

# Smoking Cessation Services in Sure Start Local Programmes:

## Findings from Local Evaluations

Nicola Moran  
Louise Harrington

**NESS**  
NATIONAL EVALUATION OF SURE START

**March 2006**

## CONTENTS

	Page
EXECUTIVE SUMMARY .....	3
1. INTRODUCTION .....	5
2. WHY SMOKING CESSATION IS IMPORTANT TO SSLPs .....	7
3. METHODS USED TO EVALUATE SMOKING CESSATION SERVICES IN SSLPs .....	9
4. RESULTS: THE PROCESS OF INTEGRATING SMOKING CESSATION SERVICES .....	13
5. RESULTS: IMPACT AND OUTCOMES OF SMOKING CESSATION SERVICES .....	24
6. MONITORING INFORMATION COLLECTED BY SSLPs RELATING TO SMOKING HABITS .....	30
7. CONCLUSIONS .....	34
APPENDIX A: SSLP REPORTS THAT HAVE CONTRIBUTED TO THIS SYNTHESIS REPORT .....	38
APPENDIX B: METHODS USED BY SSLPs TO EVALUATE THEIR SMOKING CESSATION SERVICES.....	41
REFERENCES .....	42

## Executive Summary

### Background

A reduction in smoking rates, particularly during pregnancy has been identified as a key target area for Sure Start Local Programmes and has continued to be an important area for child and adult health. This is particularly pertinent among lower income groups where there has been little change in smoking rates over the last 30 years. It is now widely accepted that growing up in a household of smokers has serious implications for a child's own smoking behaviour, health and ultimately life-chances. A number of interventions are being implemented locally through Sure Start to raise awareness of the effects of smoking, especially during pregnancy, and to support parents in stopping smoking. This NESS synthesis report brings together information on the evaluation of smoking cessation services within Sure Start Local Programmes (SSLPs).

### Methodology

A search of the NESS database up to December 2005 found 38 reports from 32 Sure Start Local Programmes that referred to smoking cessation services. Information relating to process, service delivery and findings has been extracted from the local evaluation reports and synthesised to report the impact and outcomes of different types of smoking cessation service. Many of the programmes did not report on their method of evaluation. However, of those that did, the main methods used were questionnaires, monitoring data, data from other health sources, self reports, feedback forms and interviews with parents.

### Findings

17 of the programme reports explained the process of delivering smoking cessation services and, generally, explained the interventions in some detail. 12 programme reports referred to the outcomes of their smoking cessation services, primarily through changes in the number of pregnant women, parents, or partners who smoked. And 23 of the 38 reports referred to the programme's monitoring or survey data.

#### *Process and Service Delivery:*

SSLPs reported using a number of interventions in their efforts to achieve a reduction in the number of women smoking in pregnancy, and indeed to reduce rates of smoking more generally. The main interventions reported were group sessions or courses on smoking cessation, one-to-one support, drop-in sessions, Smoke Free Homes initiatives, No Smoking Day events, leaflets, resources (including baby bibs, door stickers, coasters and materials from a local health promotion agency), referral to external services, and staff training on delivering smoking cessation.

*Outcomes:*

Nine of the thirty-eight reports analysed had been able to demonstrate tangible short-term benefits to parents who had used smoking cessation services. In general the reports tended to use quantitative data to show numbers of parents who had quit smoking with the support of SSLPs.

*Conclusions*

Programme reports have shown that smoking cessation services can provide short term outcomes and potentially long term health benefits to families who access the support available. A variety of different interventions have been developed by programmes, often in partnership with other, relevant organisations and professionals, in order to be able to deliver a flexible service that best meets local need.

The available evidence has a number of limitations; in particular there is a lack of detail about sampling and methods of data collection, resulting in the potential for inaccurate and unreliable data. In addition, programmes have, in the majority of cases, focused on the process of delivering the service, and tended not to capture the impact and short-term outcomes for parents. In order to provide more robust evidence of the effect of Sure Start smoking cessation services, it is now important for programmes to focus more on the short term outcomes for parents, and on assessing whether these outcomes are sustained over a longer period of time.

## 1. INTRODUCTION AND METHODOLOGY

1.1 Sure Start Local Programmes (SSLPs) are a key part of the government's effort to improve the life chances of children in areas of greatest challenge and need. They represent integrated approaches to service delivery specifically aimed at:

- Improving learning
- Improving children's health
- Improving social and emotional development
- Strengthening families and communities

1.2 SSLPs are required to undertake local evaluation examining the process of service delivery and the impacts and outcomes that have resulted from their activities. Evaluation outputs such as annual evaluation reports and findings reports are submitted to the National Evaluation of Sure Start (NESS) team to help develop the evidence base of the impacts of programmes. NESS also provides support to local programmes in conducting their local evaluations.

1.3 NESS acts as a repository of all evaluation outputs from the 524 SSLPs. The collation and dissemination of information relating to local evaluation is an important part of the work of NESS, and is facilitated through the NESS website ([www.ness.bbk.ac.uk](http://www.ness.bbk.ac.uk)) and through regional workshops and networks. Synthesis reports are amalgamations of evaluation findings on a particular theme. This synthesis document is the fourth synthesis report by NESS. This particular report integrates local evaluation findings related to smoking cessation within SSLPs.

1.4 The NESS database contains a record of all the evaluation reports submitted by Sure Start Local Programmes. This database was searched for all evaluation reports that refer to smoking cessation services offered by SSLPs up to December 2005. The search identified 38 reports from 32 programmes. These reports were studied and the relevant information extracted by the authors. Matrices were devised so that the authors could record the method of evaluation, the type of intervention or service offered, and whether the report referred to process, outcomes, or monitoring/survey data (see Appendix A on page 38).

1.5 Seventeen reports focus on process and service delivery, i.e. descriptions of the way in which smoking cessation services have been designed and delivered in programme areas. Recent reports tend to focus more on the outcomes of smoking cessation services. Twelve reports have attempted to measure and record the impact of smoking cessation services on service users and service providers. Twenty-three reports refer to the monitoring or survey data held by the programme and use this to indicate any changes in the number or percentage of smokers. This synthesis report refers to process and outcome evaluations separately. In a number of cases, the same evaluation report is included in each section.

1.6 The report begins with an explanation of why smoking cessation is important to Sure Start Local Programmes. It reviews the health implications associated with smoking and passive smoking, in particular for children, pregnant women and parents in general.

## 2. WHY SMOKING CESSATION IS IMPORTANT FOR SSLPs

2.1 Although the history of tobacco smoking in Europe dates back to the Fifteenth Century, when Spanish explorers returned to Europe with tobacco from The Americas, the link between smoking tobacco and lung cancer and other diseases has only been understood since the 1950s. Despite the well-documented links between smoking and pulmonary diseases, such as lung cancer and emphysema, smoking is the single greatest cause of preventable illness and premature death<sup>1</sup>, killing 114,000 people per year in the U.K, and accounting for more than half the difference in life expectancy between the rich and the poor of society<sup>2</sup>. The most common causes of death associated with cigarette smoking are lung cancer, bronchitis and emphysema and coronary heart disease<sup>3</sup>.

2.2 Evidence of the impact of passive smoking on health has increased over the last two decades, and has included evidence on the adverse effects on children of exposure to second-hand smoke, particularly within the home environment. It is estimated that between 32% and 42% of children growing up in the U.K are exposed to tobacco smoke, as a result of the smoking habits of a parent or other family member<sup>4</sup>. The knock-on effect of a child growing up within a household of smokers has serious implications for the smoking behaviour, health and ultimately life-chances of that child. Parents are key role models for young children and represent the main source of socialisation for children. It is not particularly surprising then, to discover that this mirroring in behaviour between parent and child extends to smoking habits. Children of parents who smoke are almost three times more likely to become regular smokers than children of non-smoking parents<sup>5</sup>. More alarming is the fact that children of non-smokers are three times less likely to develop lung cancer than children growing up in homes where parents smoke every day, even if they do not smoke as adults themselves<sup>6</sup>.

2.3 Parental smoking is known to be a risk factor in sudden infant death syndrome (cot death), however the harmful effects of passive smoking can begin to exert an influence on the health of a child even before she is born. Babies exposed to their mother's tobacco smoke before birth are more likely to be born of low birth weight, and be born and to grow up with reduced lung function<sup>7</sup>. Unborn babies of young mothers (women under 20 years old) are at increased risk of exposure to passive smoking due to the fact that young mothers are more likely to smoke during pregnancy<sup>8</sup>. Encouraging smoking women to give up in pregnancy is complex and cessation rates remain low<sup>9</sup>.

