



NICE Public Health Intervention Guidance
**School-based interventions to prevent the
uptake of smoking among children and
young people**

FIELDWORK REPORT

(Final)

16th November 2009

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National Institute for Health and Clinical Excellence

A report submitted by GHK

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EXECUTIVE SUMMARY

1 Purpose and methodology

GHK Consulting Ltd was commissioned by the Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE) to test draft recommendations on **school-based interventions to prevent the uptake of smoking among children and young people**.

The purpose of the fieldwork was to test the five recommendations in order to assess their relevance and usefulness, as well as exploring the barriers and facilitators to implementation and how any barriers might be overcome. It should be noted that the fieldwork did not invite comment on the considerations or evidence statements in the draft guidance, although a number of the findings are relevant to these sections.

The fieldwork was carried out with **137 practitioners** across all the English regions. In total, 17 focus groups and one set of in-depth interviews were carried out with a range of practitioners working with young people, both inside and outside schools. Participants in the fieldwork included specialists in tobacco control and smoking prevention, as well as practitioners with a wider remit for working with young people in schools (including teachers and other school staff).

2 Headline Findings

Practitioners were broadly welcoming of the recommendations on preventing the uptake of smoking among children and young people in school

Most practitioners (both tobacco control professionals and others) thought that the recommendations were addressing an important, and sometimes neglected, area of work: that of preventing smoking among children and young people. In particular, many health practitioners thought that recommendations would be useful in making the case to commissioners for focusing more resources on primary prevention.

The general tone of the recommendations was felt by many practitioners to echo other national guidance from the National Healthy Schools Programme and DCSF best practice guidance on PSHE (although the terminology used did not always overlap).

Practitioners were unsure that the draft recommendations would have much impact on schools and local agencies

While the principles behind the draft recommendations were welcomed, there was widespread scepticism as to whether they would have a great impact, particularly in schools. There were many reasons for this, not least because the recommendations were thought by many practitioners to lack 'teeth' in the same way as Ofsted inspections, for example; because of a perceived lack of recognition within the recommendations that they could not apply to such a diverse range of settings with different local circumstances, or because of a lack of detailed, clear examples or instructions within the recommendations that could assist local agencies to implement them.

Practitioners identified many barriers to the take up of smoking prevention activities, including the attitudes of some senior managers in schools (recommendation 1); the patchy implementation of smokefree policies and National Healthy Schools status (recommendation 1); a lack of time, capacity or external support to take up peer-led interventions (recommendation 3) or CPD (recommendation 4); and poor understanding of how outcome measures could be used to measure the effectiveness of prevention with young people (recommendation 5).

Practitioners also stated that the recommendations were sometimes confusing on the relationship between prevention and cessation (recommendations 1, 2, and 5). A wider glossary of terms could be one way to clarify the document, particularly for non-specialists.

Practitioners wanted to see more examples and detail on how best to implement different aspects of the recommendations

Particularly in relation to recommendations 2 and 3, many practitioners stated that they would have liked to have seen more detailed examples of how smoking prevention interventions could work in a school setting. These included examples of how effective smoke free policies could be enforced (recommendation 1); how smoking prevention could be integrated across the curriculum (recommendation 2); how parents could be engaged in interventions (recommendation 2); and examples of peer-led or other 'peer' approaches that could be attempted (recommendation 3).

Examples could also help to persuade a wider group of practitioners who do not have a sole remit for tobacco control to see the relevance of the recommendations to them. These examples could be embedded within the recommendations, or be included with the guidance as part as of the implementation process.

Practitioners felt that there was too much emphasis on the role of health professionals, and too little emphasis on empowering school staff

The vast majority of practitioners felt that there was an overemphasis on the role of health and other external professionals throughout the draft recommendations. Many practitioners, including those in local tobacco control services, strongly believed that school nurses, doctors, or other external professionals would not want to engage deeply in the smoking prevention agenda because of other commitments (recommendation 2).

Most practitioners thought that trained schools staff, supported by outside agencies where needed, would be best placed to take forward smoking prevention in their own settings. However they also recognised the challenges that this would bring – such as the need for training or persuading school leaders to integrate smoking prevention activities across the curriculum (recommendation 4).

