West Midlands
Smoking Cessation in Pregnancy (SCIP) Network
Minutes
Monday 23 January 2006, 10:00 – 13:00

Perinatal Institute, Crystal Court, Aston Cross, Birmingham B6 5RG

Present:

Jason Gardosi (JG)	Director PI (Chair)
Carmel O'Gorman (COG)	Project Manager, PI; N.Birmingham SSS
Lorna Allen (LA)	Sure Start Kingstanding
Yvette Brook (YB)	Sure Start Tamworth
Angie Collard (AC)	WMSSHA
Annabel Cooper (AC)	Gloucester SSS
Helen Efstathiades (HE)	Sure Start East Birmingham
Pauline Evans (PE)	BLT PCT
Ann Fitchett (AF)	S. Birmingham
Sue Gill (SG)	Walsall Quit Smoking Service
Lynda Jones (LJ)	RRT PCT
Terry Lawrence (TL)	Independent Consultant
Kathy Lee (KL)	HOB Stop Smoking Service
Vicky Masters (VM)	Solihull PCT
Amanda Parkes (AP)	Smoking in Pregnancy, Dudley
Michelle Pugh (MP)	Hereford PCT
Sue Randall	Warks Stop Smoking Service
Claire Sweeney (CS)	Sure Start & Jubilee Shrewsbury
Paul Hooper (PH)	Regional Tobacco Policy Manager GOWM
Amanda Harrison	Directors Assistant, Perinatal Institute (minutes)

1. **Apologies**
   Wendy Dudley, (North Staffs); Ceri Evans (South Warks PCT); Sobia Janjua (left Bham East PCT); Kevin Lewis, (Shropshire & Telford PCT); Janet Reece (East Birmingham PCT), Mary White (Cov Teaching PCT)

2. **Minutes of Last Meeting**
   The minutes of the last meeting were reviewed. Claire Sweeney referred to agenda item 5: Sure Start Programmes & Childrens Centres and clarified;
   Sure Start National yearly target is 2% (each year from 2003-2006, equalling a 6% reduction by 2006). As of March 2004, (the first year) a 1.4% reduction was achieved.

   Carmel O'Gorman (COG) advised that various documentation referred to in the minutes is viewable via the smoking website. www.perinatal.nhs.uk/smoking

   The rest of the minutes were agreed as true record.

3. **Matters Arising**
   i) *Michael Ussher Interviews*
   It was noted that the information gathered from the telephone interviews conducted by Michael Ussher with Network members is outstanding. To be chased. It was also reported that he has made the decision not to progress with interviews with pregnant women.

   ACTION COG

4. **Project Manager Update**

Nice Guidance

COG is currently a registered stakeholder for the Brief Intervention Guidance - "**An assessment of brief interventions and referral for smoking cessation in primary care and other settings, with particular reference to pregnant smokers and disadvantaged groups with consideration of the tailoring and targeting of interventions."**

In line, with this, COG has also been invited to partake as a stakeholder on a new public health programme guidance entitled **"The optimal provision of smoking cessation services, including the provision of NRT, for primary care, pharmacies, local authorities and workplaces with particular reference to manual working groups, pregnant smokers and hard to reach communities".**

i) *Brief Intervention Guidance*

This guidance is due to be published in March 06. The first stakeholder meeting took place in June last year. COG explained that stakeholder's representatives include Royal College Nurses, Royal College of GP's, QUIT and Sure Start Units etc. While stakeholders can make verbal comments on the draft scope, these have to be submitted in writing to NICE. These are then put into a document along with NICE's response.

Relevant pages pertaining to the WMSCIP network were tabled in the meeting. Comments submitted from COG included funding for training, engagement of women's partners and routine CO testing. A 'noted' response from NICE has been received by COG to some of these items. NICE use 'noted' to respond to statements of agreement or other statements not requiring response. NICE also agreed that any potential barriers to implementation are an important consideration such as the need for Heads of Midwifery to support training.

At this point, NICE assesses the evidence through for e.g., systematic reviews etc. as well as taking into account the stakeholder comments. The next stage is that NICE produce a Synopsis Report (270 pages). There was a very short consultation period of less than two weeks, which took place in November.

Taking into account stakeholder comments on the Synopsis report, the next stage involves the production of the Final Draft Guidance - to be circulated. The consultation period is 25 January to 21 February 2006 and will be our last opportunity to make comments.

ACTION COG

Jason Gardosi (JOG) encouraged everyone to read the final draft guidance and forward any comments via email. COG to produce a summary and circulate to everyone. This will then be forwarded to NICE on behalf of the group prior to the 21st Feb deadline.

Paul Hooper (PH) advised that individuals could also register as a stakeholder separately on behalf of their areas.

ii) *Programme Guidance - Best Provision of Stop Smoking Services*

This programme Guidance is due to be published around August 2007. PH advised that he has been invited to sit on the Programme Development Group (PDG) for this paper. The consultation period for this is 9 Jan – 6th February.