2.4 However it is not only the smoking habits of the mother-to-be that can have a detrimental effect on the health of a pregnant woman and her unborn child. Around a fifth of non-smoking pregnant women are exposed to second-hand smoke at home throughout pregnancy, usually as a result of a partner's smoking habits<sup>8</sup>.

2.5 Despite a reduction in smoking rates in the U.K over the last 30 years, the reduction in smoking rates among lower income groups has been lower, with

little change in these rates over the last decade<sup>10</sup>. Around two-thirds of smokers want to give up, however the most disadvantaged in society find it the hardest to quit. Rates of stopping smoking are three times lower among the least well off in society, compared with the wealthiest. **Error! Bookmark not defined.** The least economically deprived smokers are three-times more likely to give up smoking than the most economically deprived smokers<sup>11</sup>. The NHS Stop Smoking Services were established about seven years ago and are an effective service of help for those smokers who wish to quit. Free help and support is offered in the form of one-to-one sessions, with trained advisers and groups run by health professionals, specially trained to assist smokers who wish to stop.<sup>12</sup> Sure Start Local Programmes (SSLPs) were set up as the cornerstone in the current Government's commitment to tackling poverty and disadvantage, and as such SSLPs have integrated smoking cessation services into the provision of locally-based services, often in partnership with the local Primary Care Trust (PCT), using approaches tailored to the needs of the individual, offering a wide range of often innovative interventions aimed at reducing smoking, particularly during pregnancy.

2.6 The SSLPs efforts to support families in giving up smoking and maintaining their non-smoking status contributes to a Service Delivery Agreement (SDA) and the Public Service Agreement (PSA) objective underpinning it:

<b>Box 2.1 Public Service Agreements and Service Delivery Agreements for Smoking Cessation</b>		
<b>PSA</b>	<b>SDA</b>	<b>Smoking Cessation Activity</b>
Improving Health - To reduce by 6% the proportion of women who continue to smoke during pregnancy	Reduce by 10% the number of children (0 – 4 yrs) admitted to hospital as an emergency with lower respiratory infection	One-to-one and group smoking cessation activities and support tailored to the needs of the individual and delivered within a multi-disciplinary setting

### **3. METHODS USED TO EVALUATE SMOKING CESSATION SERVICES IN SSLPs**

3.1 Many of the local evaluation reports received by NESS focus upon descriptions of the process of setting up and delivering smoking cessation services and describe the interventions in detail. These processes are reported in section 4. Reports that look at outcomes, the impact of smoking cessation services on rates of smoking, are reported in sections 5 and 6. This section reports on the methods used by programmes to evaluate their smoking cessation services. The methods used by each SSLP are reported in Appendix B on page 41.

3.2 Sure Start Local Programmes (SSLPs) used a number of methods to evaluate their smoking cessation services:

- Quantitative measures:
  - Questionnaires
  - Monitoring data
  - Data collected from other health sources
  
- Qualitative methods:
  - Self-reports and feedback forms
  - Interviews with parents

#### **3.3 Quantitative measures:**

3.3.1 The majority of programmes that included smoking cessation in the evaluation reports sent to NESS used quantitative measures to evaluate the impact of their smoking cessation services.

#### **3.4 Questionnaires**

3.4.1 Questionnaires are a useful tool to elicit users' views on the services offered and the perceived impact of those services on users and their families. Since some women will find it difficult to admit to smoking during pregnancy, then anonymised questionnaires may elicit a more accurate record of smoking rates among pregnant women. However, questionnaires could prove disadvantageous in that respondents may be relatively self-selecting. For example those who did smoke or are smoking during pregnancy may prefer not to complete or return the questionnaire rather than admit to smoking in pregnancy. Questionnaires were used among current users of Sure Start smoking cessation services, regular Sure Start attendees, and throughout the wider community. Some were focused solely on smoking cessation, others formed part of much broader surveys.

3.4.2 Of the 38 reports reviewed, 9 programmes reported using questionnaires. In one programme the research was conducted by local parents, with support from the Sure Start health development worker and an

external consultant. In 6 of the programmes, questionnaires were used to elicit rates of smoking among pregnant women, parents, partners and/or other adults living in the same household, or in the wider community. For example, one programme sent a postal questionnaire to households in the area and was able to determine whether changes in rates of smoking were different between Sure Start families and non-Sure Start families living in the same area. Another programme had conducted a survey in the Sure Start area 3 years previously, and used this original survey as a baseline in order to compare responses over time and look for any changes or patterns in rates of smoking. The questionnaire also asked respondents what, if any, help they had received in their attempts to quit smoking and whether they would like help to quit smoking.

3.4.3 Three further programmes used user satisfaction surveys to evaluate parental satisfaction with the services offered; one of these programmes used questionnaires in either telephone or face-to-face interviews.

3.4.4 Some programmes also asked pregnant women if they had quit smoking during pregnancy, attempted to quit smoking during pregnancy, had quit or resumed smoking after the birth of their last child, if they had accessed any smoking cessation services, and what other help they would like to have (had) available. If programmes had comparable data from other years, they were able to comment on whether rates of smoking had increased or decreased over the period. However, none of the programmes related their results to specific smoking cessation services run by the Sure Start Local Programmes.

### **3.5 Monitoring data**

3.5.1 Nineteen of the 38 programme reports used monitoring data (M5 or M7 forms) to trace rates of smoking and smoking cessation among pregnant women, parents, partners and the wider community. Any changes in these rates may offer a reflection of the impact that smoking cessation services are having on Sure Start families and the wider community. Four programmes stated that midwives collect and/or monitor the data on smoking rates, generally on a monthly basis. One programme used client monitoring forms at a number of intervals throughout a smoking cessation course to monitor the effects of the course. Other programmes recorded the number of clients seen, the number of contacts, whether a quit date had been set, if the quit date was achieved, quit rates, and if clients maintained their non-smoking status over time.

### **3.6 Data collected from other health sources**

3.6.1 Eight programmes also utilised data from other health sources to monitor smoking rates in the area or among particular sub-groups. For some programmes, these data served as a baseline against which a programme's own monitoring data or survey findings could be compared. Other programmes relied on these data to supplement their own data, or to provide data where the programme did not have an adequate or active monitoring

system in place. Sources of data included other smoking cessation services in the area, hospitals, PCTs, health visitors, and a health promotion agency.

### **3.7 Qualitative methods**

3.7.1 A small number of programmes also used more qualitative methods to evaluate their smoking cessation services. These were self-reports/feedback forms and interviews with parents.

### **3.8 Self-reports and feedback forms**

3.8.1 Five of the 38 programme reports stated that self-reports or feedback forms had been used in the evaluation of their smoking cessation services. Self-reports and feedback forms had been completed by parents/service users (1 report), Sure Start staff who ran the services (3 reports), and Sure Start staff who were being trained to offer smoking cessation advice as part of their role (1 report).

3.8.2 In one programme, parents were asked to complete feedback forms at the end of their smoking cessation courses. They were asked to comment on the course content, the best and worst aspects of the course, the support offered, the facilitator, and how the course could be improved.

3.8.3 In three programmes, Sure Start smoking cessation workers reported on their experiences of offering help and support. The smoking cessation worker in one programme reported on her experience of working with a particular individual and how that initial support had led to other family members also quitting smoking. In the second programme, the worker had been asked to give examples of her work and any parental feedback. She reported on her experience of working on a stall during the No Smoking Day event and spoke of helping a newly pregnant woman to quit smoking. In the third programme Sure Start staff who had helped to run No Smoking Day events reported their views on what factors helped to make the events successful and on what lessons could be learned to improve future events.

3.8.4 Finally, feedback forms were used to evaluate a training day designed to teach best practice in smoking cessation advice to professionals, including Sure Start staff.

### **3.9 Interviews with parents**

3.9.1 Two of the 38 programme reports stated that parents had been interviewed as part of their evaluation of smoking cessation services, and another programme planned to do so in their forthcoming evaluation. In one programme parents had been interviewed to elicit their views on the smoking cessation advice and support they had received and to explain the impact this had had on their desire or ability to quit smoking, the change in their smoking habits, the difference this had made to their lives, or the reasons why they felt they had been unable to quit smoking on this occasion. In the second

programme, parental interviews were used to evaluate the smoke-free homes campaign.

3.9.2 A further programme reported plans to run a smoking cessation course and to evaluate that course using interviews with service users. Individuals would be interviewed at the start, middle and end of the course, and there would be a follow up interview six months later to determine any long term outcomes.