There are important gaps in the coverage of 'who should take action' throughout the draft recommendations

Practitioners identified other gaps throughout the draft recommendations in the target audience for 'who should take action'. The most commonly mentioned groups were:

- Local Tobacco Control Alliances (or equivalents);
- Healthy Schools Coordinators, Drug Education Coordinators and Local Authorities in general;
- Youth workers / youth services;
- Connexions;
- Ofsted (which was not mentioned by name in the draft recommendations);
- Trading Standards officers;
- Children's Centres (mainly in relation to primary schools, with whom they may share facilities)

Some practitioners also questioned whether the new NHS National Centre for Smoking Cessation and Training ought to be mentioned, and whether it would have a role in disseminating best practice in smoking prevention.

3 The Individual Recommendations

Recommendation 1

Broadly, the vast majority of practitioners agreed with the aims of the recommendation – for instance on reinforcing smoke free policies, taking a holistic approach to smoking prevention, and involving young people and parents.

However, practice varies considerably between schools and local areas and most practitioners felt that they needed further, more specific help in the recommendation on developing effective smoke free policies (and building up the confidence of school staff to deal with smoking as a health issue). They felt that examples would be particularly helpful.

The fit with the NHSP and the role of Healthy Schools coordinators was also felt to be very important, and practitioners were keen to see the recommendations mention this in both the ‘who should take action’ and ‘what action should they take’ sections. Most practitioners wanted to see the recommendation add value to the progress made through the NHSP, because there was still much to do.

There are also wide variations in the access to help to quit smoking, although practitioners differed in their views on whether a statement on cessation was appropriate here.

Recommendation 2

This recommendation generally provoked the most debate and interest among practitioners; the vast majority of whom thought that it was reflective of an approach to cross-curricular learning that fitted well with best practice in PSHE delivery in schools. However, practitioners think that a major barrier to implementing such an approach in respect of smoking prevention is the lack of resources, including external support; and many of them thought that the draft recommendation could have highlighted innovative examples of practice that would help them to develop lesson plans and schemes of work. Nevertheless, practitioners were able to highlight examples of lessons built around an anti-smoking message.

Given the general tone of this recommendation, many practitioners were surprised to see references to, “two or more sessions... delivered over the course of an academic year, supported by additional ‘booster’ activities”, and the emphasis placed on external clinicians to lead their delivery. It seems that even where PHSE delivery is concerned, many practitioners thought this was not delivered according to best practice (cross-curricular delivery), and that this recommendation was unrealistic to fit into a timetable that was already perceived to be squeezed. Most practitioners thought that external professionals could bring valuable insights and much-needed support, but for cross-curricular approaches to be sustained school staff needed to carry out most of the delivery. The statement that recommends that those delivering smoking prevention ought to be non-smokers also confused many of the practitioners, who did not understand its relevance to a practitioner’s competences.

Finally, practitioners showed an interest in engaging parents in smoking prevention through the home-school relationship, but would have liked to have received more advice on the most effective ways to involve them.

Recommendation 3

Practitioners were generally welcoming of peer-led approaches, but there is a great deal of variation in current practice; confusion over the definition of a peer-led approach; and concerns over the barriers which need to be overcome for schools to deliver such interventions.

Practitioners also thought that key groups of professionals, such as youth workers, were missing from the recommendation. Alongside Healthy Schools coordinators, practitioners

stated that they could provide the external support and resources that schools would need to implement peer approaches.

Perhaps most importantly, practitioners wanted to see more guidance on how to measure the effectiveness of peer-led interventions at the local level, so that an evidence base could be built up over time.

Recommendation 4

Among the vast majority of practitioners, the draft recommendation on training was welcomed, as well as the emphasis on partnership working. However the recommendation was generally not thought to address many of the key barriers faced by schools and other practitioners.

In particular, important CPD programmes or sources of external advice were not given a prominent enough position within the recommendation, nor did it mention the kind of methodologies required or skills needed by different types of practitioner working in different settings / with differing age groups.

Recommendation 5

Recommendation 5 was broadly welcomed by practitioners as giving an important push for agencies to work together more effectively at a local and national level to prioritise and improve smoking prevention in schools.

The main question for most practitioners was in relation to local outcome indicators, where they wanted to see more detail on what was expected, as they were concerned that current models did not allow sufficient room to prioritise prevention (alongside cessation). Some practitioners wanted to see a greater reference to key partners in this process, including local tobacco control alliances, Ofsted and LAAs, which could provide an important incentive for agencies to cooperate.

4 Summary of suggested changes

This section consolidates the main changes suggested by practitioners to the text.