COG reported at a Stakeholder meeting held on 13th Jan 06, smoking in pregnancy was not mentioned at all, although stakeholders can respond to the draft scope via email. CO'G made the following comments;

1. Clearly smoking cessation remains the key goal. However evidence suggests there is a dose response relationship with smoking i.e. the more cigarettes smoked – the greater

the risk e.g. reduced birth weight. NICE Guidance on Routine Antenatal Care states that women who cannot stop should be encouraged to cut down, which implies that smoking reduction may be beneficial? There is a need for clear guidance on whether harm reduction by encouraging smoking reduction is a useful strategy in pregnancy.

2. An important long term outcome measure for pregnant women should include duration of abstinence i.e. at least up to delivery, 1 year after the intervention and perhaps further post natal follow up too.

One stakeholder Jane Beach (South Birmingham PCT) suggested that it was important for the new guidance to address cannabis use, since this can influence cessation outcome. NICE are going to consider this point.

COG has also been invited to be part of the NICE PGD with a focus on pregnancy specific issues. Once a commitment to this is made it will involve attending a meeting in London every 6 weeks, for a period of at least 12 months. Unlike stakeholders, it is not possible to send a representative. CO'G will need to obtain managerial support. In the meantime JOG fully supported this engagement.

NICE want to hear from services users who have used NRT. They would also like "lay people" to represent user views to ensure that their needs are met.

ACTION ALL

JOG suggested that a link is included on the smoking website to a NICE update page with links to pertinent documents and notes of timelines etc.

ACTION COG

iii) *BMJ Article*
COG gave an update. A response has been compiled by Wendy Dudley (WD), which CO'G has received. COG has also critiqued the article and reviewed the rapid responses and associated research documents. The original article itself contained lots of statistics and was not easy to read. The primary outcome was to measure whether motivational interviewing increases the quit rate in pregnancy. A secondary outcome looked at whether smoking consumption was reduced in the intervention group too.

COG was concerned that the study did not emphasise smoking cessation rather than smoking reduction. Furthermore, the issue of paternal smoking as a public health problem is well established, yet the article does not state that there was any engagement with partners or family. The women also appeared to have obtained their NRT of their own accord, which is not good practice. Linda Jones (LJ) emphasised that Stop Smoking Services deliver a comprehensive package of care and that motivational interviewing is only one aspect. Terry Lawrence (TL) agreed. COG has communicated with Pip Mason (addiction counselling trainer) who delivers first-rate motivational interviewing courses in the West Midlands. Pip's courses are well attended suggesting that staff (Midwives and Stop Smoking Advisors) find MI a useful tool for practice. CO'G felt that the response should include examples of good practice from the WM. Michelle Pugh (Hereford) agreed for her figures to be included in the response.

A response has not yet been submitted, since the article was published in Aug last year. JOG suggested emailing the BMJ stating that the Network Group is looking to send a response to the article and ascertain whether the option to do this is still available. The group were asked if they had anything they wished to be included (e.g. examples of best practice) to forward to COG within the next couple of weeks.

ACTION ALL

COG & JOG to finalise draft response from Wendy.

ACTION COG/JOG

Thought was given to the possibility of using other mediums to voice a response i.e. journals and Global Link. There is clearly a need for a national forum of debate and suggestion was that this could be fed into the proposed conference later this year. JOG suggested that a newsletter is produced, for distribution to GP's etc and other key stakeholders which includes evidence and examples of best practice in the W Midlands.

5. **Pilot Project – Ann Fitchett**

A project was run in Glasgow last year that involved routine CO monitoring in pregnancy. Ann set up a pilot scheme in South Birmingham - Longbridge and Billsley, which ran for a period of 3 months. The CO monitors were supplied by the SSS. Midwives were encouraged to take these out with them on home visits as well as using within the clinics with a view that validated smokers were referred onto Smoking Cessation Specialists. The overall response for this initiative was positive. All antenatal patients (non-smokers and smokers) were offered a test. The results demonstrated:

In Billesley 9 out of 10 women who stated that they were non-smokers were CO validated.

In Longbridge of 42 tested 30 were non-smokers and 12 smokers. Of those 12, 4 opted out of the project and 3 have gone on to quit.

This data suggests that women have indeed been truthful with their reporting of smoking habits. In other words the women who said they were non-smokers had non-smoking CO readings.

Conversation was had regarding computer systems in maternity units, which in some instances continue to inadequate information about smoking behaviour in pregnancy. It is hoped that the implementation of the maternity data-set via the Reducing Perinatal Mortality project will prove as a useful addition to gathering accurate, relevant and timely information.

6. **NRT & Congenital Anomalies – Ann Tonks**

i) *Recent Publication in Obstetrics Gynaecology*

AT gave an overview of a paper produced in Denmark, which prompted press coverage. The paper was based on a large cohort of live births between 97-03 of around 77k pregnant women. There was no indication of how the cohort was selected, however, what it did show was that it was based on singletons and only first pregnancies within the cohort period.

Maternal interviews were undertaken between 11-25 weeks about smoking habits in the 1st 12 weeks of pregnancy. The study showed that the prevalence of smoking was about 27%. Within the cohort of non-smokers 250 cases were using NRT.