## 4. RESULTS: THE PROCESS OF INTEGRATING SMOKING CESSATION SERVICES

### 4.1 The process of integrating smoking cessation services

4.1.1 Many of the evaluation reports produced by Sure Start Local Programmes (SSLPs) have focused on the process of integrating smoking cessation services. This process evaluation describes the way in which smoking cessation services have been set up and implemented by different programmes. Such evaluation can be useful in providing the context through which outcomes can be interpreted.

4.1.2 Programmes reported using the following interventions to deliver their smoking cessation services:

- Group sessions or smoking cessation courses
- One-to-one support sessions
- Drop-in sessions
- Smoke Free Homes initiatives
- No Smoking Day events
- Leaflets
- Resources
- Advertising or referring to external smoking cessation services
- Staff training
- Other

Table 4.1 illustrates how many programmes report using each type of intervention.

<b>Table 4.1 Interventions reported by SSLPs in their evaluation reports</b>	
Type of intervention:	Number of programmes reporting the use of each intervention:
Group sessions / courses	4
One-to-one support	7
Drop-in sessions	2
Smoke Free Homes Initiative	4
No Smoking Day events	4
Leaflets	5
Resources	3
Advertising / referral to external services	3
Staff training	4
Other	8

NB. Figures do not add up to 32 as numerous programmes reported using more than one type of intervention.

## **4.2 Group sessions or smoking cessation courses**

4.2.1 Four programmes reported running smoking cessation courses or group sessions. In addition, one programme stated that although it did not run its own smoking cessation group it was aware that Sure Start families in the area were accessing other local smoking cessation groups. A further programme reported that a smoking cessation programme was organised but not attended. The possible reasons for this lack of attendance were not reported and may not have been investigated.

4.2.2 One programme explained that its smoking cessation service was jointly delivered by the programme's project worker for health and a local Health Visitor. To encourage participation, crèche facilities were also available. The courses were advertised via posters and flyers distributed in community venues, through local Health Visitors, or during other Sure Start activities. The programme ran 5 courses, each over a 7 week period, and was open to Sure Start and non-Sure Start families. Sessions were based upon materials devised by the local health promotion agency. During the course participants were asked to identify what method of support would best suit them, to look at reasons for smoking and reasons to stop smoking, to name a quit date, and to learn how to deal with cravings, cope with stress, move toward a healthier diet and increase their activity levels. Evaluations of two of the groups suggested potential areas of improvement. Participants wanted ongoing support, particularly at times of stress, they wanted more information about healthy eating and weight loss, and some reported feeling unsettled by other people's non-attendance. Those who did not complete the course stated that they needed to learn how to deal with other stressors or to develop other areas of their lives before they could focus on quitting smoking.

4.2.3 A second programme reported that smoking cessation groups were already operating in the area. However, the programme arranged 'sick of smoking' sessions for Sure Start parents who wanted to quit smoking in preparation for them joining the local support group. These sessions were arranged in conjunction with a local anti-drugs project. A third programme said that they had begun a smoking cessation group, but the venue and the timing of the sessions may need to be reviewed, presumably in order for the group to attract or keep more participants. Finally, the fourth programme reported offering group counselling to pregnant women and to the parents of young children who wanted help to quit smoking. The groups were run by a smoking cessation counsellor.

## **4.3 One-to-one support sessions**

4.3.1 Seven programmes reported offering one-to-one support sessions to help people quit smoking. One programme reported that, following a period of training, their Sure Start midwife was able to offer flexible one-to-one support to pregnant women who wanted help to quit smoking. Another programme offered both one-to-one sessions and group counselling with a smoking cessation counsellor. They report that referrals have increased leading to

more one-to-ones and that a number of pregnant women and parents of very young children have been helped to stop smoking. A third programme referred to one-to-one advisory sessions run by the smoking cessation team from the local Care Trust. A fourth programme began offering one-to-one support for individuals who wished to quit smoking. During the year 2003-4 they saw 53 clients, with an average of 3 contacts per client. The programme reports that they have extended this service and now take a “public health approach to supporting smoking cessation within the community”. This has involved linking with national initiatives such as the Roy Castle awards and the Smoke Free Homes campaign.

4.3.2 A fifth programme used one-to-one sessions as their smoking cessation worker followed up referrals and offered advice and support to parents who wanted to quit smoking. A further programme reported that their midwives, health visitors, befriending coordinator and volunteer peer group supporters offer one-to-one support in the home for parents with young children. Finally, another programme reported running one-to-one support sessions with ten parents. In the initial consultation, carbon monoxide (CO) readings were taken, coping strategies discussed and the worker liaised with GP surgeries to arrange prescriptions for aids to smoking cessation. Over a four week period parents received daily support by telephone and were visited at least once per week. After four weeks a second CO reading was taken to chart parents’ progress. The results are reported in section 5.

#### **4.4 Drop-in sessions**

4.4.1 Two programmes reported operating drop-in sessions for people who wanted help to quit smoking. One programme was able to launch a drop-in smoking cessation service once eight of its staff had been trained up as Smoking Cessation Advisors (see the section on staff training below). Owing to high demand from parents and carers in the Sure Start area, the programme increased the number of sessions offered and included an evening session which was more convenient for working parents. Sessions are now offered mid-morning, mid-afternoon and in the evening. The programme believes that their smoking cessation drop-in service meets needs:

“Right from the start the drop-in sessions were a success due to our relaxed, friendly, holistic approach to smoking and the effects that stresses and strains of life may have on each individual’s habit”

4.4.2 A second programme reported running weekly drop-in sessions at a local High School. The sessions were held at lunch times and offered advice and information to teenagers on how to quit smoking.

#### **4.5 Smoke Free Homes Initiatives**

4.5.1 Four programmes reported running a Smoke Free Homes project. The Smoke Free Homes initiative is a national campaign that aims to reduce

children's exposure to second-hand smoke in the home. Upon joining the scheme, members agree to maintain a Smoke Free Home or Smoke Free Zone(s) within the home, for example, they agree to only smoke outside or only in a designated area inside the house but out of the sight of children. Those who sign the pledge receive a Smoke Free Homes Pledge Certificate, either gold for those who pledge a smoke free home, or silver for those who pledge a smoke free zone.

4.5.2 One programme stated that the Smoke Free Homes campaign in their area had been jointly promoted by workers from education, health, the voluntary sector and Single Regeneration Budget (SRB) projects. With 91 households signing pledges to maintain a smoke free home, the programme felt that "A coordinated approach to sharing health messages may have a greater impact in smaller communities". All those who had signed pledges were also entered into a prize draw.

4.5.3 Another programme began recruitment to their Smoke Free Homes campaign during No Smoking Day. They report recruiting 37 families and contacting each family 3 times – once as a home visit, and twice via letter, promotional material and vouchers. The programme also organised a prize draw for the final day celebration event, although the programme report a poor turn-out with only two families taking part in the event. All the families were followed up and interviewed about the campaign. Of the 12 completed interviews, 8 families reportedly welcomed the support offered. Just over half of the 12 families found it easy to keep smoke free zones, but all the families aimed to maintain a smoke free home. The programme report concluded that "Overall, it seems this programme raised the profile of second hand smoke and its effects on children. Four families had changed their smoking habits".

4.5.4 A third programme explained in some detail the process of setting up a Smoke Free Homes project in their Sure Start area and beyond. In seeking to achieve the PSA target of reducing smoking among pregnant women and to reduce the number of children exposed to second-hand smoke, a working party was formed, containing representatives of three Sure Start Local Programmes within the PCT. The group researched Smoke Free Home projects in other areas and assessed the level of support for such a campaign among all 32 SSLPs within both their county and their neighbouring county. Following discussions with a Smoke Free Homes project in a neighbouring area, contact with the Regional Tobacco Policy Manager and discussions around funding and partnership working, the group decided to consult more widely and hence set up a Smoke Free Homes Conference. The conference was open to all 32 SSLPs and the Tobacco Control Leads from across the two counties who were asked to nominate representatives from a range of sub-groups, including health visitors, midwives and young people. Ten of the 32 programmes joined the Smoke Free Homes campaign. This is significant as the programme reports:

"This is the **ONLY** initiative that has been developed to network Sure Start programmes with the specific aim to

improve the health and wellbeing of families and young children.”

4.5.5 The programme developed a Pledge Pack containing:

- Information on Fire Safety and a free-phone telephone number
- A Smoke Free Homes Pledge Certificate
- Resources from the Department of Health, including a leaflet on second hand smoke, a door hanger, door sticker, window sticker, and a coaster.