Recommendation	Suggested changes to the text
General comments	<ul style="list-style-type: none"> ▪ Examples may be helpful as part of the recommendations or accompanying implementation material, to illustrate how the recommendations could be implemented ▪ Giving each recommendation a lead agency may help with implementation ▪ Consider a greater emphasis on the role that school staff can play in smoking prevention ▪ Clarify the relation between prevention and cessation in the text ▪ The meaning of specialist terms such as 'tobacco control' need to be explained for lay readers (for example using a glossary) ▪ Mention of Ofsted, youth workers and local tobacco control alliances (in particular) under 'Who should take action' ▪ Consider replacing 'schools' with 'all educational settings' ▪ Consider replacing 'parents' with 'parents or carers' throughout ▪ The recommendations could be more flexible so that they take account of schools in different circumstances and working with different populations
Recommendation 1	<ul style="list-style-type: none"> ▪ Clarify how the full implementation of National Healthy Schools status links with the recommendation

	<ul style="list-style-type: none"> ▪ Schools need more guidance on what constitutes best practice in enforcing and communicating smoke free policies (bullet point 1) ▪ More information about how to consult and involve parents (and young people) in an organisation-wide approach to smoking prevention (bullet point 1) ▪ Some parts of the recommendation may need to be tailored so they are relevant to different settings (for instance PRUs or FE colleges)
Recommendation 2	<ul style="list-style-type: none"> ▪ Clarify ‘counsellors’ (who should take action) ▪ Consider a greater emphasis on cross-curricular smoking prevention activities e.g. by stating that smoking prevention can be included in lesson plans across many subjects (including greater explanation as to how this can be ‘innovative’ and ‘interactive’) (bullet point 1) ▪ Consider a greater emphasis on interventions delivered by school staff, supported by external professionals (bullet point 1) ▪ Consider removing the reference to ‘staff who do not smoke who are confident...’ and replace with ‘staff who are competent’ (bullet point 1) ▪ Consider giving more advice on how to engage with parents effectively (bullet point 3) ▪ Consider removing or clarifying the reference to ‘Two or more sessions should be delivered over the course of an academic year...’ (bullet point 4) ▪ Healthy Schools coordinators can assist with the production of resources and lesson plans (bullet point 5)
Recommendation 3	<ul style="list-style-type: none"> ▪ Clarify what is meant by ‘peer-led interventions’ (throughout) ▪ Consider giving more emphasis to how evidence on peer-led interventions can be gathered and evaluated at local level ▪ Consider giving greater emphasis to the role of youth workers, Connexions and other relevant external agencies in supporting and establishing such programmes (throughout) ▪ Clarify the terms ‘<i>nominate</i> the peer leaders’ (bullet point 3) and ‘outside school’ (bullet point 4) ▪ Consider giving greater emphasis to ongoing support for young people involved in peer activities so that they are sustained (bullet point 4)
Recommendation 4	<ul style="list-style-type: none"> ▪ More detail on how to overcome the barriers to accessing high quality training would be helpful to practitioners (throughout) ▪ Give more emphasis on how frontline practitioners can be trained, including different methodologies that are appropriate to different settings (bullet point 1) ▪ Mention of how Healthy Schools coordinators and local tobacco control alliances can help develop appropriate training (bullet point 2)
Recommendation 5	<ul style="list-style-type: none"> ▪ Consider giving more information on what ‘clear outcome indicators’ might include (bullet point 1) ▪ Clarify ‘community-wide’ (bullet point 1) ▪ Consider mentioning local tobacco control alliances and Ofsted by name, as well as Local Area Agreements (bullet point 2)

1 INTRODUCTION

1.1 Overview and purpose of fieldwork

GHK Consulting Ltd was commissioned by the Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE) to test draft recommendations on **school-based interventions to prevent the uptake of smoking among children and young people**.

Fieldwork is an integral part of the public health guidance development process. This report presents the findings of a series of consultations undertaken with a sample of the target audience outlined in the draft recommendations. The aim of fieldwork is to gather practitioner knowledge to understand 'evidence into practice' and provide the basis for understanding whether and how public health interventions will work.

In this study, feedback was gathered from **137 practitioners** in England, including teachers, health professionals and other practitioners working with young people aged 11–19 years who are in educational settings including primary and secondary schools, and FE colleges. To do so, **practitioners were asked questions about the relevance, utility and implementability of the recommendations on preventing the uptake of smoking in school**.

In keeping with established practice in carrying out NICE fieldwork, the views contained in this report and the conclusions derived from them are entirely based on the evidence given by the practitioners to whom we spoke.

GHK would like to thank all the practitioners who committed their valuable time in order to give their feedback during this study.

1.2 Background and scope

NICE were asked by the Department of Health (DH) to develop guidance on public health interventions aimed at preventing the uptake of smoking among schoolchildren.

