health guidance 15 (available at www.nice.org.uk/PH15).

Recommendation 4: NHS specialist pregnancy services and NHS Stop Smoking Services for partners and 'significant others'

Who is the target population?

Partners and others who smoke and live in the same household as a woman who is pregnant, planning a pregnancy or who has an infant aged under 12 months (regardless of whether or not the woman smokes).

Who should take action?

- NHS specialist pregnancy services and NHS Stop Smoking Services.
- Other organisations providing intensive interventions to help people quit smoking.

13 This is an extract from a recommendation in „Smoking cessation services" NICE public health guidance 10.

14 This is an edited version of a recommendation that appears in „Smoking cessation services" NICE public health guidance 10. It does not constitute a change to the original recommendation.

15 This is an extract from a recommendation in „Smoking cessation services" NICE public health guidance 10.

What action should they take?

- Offer a multi-component intervention. Two packages which have been found to be effective comprise:
    - free NRT patches combined with smoking cessation resources and multiple telephone counselling sessions
    - video and print materials on smoking cessation combined with multiple contacts with the smoking cessation adviser.
- When deciding which interventions to use and in which order, discuss the options with the client and take into account[16]:
    - whether a first offer of referral to the NHS Stop Smoking Services has been made
    - contra-indications and the potential for adverse effects
    - the client‟s personal preferences
    - the availability of appropriate counselling or support
    - the likelihood that the client will follow the course of treatment
    - their previous experience of smoking cessation aids.
- Do not favour one medication over another. The practitioner and client should choose the one that seems most likely to succeed taking into account the above[17].

Recommendation 5: training

Who is the target population?

Healthcare professionals who come into contact with women who smoke who are planning a pregnancy, are already pregnant or who have an infant aged under 12 months.

Who should take action?

- Commissioners of NHS specialist pregnancy services and NHS Stop Smoking Services.
- Maternity services.
- Professional bodies and organisations.
- NHS Centre for Smoking Cessation and Training.

16 This is an extract from „Smoking cessation services‟ (NICE public health guidance 10).

17 This is a edited version of a recommendation that appears in „Smoking cessation services‟ NICE public health guidance 10. It does not constitute a change to the original recommendation.

What action should they take?

- Ensure all healthcare professionals know how to refer the women being targeted (see above) to local NHS Stop Smoking Services and NHS specialist pregnancy services. They should also know what these services offer.
- Ensure all midwives, health visitors, doctors, nurses, pharmacists and other healthcare professionals understand the impact of smoking and exposure to secondhand smoke on women and their unborn children. Ensure these healthcare professionals are also trained in the dangers of exposing pregnant women and their unborn child to secondhand smoke.
- Train all midwives in how to encourage women who are pregnant and smoke to quit.
- Ensure NHS Stop Smoking Services staff are trained to the minimum national standard, or on the basis of forthcoming updates from the NHS Centre for Smoking Cessation and Training. For the minimum national standard see „Standard for training in smoking cessation treatments" (www.nice.org.uk/page.aspx?o=502591).
- Provide additional specialised training for NHS Stop Smoking Services staff who are working with pregnant women who smoke.
- Ensure training addresses the perceived barriers to tackling smoking with someone who is pregnant. This may include practitioners" concerns that it might damage their relationship with the pregnant woman, the belief that current information and advice is insufficient or inadequate, limited skills and lack of knowledge of the types of intervention available.
- Ensure training addresses the important role that partners and „significant others" can play in helping a woman who is pregnant or has recently given birth to quit smoking. This includes the need to consider quitting themselves if they smoke.

Recommendation 6: incentives

Who is the target population?

Women who smoke who are planning a pregnancy, are pregnant or who have an infant aged under 12 months.

Who should take action?

- Smoking cessation commissioners and practitioners.
- Policy makers.

What action should they take?

- Practitioners, policy makers and commissioners should only endorse incentive schemes to encourage people to quit smoking if they are evaluated.
- An evaluation should:
  - biochemically validate smoking status before and after treatment
  - specify the content of the intervention and how it is delivered

  - investigate any unintended consequences (for example, misreporting of smoking status, or someone deliberately delaying their quit attempt until an incentive is available)
  - measure the impact of incentives on smoking cessation services: recruitment, retention (for example, attendance at appointments) and outcomes (effectiveness)
  - use appropriate process and outcome measures (for example, to determine intermediate outcomes such as knowledge, attitudes and skills, as well as effectiveness, acceptability, feasibility, equity and safety)
  - include a range of indicators to evaluate not only what works, but in what context, as well as the experiences of those involved
  - collect data on costs: staff time, training and overheads (premises, power, equipment), products (for example, incentives, pharmaceutical treatments, leaflets) and the client‟s own expenses.