The programme also devised a training package to help support the launch of the campaign in each participating Sure Start area. The package includes presentations on the effects of second hand smoke on children’s health, how the programme launched the campaign, a workshop on launching and delivering the campaign in other areas, and an evaluation of the project.

#### **4.6 No Smoking Day events**

4.6.1 Four programmes referred to using No Smoking Day events as a means to encourage smoking cessation. One programme organised a stop smoking day in conjunction with an external smoking cessation service. As the programme was not running its own services at the time, then the Sure Start midwife referred pregnant women who wanted to quit smoking to the external agency. The programme did not report on the content of their stop smoking day, but did state that it had been well attended (with approximately 30 attendees). A second programme used No Smoking Day to launch their Smoke Free Homes campaign (see above).

4.6.2 A third programme reported on their two No Smoking Day health promotion events and their No Smoking Day Road show. The events ran for three consecutive years and were the focus of the programme’s smoking cessation activities. The No Smoking Day stalls have been set in the local health centre, outside a national supermarket, at a local sports centre, a community centre and the local library. Two local high schools were also visited by staff members with No Smoking Day promotional materials. The events epitomised partnership working, bringing together personnel from Sure Start and the local health centre, as well as other professionals e.g. a public health nurse, a Health Visitor and smoking cessation advisor, an oral health promoter, a school health adviser, a school health administrative assistant, student nurse, a sports centre manager, a Macmillan Black and Ethnic Minority Cancer Information Worker, the neighbourhood renewal community health educators and the local healthy living centre sports outreach worker.

4.6.3 Most of the events were aimed at all local residents. Activities available on the day included:

- Checking CO (carbon monoxide) levels through using the micro CO Analyser
- Children were asked to draw and point out which parts of the body are affected by smoking

- A large variety of smoking cessation leaflets were available, some in a range of community languages
- Quiz and information sheets from the 'No Smoking Day Office'
- A No Smoking Day Quiz, complete with prizes
- Information about local smoking cessation services
- A poster competition for children, related to No Smoking Day

4.6.4 The No Smoking Day event held at the sports centre was targeted at pregnant women and their partners living in the Sure Start area. Event organisers aimed to run a Beauty and Fitness event to promote local smoking cessation services. Activities available at that event included:

- Indian head massage
- Beauty treatments provided by supervised students from a local college: makeup, manicure or pedicure
- A basketball or football taster
- A fitness test or gym induction
- Information about the Sure Start services available in the area
- Checking CO (carbon monoxide) levels
- Information about smoking cessation services in the area
- Advice and information leaflets in a number of languages
- A No Smoking Day Quiz
- Sandwiches, fruit and soft drinks

4.6.5 Although the organisers stated that offering free beauty treatments and sporting activities were good ways to promote No Smoking Day, the event did not reach its target population. Many of those who attended were pupils at the local high school. No pregnant women attended the event. The programme noted that many women will not admit to smoking during pregnancy and therefore pregnant smokers are a hard group to reach. Further, they noted that the location – a sports centre – was not ideal for pregnant women. The centre was likely to attract men and teens, but not pregnant women, especially those on low incomes. Future events may therefore be based in hospitals or health centres. However, the programme also noted that any sports provision for mothers or pregnant women needed to run during daytime and would need greater crèche provision.

4.6.6 Finally, in the fourth programme, the smoking cessation worker discussed her experiences of working on a stall at a No Smoking Day event, but the event was not discussed or evaluated in the programme's report. However, the smoking cessation worker gave an example of the potential influence or impact that the event could have:

“No Smoking Day stall brought me in contact with a huge number of the community at once. All had different stories to tell. One young couple had just come from the doctor's surgery, where their pregnancy was confirmed. Fired up and highly motivated, the father noticed the stall by chance. I was able to discuss giving up smoking with him as he appeared keen to

discuss this, especially as he was about to become a dad. Perhaps if he hadn't seen the stall, the moment would have been lost."

4.6.7 The visibility of such stalls could therefore attract those people who may want to quit smoking but who have not yet thought of seeking help or advice from smoking cessation services.

#### **4.7 Leaflets**

4.7.1 Five programmes used leaflets to advertise and raise awareness of smoking cessation services. Two of those programmes also advertised external smoking cessation services (see below). One of the five programmes was in the process of setting up a smoke free homes initiative. They were developing leaflets to advertise the smoke free homes project, and also planned to use a Smoke Free Homes Pledge Pack which would include a leaflet on second hand smoke produced by the Department of Health. Local projects who committed to the Smoke Free Homes initiative had to agree to distribute the Smoke Free Homes leaflet and discuss its content with families. A second programme used posters and flyers to advertise the Sure Start smoking cessation group. This information was distributed around community venues and via health visitors. A third programme produced and distributed leaflets explaining various ways people could try to stop smoking. This type of information leaflet could be particularly useful to those people who do not yet want to seek outside help or would not feel comfortable attending group sessions, but who nonetheless are considering quitting smoking. This programme also produced leaflets targeted directly at mothers who smoke during pregnancy. A fourth programme provided information sheets by the 'No Smoking Day office' at their No Smoking Day events, and explicitly stated that they produced their own leaflets in a range of languages. It is uncertain whether this was common practice in other programmes. Finally, the fifth programme used an information flyer to advertise existing smoking cessation services in the local area.

#### **4.8 Resources**

4.8.1 Three programmes reported using a range of other resources in their smoking cessation services. As part of their Smoke Free Homes initiative, one programme had been granted permission to use or develop resources from a Smoke Free Homes project in a different area. In addition, the programme produced a Smoke Free Homes Pledge Pack containing a Pledge Certificate, fire safety information and a free-phone telephone number. Finally the programme used resources produced by the Department of Health. These included a leaflet on second hand smoke, a door hanger, door sticker, window sticker, tent card and a coaster.

4.8.2 Another programme reported designing their smoking cessation course around materials from a smoking cessation training manual produced by the local health promotion agency. They also used posters to help advertise the course.

4.8.3 Finally, one programme reported that they distribute free baby bibs displaying a no smoking message. This intervention was not evaluated but it could be interesting to see if such a strong visual image of a baby with a no smoking message across its chest helped parents to quit smoking, or indeed if parents avoided using the bibs if that image was felt to be too strong for them.

#### **4.9 Advertising or referring to external smoking cessation services**

4.9.1 Three programmes reported that they advertised external, non-Sure Start, smoking cessation services and/or referred individuals to those services. Such advertising and referral occurred where programmes did not offer their own Sure Start smoking cessation services. Sure Start services may not have been developed if mainstream services in the area were believed to be sufficient and thus any Sure Start services would have been a duplication of the work. Alternatively, individuals may have been referred to external services while Sure Start services were being developed.

4.9.2 One programme organised a Stop Smoking day in collaboration with an external service. Pregnant mothers who smoked were referred to the external service by the Sure Start midwife. Another programme provided information and flyers on external smoking cessation services during a number of No Smoking Day events and activities which were run in conjunction with a health centre and other health services and professionals. The third programme linked with local agencies who were already providing one-to-one and group sessions for people trying to quit smoking and jointly produced an information flyer on smoking cessation services and agencies in the area.

#### **4.10 Staff training**

4.10.1 In four programmes staff had been given the opportunity to train on smoking cessation advice and practice. Such staff training has been classified as an intervention as it is a positive step towards increasing the number of sources through which parents can access advice and support. Staff who are not designated smoking cessation advisors but who have been trained in smoking cessation methods, could introduce aspects of smoking cessation into other activities and thus potentially reach more people.

4.10.2 One programme reported that 8 members of staff undertook a two day Smoking Cessation Advisors training course with the Specialist Smoking Cessation Advisor from the PCT. The staff trainees were from a range of backgrounds and included the volunteer coordinator, family workers and administration staff. These new official Smoking Cessation Advisors helped to launch a smoking cessation drop-in service, which has produced good results (reported in section 5). The same programme also saw their volunteer coordinator and drugs and alcohol worker complete a five day training course to be able to practice Auricular Acupuncture (see below). As a result of this staff training, the programme now offers acupuncture to pregnant women and other individuals who want to quit smoking.

4.10.3 In another programme the midwife was trained in smoking cessation for pregnant women by a Health Promotion Agency and as a consequence has since been able to offer one-to-one support to pregnant women who are trying to stop smoking. In addition, the programme reports that Parent Link Workers, Health Visitors and other professionals have received brief intervention training in smoking cessation. A third programme reported that the 'Sure Start team' have received training on strategies to help people quit smoking.