The **scope of the guidance on preventing the uptake of smoking among schoolchildren** envisaged the provision of recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness. The guidance is aimed at commissioners, managers and other professionals with public health as part of their remit working within the NHS, local authorities and the wider public, private, voluntary and community sectors. It is particularly aimed at: national and local education authorities, healthy school coordinators, school governors and the school workforce, and appropriate voluntary organisations.

The guidance is intended to complement NICE guidance on: mass-media and point-of-sales measures to prevent the uptake of smoking by children and young people, alcohol and schools, mental wellbeing of children and guidance on smoking cessation. NICE public health intervention guidance also supports the implementation of the preventive aspects of national service frameworks (NSFs).

1.3 Structure of this report

This report continues in the following sections:

- **Methodology** (section 2), describing the selection and achievement of the sample, recruitment, and the analysis of data;
- **Responses to the recommendations as a whole** (section 3), analysing the evidence given by practitioners that is pertinent to the content and form of all the recommendations;

- **Responses to individual recommendations** (sections 4 – 8), analysing responses to each individual recommendation; and
- **Conclusions** (section 9), summarising the most important findings.

This report also features five annexes, providing:

- **Annex A** – the final discussion guide used in the consultations;
- **Annex B** – the consent letter signed by the consultation participants;
- **Annex C** – the prior reading task set for the participants;
- **Annex D** – the sign in sheets completed at the focus groups; and
- **Annex E** – equalities monitoring data for the individuals participating in the fieldwork.

2 METHODOLOGY

This section describes the aims and methodology used to carry out our fieldwork and analysis, including:

- the key fieldwork questions;
- sampling and recruitment; and
- techniques for carrying out the fieldwork consultation and analysis.

2.1 Aims and questions for the fieldwork

The aim of the fieldwork was as follows:

To examine the relevance, usability, acceptability, and implementability of the draft NICE recommendations on school-based prevention of smoking.

We therefore developed the following questions for fieldwork to examine 'evidence into practice' focusing on the following key issues of importance to NICE:

- Would the recommendations help practitioners in their efforts to develop school-based approaches to smoking prevention and tobacco control?
- Would the recommendations be useful to practitioners?
- To what extent would the draft recommendations be effective, and impact on or improve, current professional practice and service provision?
- What barriers might influence the recommendations' implementation or usefulness?
- What is the relative priority of, and the emphasis that ought to be given to, each of the draft recommendations?
- Are the draft recommendations clearly worded, and how can their wording be improved?
- What are the perceptions of NICE's involvement in this policy area, if appropriate to the audience under consideration?
- What additional evidence or advice ought to be taken into account in the final guidance?

Throughout the fieldwork we asked practitioners for examples that illustrated current (and good) practice in smoking prevention in school settings (including non-mainstream schools such as Pupil Referral Units). In sections 3 to 8 of this report, we have drawn on these examples to show how practitioners might work with the final recommendations.

The fieldwork methodology was designed by GHK in conjunction with the NICE CPHE team, in order to conform to the CPHE methods manual.

The discussion guide used with practitioners in this fieldwork can be seen at **Annex A**.

2.2 Sampling – key principles and achieved sample

A sampling frame for the fieldwork was developed in order to give a robust picture of how diverse professional groups, working in different settings, were likely to respond to the draft guidance. These were structured around samples at regional and local levels.

Owing to high participation and interest in the fieldwork consultation among practitioners, **we achieved a final sample of 137 practitioners (46% in excess of the total target sample of 94 practitioners).**

2.2.1 **Regional level sample**

We carried out **nine focus groups at regional level**. These were organised with the assistance of regional tobacco control coordinators in each of the Government Offices. The practitioners that we spoke to included:

- regional tobacco control coordinators;
- local leads of tobacco control alliances;
- representatives of local smoking cessation / tobacco control services; and
- Healthy Schools coordinators¹.

At a regional level, we were able to draw on the expertise of professionals working in the fields of smoking prevention, smoking cessation and health promotion, in particular their experiences of working in schools and implementing NICE guidance that was intended to influence schools.

The nine regions, which correspond with Strategic Health Authority (SHA) boundaries, were:

- East of England
- East Midlands
- London
- North East
- North West
- South East Coast / South Central
- South West
- West Midlands
- Yorkshire and the Humber

The number and type of practitioners that were interviewed in each region is shown in **Table 2.1** below.

2.2.2 **Local level sample**

To supplement the regional level focus groups, we also carried out **eight focus groups and one set of in-depth interviews in local areas**. These were organised with the assistance of local Healthy Schools coordinators, local tobacco control alliance staff, and school staff.