- PCTs should consult with other trusts and local universities if they want to get involved in research to assess the effectiveness of incentive schemes. Such research should meet the minimum criteria recommended by NICE (see sections 3 and 5 in “Methods for the development of NICE public health guidance‟ [Second edition 2009]).

Recommendation 7: preventing a smoking relapse

Who is the target population?

Women who have given up smoking in the 12 months before pregnancy, during pregnancy or who have an infant aged under 12 months.

Who should take action?

- Practitioners providing support to help women stop smoking or to prevent a return to smoking (relapse).
- Commissioners of smoking cessation services.

What action should they take?

- Practitioners and commissioners should only endorse schemes to prevent a smoking relapse if they are evaluated.
- An evaluation should:
  - biochemically validate smoking status before and after treatment
  - specify the content of the intervention and how it is delivered
  - investigate any unintended consequences

- measure the impact of relapse prevention on smoking cessation services: recruitment, retention (for example, attendance at appointments) and outcomes (effectiveness)
- use appropriate process and outcome measures (for example, to determine intermediate outcomes such as knowledge, attitudes and skills, as well as effectiveness, acceptability, feasibility, equity and safety)
- include a range of indicators to evaluate not only what works, but in what context, as well as the experiences of those involved
- collect data on costs: staff time, training and overheads (premises, power, equipment), products (for example, incentives, pharmaceutical treatments, leaflets) and the client‟s own expenses.

- PCTs should consult with other trusts and local universities if they want to get involved in research to assess the effectiveness of relapse prevention schemes. Such research should meet the minimum criteria recommended by NICE (see sections 3 and 5 in "Methods for the development of NICE public health guidance" [Second edition 2009]).

Your role

We have identified all delegates present today as working directly with women who are planning to become pregnant, who are pregnant or who have recently given birth, and their families or partners; or those that are representing an organisation that supports women at this life stage.

The role of each of you is to provide feedback that can be used by NICE to review and refine the recommendations to ensure that they are useful, implementable and relevant in the working environment. We are also looking for case study examples of situations where the recommendations may and may not work, and will be asking for these in the second part of this workshop.

This focus group

This focus group will last for approximately two hours and will consist of the following sessions:

- Current practice and situation – 25 minutes
- General review of the guidance – 25 minutes;
- Recommendation-specific review – 50 minutes; and
- Your individual evaluation of today – five minutes.

Please be aware that I am recording today‟s discussion using a digital voice recorder. The recording will be kept in an archive by NICE. I will not identify any individual by name or incidentally in our report. The recording will only be used to check the summary of the discussion. Please advise me if you object to being recorded.

Housekeeping

Before we start today I will just run through a few housekeeping issues:

- Fire escape and location of toilets;
- There is no right or wrong answer today, we value your opinion for this evaluation;
- Ground rules – only one person to talk at one time, value each others contributions, be supportive etc;
- Everything you say is confidential – the reporting of proceedings will be anonymised;
- I will produce a written summary of your feedback based on any notes I take and on any papers you return to me at the end of the session; and
- In a week or two I will send you the summary for your comment before I finalise it.

Session 1 – Review of current practice and general review of the guidance (50 minutes)

Questions about your PCT/organisation (10 minutes) – **please consider this in advance of the focus group**

1. What is the mix of population in the catchment area for your PCT/organisation? E.g. what ethnic groups or types of women do you most frequently come into contact with?
2. What are the particular concerns for your PCT/organisation? E.g. what are the main ethnic groups in your area? Do you have many people on low income using your services? Do you have a high rate of teenage pregnancies? What are your smoking rates? What smoking cessation services do you have available or have access to?

Questions about current practice (15 minutes)

3. What is your current referral process?
    - Do you currently refer smoking pregnant women and mothers to stop smoking services?
    - If yes,
        i. Where to?
        ii. How is this conducted – are all women offered referrals, or is there an „opt-in" and „opt-out" option?
        iii. Do you offer alternatives to women who are not able to attend clinics?
    - How do you identify smokers and/or partners/families that smoke?