4.10.4 Finally, a fourth programme reported that Sure Start workers attended a smoking cessation training day run by a local smoking cessation service and attended by a range of health and related personnel from other organisations. Trainees were informed about the latest advice and guidance on best practice in smoking cessation, and it was hoped that trainees would pass the information on to their co-workers who had not attended the training day. The programme reported that, in addition to the new skills and techniques learned, the training day offered an opportunity for Sure Start staff to strengthen their links with other agencies and thus further promote partnership working. Indeed, the programme report concluded:

“The success of this training session reinforced the need to use existing skills and knowledge bases to provide training throughout the Sure Start area. Different agencies have specialised skills and the Local Programme will seek to use these 'local experts' to share best practice and latest advice with all partner organisations, ensuring consistency of information.”

4.10.5 Thus, staff training on smoking cessation can not only increase the number of potential smoking cessation advisors, but can also help to develop or maintain links with other agencies, thus promoting partnership working and further serving the needs of local families and communities.

#### **4.11 Other interventions**

4.11.1 Programmes reported using eight other types of intervention: reactive support, support and advice by midwives, additional health promotion work, acupuncture, a Clean Air Campaign, the Roy Castle awards, a Pregnancy Project, and discussions at the Parents Forum.

4.11.2 One programme reported that, in addition to running smoking cessation courses and offering one-to-one support, their smoking cessation advisor also attends various other activities and can therefore be approached to provide 'reactive' support to individuals who are considering quitting smoking.

4.11.3 Three programmes referred to the support and advice offered by midwives, but did not specify how or where this support and advice takes place, for example in one-to-one settings or as part of a smoking cessation course.

4.11.4 Two programmes referred to 'health promotion'. One programme stated that health promotion events had taken place and that health promotion helped to sow the seeds of smoking cessation in the minds of smokers. The other programme referred to the delivery of health promotion and information through the outreach contact undertaken by Community Development Workers or by members of the outreach team during home visits. No further information was provided.

4.11.5 One programme reported using acupuncture to help service users quit smoking. The report states that two of the Sure Start workers undertook a training course in Auricular Acupuncture which is reportedly specifically designed for any type of detoxification, including detoxification from nicotine. The treatment was first tested on willing staff members and is now open to the general public, with ante natal clients able to access the acupuncture sessions on a regular basis. The report suggests that the course is very popular, with a relatively high number of people (25) applying to take part.

4.11.6 The other four interventions - a Clean Air Campaign (aimed at minimising the harm of smoking on children), the Roy Castle awards, a Pregnancy Project, and formal discussions on smoking cessation at the Parents Forum – were not discussed in any detail. Finally, one further programme made a statement that their smoking cessation plan had been implemented, but gave no further details.

#### **4.12 Personnel involved in the delivery of smoking cessation services**

4.12.1 A number of professional personnel are involved in the delivery of smoking cessation services in Sure Start Local Programmes. Not all programmes reported on who delivers their smoking cessation services, but of those that did the results are as follows:

<b>Table 4.2 Personnel involved in the delivery of smoking cessation services</b>	
<b>Personnel involved in delivering smoking cessation services</b>	<b>No. of programmes who report these personnel groups</b>
Health Visitor	7
Midwife	13
Smoking cessation advisor	5
Sure Start Health worker	3
Other Sure Start staff	9
External / mainstream service	3
Other	4

NB. Figures do not add up to 32 as numerous programmes reported that smoking cessation services were delivered by more than one personnel group.

4.12.2 According to the reports, midwives are the largest group to deliver smoking cessation services, with 13 programmes reporting their involvement. Nine reports made reference to other Sure Start staff or did not clearly explain which members of the Sure Start team deliver the services. Seven programmes reported that Health Visitors deliver their smoking cessation services; five programmes made reference to a smoking cessation advisor; three programmes reported that Sure Start health workers deliver the services; three programmes stated that external or mainstream services or agencies delivered the services; and four programmes reported other sources.

4.12.3 The category 'other' included an acupuncturist who used acupuncture as a method of smoking cessation, and non-Sure Start smoking cessation workers and staff from link agencies. It also included non-Sure Start personnel who had been involved in running No Smoking Day events, such as a public health nurse, and personnel from health centres, oral health, and school health. Finally, this category included those involved with the Smoke Free Homes initiatives, for example personnel from education, health, voluntary organisations and SRB projects.

## 5. RESULTS: IMPACT AND OUTCOMES OF SMOKING CESSATION SERVICES

### 5.1 Introduction

5.1.1 A commitment by parents and parents-to-be to give up smoking is likely to have an effect on the long-term health of their children. However, these long-term benefits cannot be easily measured by Sure Start Local Programme (SSLP) evaluations. The evaluative efforts of SSLPs in relation to smoking cessation are generally concerned with demonstrating the short-term changes associated with active attendance at smoking cessation services. Local programmes recognise that behavioural change is complex and as such they try to embrace the smallest steps made by parents towards giving up smoking.

5.1.2 A midwife providing one-to-one support to those wishing to stop smoking in one programme expressed the difficulty that a number of reports mentioned in engaging parents, in this case pregnant women in using smoking cessation services:

“It’s very hard to engage pregnant women in giving up smoking. Many of them have no desire to stop, and even those who express an interest frequently do not take up the support offered.”

5.1.3 In the previous section (Section 4) of this report a wide range of smoking cessation interventions offered by programmes have been described. There is, however relatively scant evidence of how these services have been evaluated, and little more information on the tangible difference that these services have actually made to the lives of users in terms of giving up smoking, or changing users’ smoking habits.

5.1.4 The outcomes of programmes’ efforts to support families in quitting smoking can most sensibly be categorised according to the type of intervention implemented. There are four main kinds of intervention used, which have yielded tangible outcomes for those who participated: -

- One-to-one support
- Group support
- Drop-in services
- Smoke Free Homes Initiative
- Other interventions

Table 5.1 illustrates how many programmes report using each type of intervention and can demonstrate that there is an outcome for families as a result.

<b>Table 5.1</b>	
<b>Interventions reported by SSLPs as yielding outcomes in their evaluation reports</b>	
Type of intervention:	Number of programmes reporting the use of each intervention:
One-to-one support	4
Group support	2
Drop-in sessions	1
Smoke-free homes initiative	1
Other	1
Not specified	2

5.1.5 However, it should be noted that the majority of programmes that have delivered smoking cessation services which have led to outcomes for users have, in fact used more than one method of service delivery to target smoking parents.

5.1.6 In most cases the report details the outcomes for participants in relation to a specific service or intervention. Although, in one case, where multiple approaches and services were employed to support families in stopping smoking it is not clear in the report which service(s) the recorded outcomes relate to, or how these data were collected.

5.1.7 Two reports which show outcomes for families discuss the fact that staff members were trained in strategies to support and enable people to stop smoking. However in both these cases other targeted interventions were run alongside this support, and the outcomes relate specifically to the targeted support provided. It is important to bear in mind that the impact of this kind of holistic approach to supporting parents in giving-up smoking, provided within the course of a professional's work with families, is not always realised or captured within reports.

## **5.2 One-to-one support**

5.2.1 As detailed in section 4, seven reports stated using one-to-one support to assist parents in stopping smoking. However, only four of these reports were able to demonstrate outcomes as a result of providing these one-to-one services. In one programme the midwife delivered one-to-one support to pregnant women in the home environment, this resulted in four women quitting smoking. Another programme had a Smoking Cessation Advisor who, as part of his role took on referrals from other Sure Start staff which he followed up by providing advice and support to parents who wished to stop smoking (see Box 5.2). The other two programmes that delivered one-to-one support and that were able to show a change in behaviour as a result of this service did not specify who provided the support. One of these programme reports did state that they supported pregnant women, mothers and fathers to stop smoking and said that a total of fourteen parents had been seen, five had

managed to give up, two of whom were pregnant women. This programme provided both one-to-one and group support to families. Unfortunately the report does not specify whether the quit rates relate to the group or one-to-one support.

<b>Box 5.1</b>
<b>Results following daily contact with a smoking cessation worker</b>
<p>This programme undertook one-to-one visits with ten parents. The visits involved taking Carbon Monoxide (CO) readings, discussing coping strategies and liaising with surgeries to arrange prescriptions. The support continued with daily contact by telephone as well as at least a weekly visit.</p> <p>At four weeks a second CO reading was taken to chart progress.</p> <p>70% managed to stop smoking successfully with this support.</p>

5.2.2 Lack of referrals into the smoking cessation service by GPs was said in one report to be a major obstacle in delivering one-to-one support to those who needed it. Some programmes have worked in partnership with the local Primary Care Trust (PCT) to deliver smoking cessation services.