We carried out **five focus groups with groups of local practitioners**, who either had a particular interest in smoking prevention, or practitioners who had a more general remit for working with children and young people. These practitioners included:

- representatives of local smoking cessation / tobacco control services;
- local authority Healthy Schools coordinators;
- local authority drug education coordinators;
- youth workers;
- representatives of local voluntary sector agencies working with young people;
- commissioners in PCTs and children's services;
- representatives of local public health and health promotion services; and

¹ Most Healthy Schools Coordinators are employed by Local Authorities; some are employed by PCTs.

- school improvement consultants.

The five focus groups were carried out in:

- Stevenage (East of England);
- Hartlepool (North East);
- Salford (North West);
- Dudley (West Midlands); and
- Walsall (West Midlands);

We also carried out **three focus groups and one set of depth interviews** in four different types of school. These types of school were chosen in order to give the best possible coverage of the views of staff working in different settings. The participants at these focus groups included:

- teachers;
- headteachers; and
- support staff working in schools.

The focus groups were conducted in the following schools:

- an Academy school in London;
- a secondary school in Yorkshire and the Humber;
- a primary school in Yorkshire and the Humber; and
- a pupil referral unit in the East Midlands.

Table 2.1 below gives details of the numbers and types of practitioners that participated in the fieldwork.

Table 2.1 Achieved sample, by regional or local location and professional group

	Number of NHS practitioners ²	Number of Local Authority practitioners ³	Number of other practitioners ⁴	(of which were school staff)	TOTAL NUMBER OF PRACTITIONERS
REGIONS					
East of England	7	1	0		8
East Midlands	5	3	0		8
London	8	1	1		10
North East	6	1	0		7
North West	4	0	0		4
South East	17	8	0		25
South West	7	2	0		9
West Midlands	6	1	0		7
Yorkshire & The Humber	10	1	0		11
LOCAL PRACTITIONERS					
Stevenage (East of Eng)	2	6	1		9
Hartlepool (North East)	3	2	1		6
Salford (North West)	6	2	0		8
Dudley (West Midlands)	4	1	2	(1)	7
Walsall (West Midlands)	3	1	1	(1)	5
SCHOOLS					
Secondary - non LEA controlled	0	0	4	(4)	4
Secondary - LEA controlled	1	0	2	(2)	3
Primary	0	0	2	(2)	2
Pupil Referral Unit	0	0	4	(4)	4
TOTAL	<u>89</u>	<u>30</u>	<u>18</u>	<u>(14)</u>	<u>137</u>

² Including school nurses, smoking prevention and cessation workers, health advisers, school nurses, health promotion staff and other staff employed by the NHS.

³ Including Healthy Schools coordinators, school improvement staff, youth workers, and regional civil servants.

⁴ Including teachers, other school staff and voluntary sector staff.

Table 2.2 gives more information about practitioners' job roles.

Table 2.2 Practitioner job roles

My responsibilities are mainly for:	
... all children (no specific groups)	91
... disadvantaged children	10
... BAME children	1
... Looked After children	1
... children with mental health needs	1
None of the above	33
TOTAL	<u>137</u>

Of all the practitioners that we spoke to, **71 (52%) stated that they had a specific responsibility for smoking prevention as part of their role.**

66 practitioners (48%) stated that they had no specific responsibilities for smoking prevention, although they did work closely with children and young people in schools.

2.3 Recruitment

2.3.1 Methods for recruitment and engagement

Recruitment was carried out using a purposive sampling process, designed to recruit a diverse group of participants who could give useful feedback.

The recruitment process was carried out as follows:

- An initial contact was made with the regional tobacco control coordinator in each Government Office, with a request to carry out a focus group for this fieldwork in their region.
- The regional tobacco control coordinators were able to give us the contact details of local Healthy Schools leads, who were able to assist us in setting up local practitioner groups.
- Local Healthy Schools leads were able to give us the contact details of schools, who we then invited to host and participate a group of staff in their schools.

Informed consent was obtained from each participant once they had agreed to take part (an example consent letter can be seen at **Annex B**). Shortly before the fieldwork took place, the draft recommendations were sent to all participants to read, along with a short pre-read task designed to help structure their thoughts prior to attending (**Annex C**).

Those participants who did not return their consent forms were given the opportunity to complete them at the focus group or interview. At this point, participants were also asked to complete a sign in sheet and ethnicity / disability status monitoring form (**Annex E**).