4. What advice do you provide?
    - Do you recommend NRT (Nicotine Replacement Therapy) to all smokers, or just those that ask?
    - What (if any) other products do you advise?
    - Do you advise cutting down and if so under what circumstances?
    - What other advice do you provide?

5. Are non-healthcare professionals working with these women aware of stop smoking services?
    - How do they find out about them?

6. What data do you currently collect on smoking cessation e.g. use of incentives, relapse prevention etc?

- How do you evaluate the effectiveness of any programmes that you conduct?

Questions about the recommendations (25 minutes)

We would first like to explore your thoughts on the recommendations, specifically considering the relevance, utility and implementability of the recommendations. You should have received the draft recommendations in your delegates pack. Please be aware that we will talk through each specific recommendation in the next session, this section is to explore the recommendations as a whole.

< Facilitator to run through an overview of the Recommendations >

7. How useful do you think the recommendations would be? For example:
   - Do you perceive that the recommendations have identified the most effective options? Will they address your main issues in this area?

8. Would the recommendations work (in specific settings)? For example:
   - Would PCTs/organisations have the resources to implement the recommendations at a local level?
   - What impact might the recommendations have on the local population?
   - What might the practical barriers be to accessing and communicating with various groups such as:
     - Ethnic minority groups;
     - Young mothers (under 20 years) and their partners and families;
     - Low income mothers and their partners and families;
     - Unsupported mothers;
     - Mothers who are or who had been looked after children or in care settings; and
     - Refugees and asylum seekers etc?

9. What factors could affect the implementation and delivery of the recommendations? What are the barriers to successful delivery? For example:
   - Are there any groups that might not be covered by the recommendations?
   - What might the impact on health inequalities be?
   - Are there any groups that might be harder to access or excluded from the recommendations?
   - How might the recommendations be received by women who are planning a pregnancy, are pregnant or who have recently given birth? How might the recommendations be received by their partners or by significant others (i.e. family such as parents or grandparents, or friends that they live with)?

- How might implementation impact the resources for your PCT/organisation?
- Would your PCT‟s/organisation‟s policies need amending?

Session 2 – Assessment of specific recommendations (50 minutes)

The aim of this section is to formulate an appraisal of each of the recommendations. We would like you to consider one to start with, but would like to move on to others as time allows. In addition to discussing each recommendation as a group, we would ask that each of you make notes on the appraisal form and hand them back at the end of this session.

Your views should be based on the current Recommendations, not how they could be if they were changed. You can come back to the rating at the end of the exercise if you feel you need to discuss first.

[NOTE TO FACILITATOR: run through rationale for Recommendations 6 and 7 if necessary i.e. background to the research about incentives and relapse programmes. Delegates can also find more information in the guidance – especially Appendix C on evidence]

Recommendation XX

1. What would need to be done to make this recommendation work?
   - What do we need to do next to ensure that this topic receives appropriate support to facilitate implementation?
   - Who needs to be involved in this?
2. What impact might this recommendation have on current practice?
3. If this recommendation would not work, why not and what would work?
4. How feasible would this recommendation be to implement?
   - Do you have any examples of how these issues have been put into practice?
5. What are the barriers to and facilitators for applying the recommendation?
6. Are there opportunities to link with or support existing or forthcoming national initiatives? Are there any existing resources or support that we could signpost people to?

7. Are there any gaps in the recommendation that you feel need to be filled?

<REPEAT QUESTIONS ABOVE FOR THE NEXT RECOMMENDATION PROVIDED BY THE FACILITATOR>

Session 3 – Small group evaluation (five minutes)

Hand out the evaluation sheets and collect all papers from meeting attendees.

Thank you for attending this workshop – your contribution and support is welcomed and appreciated

[Please note that an appendix was attached to the end of this proforma to provide background information to the work. To save duplication in this report, this appendix has been saved as an annex at Annex E: Background to the work.]

ANNEX E: BACKGROUND TO THE WORK

Smoking in the UK

Smoking is the greatest single cause of preventable illness and premature death in the UK, killing around 106,000 people a year.[1] Half of all those who continue to smoke for most of their lives will die of their habit, half of these before the age of 69. Smoking rates and therefore smoking related mortality and morbidity are highest in the routine/manual population group and smoking is the single biggest contributor to health inequalities.