<b>Box 5.2</b>
<b>Results from work with a Smoking Cessation Advisor</b>
<p>The programme employs a Smoking Cessation Advisor, part of this role was to provide one-to-one support to parents wishing to quit smoking.</p> <p>In one year ....</p> <p>54 parents discussed stopping smoking with the advisor</p> <p>28 set a quit date</p> <p>22 stopped smoking and remained non-smokers</p>

5.2.3 All of these programmes demonstrated some success in terms of assisting clients in quitting smoking. However, it is not clear in any of these reports how the data on those who stopped smoking, with the help of one-to-one support, were collected. None of the reports analysed gave any detail on the evaluation methodology used, programmes tended to record information on how many clients set dates for when they aimed to stop smoking, how many actually stopped and for how long. Unfortunately the programmes have not indicated how long after the support offered to stop smoking was withdrawn, were clients followed up to find out if they were still not smoking.

### 5.3 Group Support

5.3.1 Two programmes provided information on the kind of group support they had in place and the difference this support made to parents using these services. These programmes employed specialist professionals to deliver stop smoking groups.

5.3.2 One programme used a Smoking Cessation Counsellor who established a 'stop smoking group'. This group was run alongside a programme of one-to-one support enabling referrals from one service to another. This system of support which was offered to mothers, mother-to-be and fathers has increased the number of referrals to one-to-one support and yielded a doubling in quit rates between February and March 2004. However the programme did not provide details of the exact figures nor how the data were gathered.

5.3.3 The other programme that reported using the skills of specialist staff ran two group sessions based on materials contained within a 'Smoke Stop Tutor Manual' developed by the local health promotion agency. Evaluation forms were distributed and completed within the sessions, no details on the content of the evaluation forms was discussed (see Box 5.3 below for further details).

<b>Box 5.3</b>
<b>Results from group sessions using a 'Smoke Stop Tutor Manual'</b>
<p>This programme ran 2 group sessions using the 'Smoke Stop Tutor Manual' developed by the local health promotion agency. The purpose of the sessions was to assist participants to:</p> <ul style="list-style-type: none"> <li>• Identify a method of support</li> <li>• Consider reasons for smoking</li> <li>• Consider reasons for giving up smoking</li> <li>• Set a quit date</li> <li>• Identify strategies for dealing with cravings and coping with stress</li> <li>• Focus on activity levels and maintaining a healthy diet</li> </ul> <p>The sessions were promoted by staff and advertised using posters and flyers. A crèche was provided.</p> <p>Monitoring forms were completed in both sessions to provide statistical data on smoking habits and evaluation forms were also completed.</p> <p>Unfortunately no detail was provided on attendance rates or numbers completing monitoring and evaluation forms</p> <p>After 3 months 14% had still given up smoking</p> <p>No detail provided on how many people this percentage actually represents</p>

## 5.4 Drop-In Services

5.4.1 One programme provided a smoking cessation drop-in service to parents and carers in the Sure Start area that demonstrated outcomes for those who participated. This service was delivered and supported by a multi-disciplinary team consisting of the volunteer co-ordinator, family workers and administration staff, who undertook a two day smoking cessation advisor training course, in collaboration with the health visitors and Sure Start midwife. In February 2004 this team launched a smoking cessation drop-in session which quickly developed into three drop-in sessions due to the demand from parents and carers for this service. The programme reported that over a fifty-one week period they had seen ninety-seven clients and recorded a sixty-two per cent successful quit rate maintained at four weeks after giving up smoking. No information was provided in the report on how the monitoring data on client numbers or the follow-up information on those who were still not smoking at four weeks was gathered.

## 5.5 Smoke-free Homes Initiative

5.5.1 A programme launched a smoke-free homes campaign on National No Smoking Day. Thirty-seven families signed up to take part in the campaign. The programme then contacted each family three times during the campaign – once by letter, once through a home visit and once using promotional material and vouchers. A celebration event including a prize draw was organised for the final day of the campaign, unfortunately only two families took part in the day. The programme followed up the families who took part in the initiative by visiting and conducting semi-structured interviews to find out:

- whether they found the campaign useful
- how useful they found the support offered
- how they were managing to maintain a smoke-free zone
- reasons for non attendance at the celebration event, where relevant
- any ideas on how the support offered could have been done differently

5.5.2 Interviews were conducted with twelve out of the thirty-seven families who took part. No information was provided about why the other twenty-five parents did not take part in the follow-up interviews. Eight out of the twelve families who took part in the interviews welcomed the support offered to them by the programme in keeping the pledge. Just over half the families were finding it easy to maintain the smoke-free zones, the rest were finding it difficult. No further ideas were suggested for how the help provided could have been done differently, and whilst the report stated that many different reasons were given for non-attendance at the celebration day event, it did not provide any insight into the different reasons provided.

5.5.3 All families aimed to maintain a smoke-free home or zone in the future and four families had changed their smoking habits. The programme felt that the findings supported the fact that the campaign had raised the profile of the effects of second-hand smoke on children.

## 5.6 Other Initiatives

5.6.1 One report states that the programme provides a service to assist pregnant women and their partners in stopping smoking. However no detail is provided as to the kind of support offered, although the report does provide detail on quit rates for 2004. Nineteen parents set a quit date, and of the nineteen, ten actually quit and were still not smoking after four weeks. However, nine relapsed at a later date (see Table 5.2).

<b>Table 5.2</b>				
<b>Quit rates for one programme's smoking cessation service run for pregnant women and their partners</b>				
Service users 2004	Quit date set	Quit at 4 weeks	Relapsed	Lost to follow up
Pregnant	13	8	5	0
Non-pregnant	6	2	4	0

5.6.2 The report provided no explanation of how these follow-up data on quit rates were gathered.

## 6. MONITORING INFORMATION COLLECTED BY SSLPS RELATING TO SMOKING HABITS

### 6.1 Introduction

6.1.1 As detailed in section 2 of this report, SSLPs aim to achieve a 6% reduction in the proportion of women living in the programme area, who continue to smoke during pregnancy.

6.1.2 Programmes have chosen to use different methods to demonstrate a change in smoking rates of parents, specifically mothers-to-be within the Sure Start area. Of the thirty-eight programme reports included in this synthesis report, twenty-three reports include statistical data on the smoking rates for pregnant women and new mothers living within the programme area.

6.1.3 Two of the thirty-eight programme reports state that they have been unable to obtain accurate data to demonstrate a 6% reduction in smoking rates among pregnant women. Of the twenty-three programme reports that do supply data on smoking rates, the data has been obtained or collected in one of three ways:

- Survey administration
- Programme monitoring
- Health services data with SSLPs

6.1.4 Table 6.1 illustrates how many programme reports used each of the three data collection methods

Method of data collection	Number of programmes reporting the use of each data collection method
Survey	8
Programme monitoring data	10
Health services data	5

6.1.5 It should be noted that some of the programme monitoring data could constitute data that originated from health service systems and were then shared with SSLPs. Only 5 programmes specifically reported health services as the source of the data included in the reports.

### 6.2 Survey data

6.2.1 Eight reports provided information on data collected through surveys. The surveys used were administered using one of three approaches – postal

questionnaire, face-to-face interviews within the community or face-to-face and self-complete surveys within Sure Start settings with existing users of services. In four out of the eight reports the information provided related to whether mothers had smoked during pregnancy and if they had continued or resumed smoking after the birth of their child. The remaining four reports asked questions relating to the smoking habits of other family members living in the household and asked about whether the respondent had a desire to quit and if they would require support in doing so. Finally one programme asked participants about their knowledge and awareness of the risks associated with smoking and smoking in pregnancy.

<b>Box 6.1</b> <b>Results from a postal questionnaire</b>
<p>This programme sent out a postal questionnaire to all the households registered with a GP who were resident in the SSLP area. No information was provided on the percentage of returned, completed questionnaires.</p> <p>During 2001, 36.6% of respondents reported that they smoked.</p> <p>During 2003, 30.6% of respondents reported that they smoked.</p>

6.2.2 Two of the eight reports compared the findings of a baseline survey with a follow-up completed at a later date. Both reports showed a decrease in the percentage of women who smoked during pregnancy

<b>Box 6.2</b> <b>Results from a household survey on smoking habits</b>
<p>One programme reported the change in smoking rates in pregnancy from baseline to follow-up (exact period not stated). The data were collected using a household survey –</p> <p><b>At baseline – 54.5%</b> of mothers who responded said they gave up smoking as soon as they found out they were pregnant</p> <p style="padding-left: 40px;">- <b>33.3%</b> of mothers who responded said that they gave up during their last pregnancy</p> <p><b>At follow-up – 75%</b> of mothers who responded reported giving up immediately when they found out they were pregnant</p> <p style="padding-left: 40px;">- <b>44.4%</b> of mothers who responded said they gave up smoking during their last pregnancy</p>

### 6.3 Programme monitoring data

6.3.1 Ten of the reports provide details of programme monitoring data relating to smoking prevalence rates. We can only assume that these data were collected by the programmes using programme registration forms, however, it is possible that some of the data were originally shared with the programme from the local PCT and had been absorbed into the programme monitoring systems.