2.4 Methods used for the fieldwork

Both focus groups and in-depth interviews were used. Focus groups were the main method used. A discussion guide (**Annex A**) was used to structure the discussions. Discussions were facilitated rather than led; it was important that fieldwork participants made their own conclusions (with as little prompting as possible) on what in their view was good or bad about the draft recommendations, and where the gaps lay.

Focus groups were attended by one lead researcher and one scribe to make fieldwork notes; and were digitally recorded to ensure the accuracy of quotes, although they were not transcribed. Where possible, CPHE team members observed fieldwork sessions to hear participants' views first hand.

2.5 Data analysis

Once fieldwork notes were completed, data analysis took place using a content analysis approach, including the iterative use and immediate analysis of field notes throughout the fieldwork period. Using the main questions for the fieldwork, the researchers identified core themes emerging from the data, defining concepts, creating typologies, providing explanations and finding associations between the views of different participants. These were inserted into a grid.

Regular briefing and debriefing sessions took place during the fieldwork process to ensure that analysis was carried out in a robust manner.

3 RESPONSES TO THE RECOMMENDATIONS AS A WHOLE

This section examines participants' responses to the NICE recommendations on school based prevention of smoking as a whole. Subsequent sections then examine the responses to each of the recommendations individually.

For clarity, we have reproduced each of the draft recommendations that we consulted on at the start of each chapter.

Throughout the report, we have used the following terms to give an indication of the weight of evidence given by practitioners.

'The vast majority of practitioners thought that...' means that over 80% of the population referred to in the statement agreed with the particular view expressed. This constitutes very strong evidence in favour of a particular view.

'Most / many practitioners thought that...' means that over 50% of the population referred to agreed with the particular view expressed. This constitutes strong evidence in favour of a particular view.

'Some practitioners thought that...' means that a significant minority (10 or more people) of the total population across all the focus groups referred to agreed with the particular view expressed. While this may constitute a minority view, such evidence could be taken into account when read alongside the other evidence provided by practitioners.

Where the terms **'should'** or **'could'** are used in the text to denote the strength of feeling expressed by practitioners in relation to a particular idea, this is linked to the views of the group referred to in the sentence. For instance:

"Most practitioners thought that the recommendations should contain examples of practice..." means that most practitioners expressed a strong view that the recommendations needed examples. It implies that a minority of practitioners did not agree, or did not express a view.

"Some practitioners thought that English lessons could be used for smoking prevention messages" means that some practitioners thought that this was a possible idea that could be mentioned. Again, it implies that the rest of the population did not express a view or thought something else.

We also refer to staff from different sectors collectively. For example, we refer to local practitioners with a particular remit for / expertise in smoking cessation, prevention or other aspects of tobacco control policy at a local level as 'tobacco control professionals'.

The findings of the fieldwork are illustrated by quotes from participants, as well as examples of practice described by participants.

3.1 Findings

3.1.1 **Practitioners agreed that it was important and timely to emphasise the role of schools and educational settings in preventing smoking**

Most practitioners (both tobacco control professionals and others) thought that the recommendations were addressing an important, and sometimes neglected, area of work: that of preventing smoking among children and young people.

In particular, many health practitioners thought that recommendations would be useful in making the case to commissioners for focusing more resources on primary prevention alongside increasing the number of smoking quitters.

"There is a real role for stop smoking services to do much more in school, it is just that we are completely shackled...but we are actually up for it and trained for it and it wouldn't take much"

Local stop smoking lead

Many school-based practitioners also felt that smoking prevention was not given enough importance in educational settings, as schools also tend to focus on those children that already smoke. However they mostly tended to be more sceptical about the potential impact of the recommendations, even though they built on and could reinforce existing National Healthy Schools Programme (NHSP) guidance.

3.1.2 Practitioners were unsure that the draft recommendations would have much impact on schools and local agencies

While the principles behind the draft recommendations were welcomed, there was widespread scepticism as to whether they would have a great impact, particularly in schools. This is reflected by the comments of one headteacher:

“If we take the last 30, 40 years, anti-smoking only really got going in the mid-1970s. And what has changed since then, in terms of smoking uptake amongst young people? Not a great deal. We’ve tried the shock tactics, we’ve tried... the PHSE route, the science route and it’s still very much a prevalent issue and it’s all about attitudes isn’t it... peer pressure. Somehow there has to be some kind of practice where you make smoking uncool”

Headteacher

This appears to be coupled with a lack of both awareness and consistency in relation to enforcing non-smoking policies in many schools and other educational settings, and amongst staff and students (see the findings for recommendation 1, below).