Cases were matched to the Hospital Birth Database of anomalies diagnosed at birth up to 12 months. Whilst comparing smokers to non-smokers there appeared to be very little difference in anomalies 5.0% against 4.9% respectively.

Within the anomaly groups there was increased prevalence of cleft lip, digestive and cardio problems. There were lower rates for eye, ear, neck, face, urinary or musculoskeletal conditions.

Within the NRT user group they reported 19 malformations. The relative relevance ratio of 1.6 was used which was significant, however when minor anomalies (e.g. skin tabs and webbing) were excluded this was 1.31 (not significant). The analysis was then split into all vs musculoskeletal anomalies.

AT commented that in general the data on smoking was good with little recall bias but the use of a hospital based register rather than a population based register would have a

bearing. Basing the study on live born cases with anomalies at delivery up to 12 months cuts out terminations of pregnancy (TOP's), which would bias results. This poses a concern as to the validity of the information and message relayed.

The paper included lots of stats and Angie Collard (AC) who has also read the paper pointed out that the some of the figures did not appear to add up. JOG commented that table 6 inferred that smokers had the increased risk. Ultimately the main result hinges on small numbers with very narrow focus that takes results out of proportion.

The main concern regarding the article is that it appears to suggest that it is better to smoke than to use NRT.

Stop smoking services had expressed their concern to ASH about women's reaction to the newspaper article. On this basis ASH produced a response, which COG tabled. The reviewers conclusions were similar to AT's earlier feedback. The group reported that there has been negative feedback about the use of NRT in pregnancy from midwives, GPs and the women themselves since the article was published and the subsequent press interest.

COG tabled key pages from the ASH Guidance for Health professionals published in December 2005. CO'G pointed out that the guidance recommends that written confirmation from the mother is obtained and also that the clinician supervising the pregnancy management is consulted, both of which have implications for practice. Conversation was had regarding the issue of consent for the use of NRT. Systems across the network vary and some services are asking women to sign a form to confirm that they have understood the information.

There is a need to ensure that practice is in accordance with policy guidance. The need for standardised practice in the WM was highlighted. In the meantime the group were asked to forward details of their consent practice to COG with a view to creating a WM standard policy for disseminating accordingly.

ACTION ALL/COG

JOG advised that it is important to show that good quality data in line with policy requirements is being collected. This will assist with evaluating practice.

ii) *Data from the WM Congenital Anomaly Register (WMCAR)*
AT gave information about a research project that WMCAR had been involved in. A case control study had taken place in 3 regions looking at causes of Gastroschisis (protrusion of abdominal contents through its wall), which occurs more commonly in younger mothers. Information has been gathered via maternal questionnaires and hair sampling. Whilst there is an increased risk from recreation drugs and from smoking, since smoking is more prevalent than drug taking, the attributable risk from smoking is higher. Results will be published in the summer.

ACTION AT

7. **West Midlands Training Needs**
COG has been liaising with Terry Lawrence regarding training needs across the board. National standards now exist for smoking cessation training. JOG outlined some training, which has previously been rolled out via the Institute, involving TL, which has proved very useful and effective. There is a need to ascertain what the immediate requirements are. COG suggested there are two distinct training needs. Firstly was a perhaps a need for advanced training for Stop Smoking Advisors and a similar need for regular refresher courses. Michael Ussher (Psychology Lecturer) had informed CO'G that many advisors involved in his research interviews had expressed a pressing need for pregnancy-specific training. Secondly front line staff in particular midwives may require brief opportunistic training.

Comment was made that whilst the conference last year was well attended, there were not many Midwives and Health Visitors. Pauline Evans (BLT) pointed out that front line midwives locally are on 'special measures' only and therefore are not being released for training in smoking cessation. JOG made a suggestion of organising a conf/forum with a 'tilt' towards training needs for this area. TL also suggested contacting MU to clarify exactly what sort of staff training needs had been highlighted. There is clearly a need for further discussion.

ACTION TL/PH

8.AOB

i) *Smoking in pregnancy issues requiring further work*

PH announced that funding has been made available for further work to be carried out around smoking and pregnancy - to look at best practice and data collection issues etc. with a view to improving current situations. The group were asked if they were interested in undertaking this work, or if they knew of anyone who maybe interested to contact the WMPI.

ACTION ALL

ii) *Annual Public Health Conference in Telford*

COG reported that an abstract for the above event was submitted on the work of the WMSCIP. A response has been received asking for her to produce a poster. Unfortunately CO'G is currently having problems obtaining funding for production and attendance at the conference.

iii) *Magazine Article*

CO'G reported that in the Autumn edition of the Sure Start newsletter there was an article on examples of good practice in communities for helping various groups including pregnant women to stop smoking. Alison Trout (Solihull PCT) features in this article. It is available via www.surestart.gov.uk

iv) *Health Bill*

PH advised that matters have improved somewhat in that the Government have decided to give a free vote to MPs in relation to the smoking ban. People need to be encouraged to write to their MPs backing the decision to ban smoking in public places. Further information can be obtained via the ASH website www.ash.org.uk

Date & Time of Next Meeting

Monday 20 March. 10.00 – 13.00hrs to be held at the Perinatal Institute. A light buffet lunch will be available following the meeting.