6.3.2 Nine of the reports present data on smoking rates in pregnancy and after birth. Two reports compare the smoking rates from their own monitoring figures with the national average. Below is a typical example of the kind of data detailed in these reports on smoking rates for new mothers and mothers-to-be.

<b>Box 6.3</b> <b>Typical example of programme monitoring data</b>
<p>Sample of new mothers (N=214) in 2004. No sampling details provided.</p> <p>24% of the respondents smoked before the birth of their child</p> <p>2.8% of respondents stopped smoking during pregnancy</p> <p>0.46% started smoking again after their child was born</p> <p>21.5% of respondents smoked during pregnancy</p> <p>The report adds that the national average for women smoking in pregnancy is 20% (Office of National Statistics, 2000).</p> <p>Therefore the report concludes that the rate of women smoking in pregnancy for the programme is 1.5% above the national average.</p>

6.3.3 Caution should be exercised when quoting these prevalence figures. These figures relate to responses provided by registered Sure Start members and do not necessarily represent the smoking prevalence rates of mothers in the area as a whole.

6.3.4 One of the nine reports that focused on rates of smoking in pregnancy went a step further and categorised respondents as non-smokers, moderate smokers or heavy smokers. Unfortunately the programme did not provide any information on what constituted a 'moderate' or 'heavy' smoker.

6.3.5 The tenth programme did not just ask about mothers' smoking habits during pregnancy but asked parents about smoking habits in general.

#### 6.4 Health Service data

6.4.1 Five reports specifically stated that the source of data on smoking rates before, during and after pregnancy was the local PCT or other health service. Clearly the accuracy of the data cannot be verified by the programme directly.

##### Box 6.4

##### Typical example of Health Services Data

% of women smoking at delivery (2002-2003) = 32% (N=41, 7 missing )

%of women smoking at delivery (2003-2004) = 27% (N=38, 8 missing)

## 7. CONCLUSIONS

### 7.1 Methods and findings

7.1.1 Programmes have used a range of methods to evaluate their smoking cessation services. The main methods were questionnaires/surveys, monitoring data, data from other health sources, feedback forms/self-reports and interviews with parents. Most of the programme reports did not give much detail about why particular methods were employed or how the collected data were checked or analysed. This raises questions about reliability, validity and generalisability of results.

7.1.2 There are other limitations with the reports examined for this synthesis document in that some programmes are clearly providing a number of different kinds of interventions to parents to support them to give up smoking, however the short-term outcomes of this work are not being measured. A number of programmes run a variety of different interventions to support families in stopping smoking, this is often realised through the training of staff to deliver smoking cessation support which is then integrated into the on-going work with families. The benefits of this kind of holistic approach to supporting parents in giving-up smoking is not generally captured within reports. This is not to say that this work has not had any effect on those families concerned. Indeed it maybe as simple as the information provided by staff trained in smoking cessation strategies led to a greater awareness by families about the dangers of passive smoking. This could, in turn lead to parents changing their smoking habits. This kind of information on the impact of awareness-raising activities and the benefits of multi-disciplinary and holistic approaches to the delivery of smoking cessation support has not, as yet, been captured in the reports.

7.1.3 Many programmes have collected data using surveys or in-house monitoring systems to try and demonstrate that smoking rates within the programme area have decreased, especially in relation to smoking during pregnancy. It should be stressed that any reduction in smoking rates demonstrated year on year by these population-level data could not be directly attributable to any smoking cessation intervention employed by a particular programme, although awareness-raising and targeted smoking cessation services are likely to have a positive effect on these figures over time. Two of the twenty-three reports that include this kind of surveillance information in their reports acknowledge this issue as important.

7.1.4 Many reports have used surveys in order to collect data on smoking habits within the Sure Start population. In the vast majority of cases it is not possible to glean from these reports whether the sample size and composition of the samples were representative of the population. Therefore, it is not possible to ascertain whether the smoking rates concluded from these survey results are accurate and representative. There may also be a reporting bias in that respondents may be reluctant to divulge their smoking status given the social unacceptability of smoking, particularly during pregnancy.

7.1.5 Many of the process evaluations contained significant levels of detail. This synthesis report has therefore been able to highlight some of the ways in which programmes have developed and implemented their smoking cessation services. These include courses or group sessions, one-to-one support sessions, drop-in sessions, Smoke Free Homes projects, No Smoking Day events, advertising or referring people to external smoking cessation services, and staff training on smoking cessation. The process evaluations have provided useful information about attempts to develop services that meet local needs, for example the introduction of evening drop-in sessions to reach working parents or the recognition that the venue of smoking cessation services may have an impact on who is able to attend the sessions. Process evaluations have also been able to illustrate productive cases of partnership working between Sure Start, external smoking cessation services and other local 'experts'. These findings could contribute to the mainstreaming agenda with the move to Children's Centres.

7.1.6 This report has demonstrated that around a quarter of the programme reports included in this synthesis document have been able to demonstrate short-term outcomes for families in terms of numbers of parents managing to give-up smoking and maintain a smoke-free environment for their children to live in. Although it should be emphasised that in all cases, the number of those participants who actually gave-up smoking is relatively small and the follow-up period afterwards to monitor the participants' smoking status over time was relatively short, generally no longer than four weeks after the quit date.

## **7.2 Recommendations from Sure Start Local Programmes**

7.2.1 Eleven of the 38 programme reports made recommendations as to how their smoking cessation services could be improved. The recommendations were generally based upon feedback given by service users during the evaluation of the service(s). The main recommendations were:

- Greater advertising of smoking cessation services
- Increase the length of support or follow-up
- Change the timing and/or venue of sessions
- Change the focus of smoking cessation services.

7.2.2 Two programmes stated that they needed to better advertise their smoking cessation services. One programme referred to the results of their user satisfaction survey which concluded that the programme needed to increase the profile of its smoking cessation services. However, this concern over the lack of publicity and public awareness was not specific to smoking cessation services; the programme's report concluded that many families felt they were not sufficiently aware of the range of services on offer. The other programme ran a number of No Smoking Day events and a No Smoking Day road show. They also concluded that health promotion events needed to be advertised more widely as they had received comments that people would have attended the events if they had been aware of them.

7.2.3 Two programmes raised the issue of follow-up support. One suggested that the programme could follow up people who had expressed an interest in stopping smoking to see how they were getting on and to encourage them in their efforts. In the second programme, an evaluation of the Stop Smoke groups found that stress and a lack of ongoing support were cited as key issues that needed to be addressed.

7.2.4 Two programmes expressed an awareness of the need to change or reconsider the timing and/or venue of their smoking cessation sessions. One programme had targeted a No Smoking Day event at pregnant women and their partners. The event was held on the first floor of a sports centre. It attracted men and teens but did not attract any pregnant women. The event organisers thus decided that any future events aimed at pregnant women should be held in hospitals or health centres, not sports centres which are typically male-dominated and may be out of the reach of those on low incomes. The second programme made a more general comment regarding the need to increase capacity. Although not explicit recommendations, other programmes had commented on the need to offer smoking cessation services at various times during the day and during the evening to fit into the lives of most parents, including working parents.

7.2.5 Three programmes made recommendations around the focus of smoking cessation services. Two of those programmes recommended that services should focus more specifically on helping pregnant women to quit smoking; one programme recommended that services be targeted at male smokers (particularly fathers and the partners of pregnant women); and one programme stated that there should be more support available to teens. Finally, one of the programmes reported that the stop smoking message did not seem to be filtering through to families living in the Sure Start area and thus a “family of strategies” needed to be developed to help reduce the number of cigarettes smoked and to help increase the number of smoke free zones within homes.

7.2.6 A number of other recommendations were made by single programmes. These ranged from increasing the number of smoking cessation services or sessions, to providing more practical information such as help with coping with stress and advice on healthy eating, providing leaflets and information about smoking cessation in a greater number of languages, and referring families to NHS smoking cessation services and evaluating the outcomes. A number of programmes noted the difficulties in engaging pregnant women in smoking cessation.