The vast majority of practitioners considered that Ofsted was the one institution to which all educational settings had to pay attention to; and commented that any insistence from Ofsted that the recommendations were taken up would lead to greater impact (Currently, it appears that in some areas of England, implementing Healthy Schools is important to inspection grades, while in other areas it is not). Second to Ofsted, local authorities are also considered to be influential, and likewise, smoking prevention would need to be a priority for them before there would be widespread implementation of any recommendations on preventing smoking in schools.

3.1.3 The clarity of certain aspects of the draft recommendations could be improved

Throughout the draft recommendations, the vast majority of practitioners identified terminology that was unclear, or instances where certain references within the document appeared to go against the general tenor of the recommendations.

Firstly, practitioners were often confused as to whether the recommendations addressed **prevention or cessation** (while the focus is clearly on prevention, there are also references to cessation in recommendations 1 and 5). In some of the group consultations, there was lively debate among practitioners as to whether it was better to address prevention separately or whether it could only be addressed alongside cessation – both were felt to be areas where there was inconsistent practice in schools, and where there was potential for a clearer, more standardised approach (to which the recommendations could contribute).

For instance, schools have different approaches to pupils who are known to smoke – where smoking is treated as a health issue, offering support and where available, access to nicotine replacement therapy (NRT) – or as a behavioural issue, emphasising sanctions such as suspension from school. This in turn tends to influence their approach to the prevention of smoking and identifying need for smoking prevention activities.

Secondly, many practitioners also wanted each recommendation to be clearer about the **definition of ‘schools’ and ‘young people who attend school’**. While the preamble explains the use of the term, many practitioners thought that ‘educational settings’ and ‘young people receiving education’ might be more appropriate because staff at FE colleges and non-mainstream schools might think they were not included.

Finally, not all of the **terms used** in the draft recommendations are well known to all the target groups. Few school-based staff had heard of the term 'tobacco control', and the recommendations might benefit from a glossary of terms to explain this. Other terms were felt to be ambiguous, such as bullet points which begin 'Consider...' and even the term 'smoking' was felt by some practitioners to be insufficiently reflective of other ways young people can consume tobacco e.g. chewing or shisha. More specific instances are detailed under the 'Findings' section for each of the recommendations below.

3.1.4 *Most practitioners thought that the recommendations should reference, and use the same wording as, the Healthy Schools Programme and other national policies*

All of the practitioners were familiar with the joint DCSF / DoH National Healthy Schools Programme, and thought that this was well known to schools. Some practitioners made the argument that the draft recommendations would have greater impact (and look more 'joined up') if they used the same terminology as the Healthy Schools guidance, as well as DCSF guidance on Personal, Social and Health Education (PSHE), and the national PSHE continuing professional development (CPD) programme. This included the consistent use of:

- 'National Healthy Schools Programme' instead of 'Healthy Schools';
- 'Parent or carer' instead of 'parent'

In the group consultations, practitioners sometimes disagreed whether 'organisation-wide' was more appropriate than 'whole-school'. The former term was felt by some practitioners to be more inclusive of settings such as FE colleges, while the latter seems to be better known and is consistent with the terminology used in PSHE and Healthy Schools. Many practitioners did not express a view either way.

Many practitioners also thought that if Healthy Schools status was implemented thoroughly, this would contribute towards fulfilling parts of the recommendations.

3.1.5 *Leadership and accountability should be given greater emphasis in the recommendations*

Alongside the terminology used in the draft recommendations, many practitioners thought that the breadth of groups of professionals who should take action made the recommendations less clear. Whilst the vast majority of practitioners welcomed the involvement of many professionals in smoking prevention and thought the 'long lists' were helpful, many thought that the recommendations ought to set out who was accountable for delivering each recommendation (or bullet points within) and who, or which agency, should lead the implementation at a local level. This comment reflects this view:

"As this stands, the principles are very sound and I really welcome the guidance but there's no indication of accountability and so it won't lead to action and action is what we really require....I can't see it leading to action on the part of headteachers, counsellors or governors or anyone else"

Local practitioner

In general, the importance of leadership was felt by many practitioners to be a key driver behind the effectiveness of no smoking policies, developing an effective PSHE curriculum or innovations in partnership working: if leaders believed that smoking prevention was important, then there was an increased likelihood of action.