The seriousness of the problem, and the Government‟s commitment to tackle it, were reflected in the announcement of a Government Public Service Agreement (PSA) target in 2004. This target was to „reduce adult smoking rates to 21% or less by 2010, with a reduction in prevalence amongst manual and routine groups to 26% or less. [2] This PSA target is however no longer in use and has been overtaken by the new Local Area Agreements. There is a National Indicator (NI) 123 (in the Adults Health and Wellbeing section) that is concerned with reducing smoking prevalence in those above 16 years old. Related indicators include:

- NI119 Self-reported measure of people‟s overall health and wellbeing;
- NI121 Mortality rate from all circulatory diseases at ages under 75; and
- NI122 Mortality rate from all cancers at ages under 75 years.

The public health White Paper „Choosing Health‟[3] (available at www.dh.gov.uk) sets out a programme of work on tobacco control and smoking that will support delivery of the PSA target. This programme furthers the commitments made in the 1998 White Paper „Smoking Kills‟.

Current Government advice in relation to smoking includes:

- Trying to avoid starting smoking in the first place;
- Quitting when young is easier than quitting when you are older;
- It is better to quit than just to cut down – there is much more evidence for this making a difference to health outcomes; and
- Cutting down is better than nothing.

The Government have undertaken a consultation on the future of tobacco control (details available at: www.dh.gov.uk/en/consultations/liveconsultations/dh_085120). The new strategy was due to be published in November.

Smoking before, during and after pregnancy

In 2005, 32% of mothers in England smoked before pregnancy. Of these, 49% quit before birth. Although most of those that quit before birth were still not smoking after birth, 30% of them started again before their child reached its first year. [4]

Smoking can be a particular health risk during and after pregnancy for both mother and child. According to the Royal College of Physicians[5] risks to the mother include complications during labour and increased risk of miscarriage, premature birth, still birth and sudden unexpected death in infancy. It is also estimated to increase infant mortality by about 40%.[6]

Research on the risks to the infant from maternal smoking during pregnancy shows the following:

- Physical and mental retardation in children of seven and 11 years – this deficit was found to increase with the number of cigarettes smoked after the fourth month of pregnancy. Children of mothers who smoked 10 or more cigarettes a day were found to be shorter and between three and five months retarded on reading, mathematics, and general ability than children of non-smokers. [7]
- Lower birth weight and neonatal/perinatal mortality has been linked to smoking after the fourth month of pregnancy although there is mixed opinion on this. [8 9 10]
- Lower functional residual lung capacity in infants. [11]
- Increased risk of asthma in children. [12]
- Increased risk of early adult onset diabetes. [13]

Maternal smoking during pregnancy has also been linked with a range of behavioural outcomes including:

- Higher risk of Attention Deficit Hyperactivity Disorder in those that are genetically predisposed to the Disorder (ADHD); [14 15]
- Increased risk of male criminal outcomes in adulthood; [16]
- Greater irritability in newly born infants; [17] and
- Possible links with psychopathology in adulthood.[18]

Parental smoking around or in front of a child under 12 years (i.e. causing the child to be a passive smoker) has also been linked with a range of negative health outcomes.

Almost half of all children in the UK are exposed to tobacco smoke at home. [19] Infants of parents who smoke are more likely to suffer from breathing disorders such as bronchitis or asthma. Smoking before and after birth puts babies at three to four times greater risk of Sudden Infant Death Syndrome. [20]

Some studies also suggest that some of these health impacts can be greater with a higher number of cigarettes smoked per day. Additionally, it has been found that stopping smoking after the third month of pregnancy is of greatest importance. [21]

Health inequalities

There is little evidence that education levels among white women is a factor in relapse in those that stopped smoking during pregnancy but started again after birth.[22] However, there is evidence to suggest that generally less educated smokers are less likely to quit smoking than more highly educated smokers. [23]

There is evidence to suggest that smoking disproportionately affects lower socio-economic groups: 31% of manual groups smoke, compared with 20% of non-manual groups. [24]

There is also evidence to suggest a link between smoking and age. Mothers under the age of 20 years are five times more likely than those aged over 35 to smoke throughout pregnancy (45% for the under 20s and 9% for the over 35s). [25]

Finally, a 2007 study by Bauld et al[26] concluded that: "NHS stop smoking services have probably made a modest contribution to reducing inequalities in smoking prevalence. To achieve government targets, however, requires both the development of more innovative cessation interventions for the most addicted smokers and action to ensure that other aspects of tobacco control policy make a larger contribution to inequality goals."

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ANNEX F: REFERENCES FOR THE MAIN REPORT

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