7.2.7 One programme recommended that guidance on good practice or examples of successful models operating in other SSLPs be disseminated by the Sure Start Unit. In another programme a sub-group of the Partnership Board recommended that Sure Start adopt a no-smoking policy across all of its services and help to encourage and support smoke-free environments for children and families, particularly pregnant women and their partners. They suggested that this could be achieved through training, promotional materials and helping to ensure that smokers have access to pharmacological support

to help them quit smoking. Finally, one programme advocated the continuation of working with and learning from 'local experts' and agencies. While this was not an explicit recommendation, the suggestion is that such partnership working can be particularly fruitful and should be employed, where possible, in the future.

### **7.3 The future**

7.3.1 The fact that SSLPs reported on the suggestions made by service users and made such recommendations demonstrates their understanding of the limitations of current services and their willingness to improve on those services. Programmes have shown an awareness of the need to target their smoking cessation services at the needs of families. This includes changing the timing of the service so that working parents or those with other time constraints can attend sessions, changing the venue to one that is more accessible to pregnant women (in particular), and changing the focus of smoking cessation services to target pregnant women and parents with young children. Some programmes have also recognised the need to increase the length of follow-up support offered to those who are trying to quit smoking, and possibly to widen their advertising. Each of these possibilities has implications for a programme's staffing, timetabling and resources, but could all help programmes to achieve their PSA target of reducing smoking among pregnant women.

7.3.2 This document has reported on early findings from Sure Start Local Programmes and as such the conclusions are preliminary. With our increased knowledge of the process of implementing smoking cessation services, future evaluations need to focus on outcomes. This may enable NESS to identify which types of intervention have proven most successful, which could in turn filter into the Children's Centre agenda. Future evaluations would also benefit from conducting more long-term follow-up, to get a more accurate picture of which interventions work best and to see if the short term outcomes of reductions in rates of smoking are sustained in the longer term.

**Appendix A: Programme documents that have contributed to this synthesis report**

No	District	Programme	Report Title	Year of Report	Process	Outcomes	Monitoring/ Survey
1	Rossendale	Bacup & Stackstead	Smoking Cessation & Volunteers Befriending Scheme	June 2005	√	√	
2	Norwich	Catton Grove, Fiddlewood & Mile Cross	Annual Report, Year 2	January 2005	√		Monitoring Data
3	Stoke-on-Trent	SureStart4U (Bentilee & Berryhill)	Annual Evaluation Report	2004		√	Health Data
4	Bournemouth	Bournemouth	3 Year Evaluation Report	June 2005	√	√	
5	Nottingham	Aspley & Bells Lane	Health Services Evaluation Report (not audit of HV Report)	2004			Survey data
6	Ealing	South Acton & Acton Vale	Annual Evaluation Report	2002/3-4	√		Survey Data
7	Sedgemoor	Bridgwater	Measuring Change Report	2004			Survey Data
8	Nuneaton & Bedworth	Nuneaton	Annual Evaluation Report	2004			Health Data
9	Bristol	Knowle West	3 Year Annual Evaluation Report	2001-2003	√	√	
10	Westminster	Westminster Church Street	Annual Review	2003-2004	√	√	Monitoring Data

11	Birmingham	Small Heath	Annual Evaluation Report	2003-2004	√		
12	Norwich	Catton Grove, Fiddlewood & Mile Cross	Annual Report (Year 1)	2004	√		Health Data
13	Sheffield	Tinsley	Annual Evaluation Report	2002-3/4			
14	Westminster	Westminster Church Street	Annual Review	2003	√	√	
15	Leeds	Bramley	Community Survey (Feb 2001 – March 2004)	2004			Survey Data
16	Bournemouth	Bournemouth	Family Survey Report	2004			Survey Data
17	Northumberland	Bedlington	Three Year Report	2001-2004	√		
18	Stockport	Adswold & Bridgehall	3 Year Report	2003 - 2004	√		Monitoring Data
19	Bradford	Manningham	User Satisfaction Survey Report (Feb–May 2004)	2004			Survey Data
20	Doncaster	Intake & Belle Vue	Baseline Survey Report	2002			Survey Data
21	Sheffield	Tinsley	Annual Evaluation Reports	2005			Monitoring Data
22	Folkestone	Folkestone	Annual Evaluation Report	2005			Monitoring Data
23	Wandsworth	Battersea	Evaluation of First Year	2003		√	
24	Havant	Leigh Park	User Satisfaction Report	2004			Survey Data
25	Waveney	North Lowestoft	Annual Report Year Three	Jan 2005	√	√	
26	Cambridge	Cambridge	Evaluation Report	2004	√	√	

27	Lambeth	Larkhall	Evaluation Report 2003-4	Jan 2005			Monitoring Data
28	Lambeth	Stockwell	Evaluation Report 2003-4	Jan 2005			Monitoring Data
29	Norwich	Catton Grove, Fiddlewood & Mile Cross	Evaluation Report Year 2	Jan 2005	√		
30	Rossendale	Bacup & Stackstead	Evaluation Report (April 2002-March 2003)	2003	√		
31	Slough	Britwell-Northborough	3 Year Evaluation Report 2000-4	2004			Monitoring Data
32	Milton Keynes	Milton Keynes	Annual Evaluation Report 2004-5	2005	√		
33	Norwich	Thorpe Hamlet	3 Year Report 2000-4	2004			Monitoring Data
34	Stoke-on-Trent	Abbey Bucknall	Evaluation Report	Jan 2005		√	Health Data
35	Stoke-on-Trent	Longton South	Evaluation Report	Jan 2005		√	Health Data
36	Torbay	Paignton	Evaluation Report	2004	√	√	
37	Dudley	Kates Hill & Sledmere	Annual Report (Phase 2)	June 2005			
38	North East Lincolnshire	Nunsthorpe & Bradley Park	Year 3 Report	Jan 2005			Monitoring Data
		Represents 32 SSLPs			17	12	23

## Appendix B: Methods used by SSLPs to evaluate their smoking cessation services

Table 3.1 Methods used by SSLPs to evaluate their smoking cessation services						
Programme report	Questionnaires / Surveys	Monitoring data	Health data	Self-reports	Parent interviews	Other
1		√			√	
2	√	√				
3			√			
4		√		√		
5	√					
6				√		
7	√					
8		√				
9		√				
10		√		√		
11						
12		√			√	
13		√				
14		√		√		
15	√					
16			√	√		
17						
18		√	√			
19	√					
20	√					
21		√				
22		√				
23						
24	√					
25	√	√				
26					√	
27			√			
28			√			
29		√	√			
30						
31		√				
32				√		
33		√				
34		√	√			
35		√	√			
36						√
37	√					
38		√				
<b>Total</b>	<b>9</b>	<b>19</b>	<b>8</b>	<b>6</b>	<b>3</b>	<b>1</b>

## References

---

- <sup>1</sup> Wanless D (2004), Securing Good Health for the Whole Population. London TSO
- <sup>2</sup> Wanless D (2004), Securing Good Health for the Whole Population. London TSO
- <sup>3</sup> Doll R et al (1995), Mortality in relation to smoking: 50 years' observations on male British Doctors. *BMJ*, 328, 1519 – 1527
- <sup>4</sup> Office for National Statistics (1998) General Household Survey 1997. London ONS
- <sup>5</sup> Office of National Statistics (1997) Teenage Smoking Attitudes in 1996. London ONS
- <sup>6</sup> Vineis P et al (2005) Environmental tobacco smoke and risk of respiratory cancer and chronic obstructive pulmonary disease in former smokers and never smokers in the EPIC prospective study. *BMJ*, 330, 277
- <sup>7</sup> Gilliland F D et al (2000) Maternal smoking during pregnancy, environmental tobacco smoke exposure and childhood lung function. *Thorax* 55, 271 – 276
- <sup>8</sup> Hamlyn B, Brooker S, Oleinliova K and Wands S (2002) Infant Feeding Survey 2000. London TSO
- <sup>9</sup> Elizabeth Holmes, (2005) Sure Start The Magazine for People Working with Children and Families, Issue 9, Winter, 10 – 13
- <sup>10</sup> Office of National Statistics (2004) General Household Survey 2003/04. <http://www.statistics.gov.uk/ghs>
- <sup>11</sup> Jarvis, M J and Wardle J (2005) Social patterning of health behaviours: the case of cigarette smoking. In: Marmot, M. and Wilkinson, R. (eds) *Social Determinants of Health*. Oxford. OUP, 2<sup>nd</sup> Edition
- <sup>12</sup> West R, McNeil A and Raw M (2000) Smoking cessation guidelines for health professionals: an update. *Thorax*. 55, 987 – 999