3.1.6 *Practitioners felt that there was too much emphasis on the role of health professionals, and too little emphasis on empowering school staff*

The vast majority of practitioners felt that there was an overemphasis on the role of health and other external professionals throughout the draft recommendations. Many practitioners, including those in local tobacco control services, strongly believed that school nurses,

doctors, or other external professionals would not want to engage deeply in the smoking prevention agenda because of other commitments.

Most practitioners thought that trained schools staff, supported by outside agencies where needed, would be best placed to take forward smoking prevention in their own settings, whilst recognising the challenges that would bring – such as the need for training or persuading school leaders to integrate smoking prevention activities across the curriculum.

3.1.7 *The recommendations should be flexible enough to reflect the different circumstances of different types of school*

Many practitioners stated that the draft recommendations did not take sufficient account of different types of school settings and local circumstances. Primary schools, secondary schools, Pupil Referral Units (PRUs) and FE colleges will all have very different populations and needs, and although the general principles behind smoking prevention might be similar, differing interventions are likely to be needed. For instance, many students in PRUs already smoke – so many practitioners stated that the recommendations ought to recognise their unique circumstances, and state that they may need more external support in order to implement policies on smoking cessation and prevention.

Similarly, many practitioners also thought that local circumstances varied considerably – for example in the availability of external support and composition of the school population – and that agencies would need to tailor any interventions on smoking prevention to this context. Therefore many practitioners thought that examples of prevention activities, from which they could choose or use as a basis for designing their own local interventions, would be useful for them. This was particularly true of those recommendations where there are few interventions that have a firm evidence base, such as in the field of peer-led approaches (recommendation 3).

3.1.8 *The role of parents and carers is central to influencing young people's smoking behaviour*

Many practitioners thought that the role of parents and carers in the 'who should take action' sections needed to be given a higher profile, because they are one of the most important factors contributing to smoking behaviour in children and young people. They can be a barrier to interventions which are led by schools, and some practitioners stated that parental behaviour was a much greater influence on children's behaviour than school (and therefore advocated focusing primary prevention resources on interventions that targeted parents directly).

Most practitioners, even those in health, seemed to be unaware of the links to other pieces of NICE guidance on smoking prevention and young people and highlighting these links is likely to be important for the implementation process.

3.1.9 *There are important gaps in the coverage of 'who should take action' throughout the draft recommendations*

Practitioners identified other gaps throughout the draft recommendations in the target audience for 'who should take action'. The most commonly mentioned groups were:

- Local Tobacco Control Alliances (or equivalents);
- Healthy Schools Coordinators, Drug Education Coordinators and Local Authorities in general;
- Youth workers / youth services;
- Connexions;
- Ofsted (which was not mentioned by name in the draft recommendations);
- Trading Standards officers;

- Children's Centres (mainly in relation to primary schools, with whom they may share facilities)

Some practitioners also questioned whether the new NHS National Centre for Smoking Cessation and Training ought to be mentioned, and whether it would have a role in disseminating best practice in smoking prevention.

3.1.10 *Many practitioners questioned whether there was a sufficient evidence base underpinning some of the draft recommendations*

Many of the practitioners consulted were tobacco control leads, or practitioners whose main role was to promote smoking prevention or cessation. As they were familiar with the evidence behind the draft recommendations, some of them questioned whether there was a sufficient evidence base underpinning them. In some cases, they believed that NICE ought not to state anything (for instance on recommendation 3), or that the draft recommendations should acknowledge that the evidence was still being gathered, and that schools and local agencies ought to know how to contribute to this, drawing on the evidence available.

It should be noted that because the practitioners were consulted on the draft recommendations alone, they were not aware that the evidence statements in the final guidance might refer to the strength of evidence underlying each recommendation.

3.2 Discussion - implications for the implementation process

The common themes identified above emphasise the importance of effective implementation. The main implications of this are outlined below, as many of the barriers are cultural. The vast majority of practitioners stated that resources such as money from commissioners, or finding time in the curriculum, were barriers to implementation. However many also stated that improving smoking prevention in schools was related to encouraging professionals to work better together to change current practice – an approach emphasised in DCSF guidance on PSHE practice, or the 'whole school' approach promoted by the National Healthy Schools Programme.

3.2.1 *Persuading schools and local agencies of the relevance of the recommendations*

Practitioners commented on the reluctance of many schools and local agencies to give a higher priority to smoking prevention (see for example the feedback on recommendation 1). Therefore there may be a role for the guidance to explain why these recommendations are relevant for schools in a preamble or the 'Considerations' section, and the implementation process will also need to stress the benefits to children and young people – not only in relation to health, but also to learning.

Practitioners also believed that a clearer stance on the relation between prevention and cessation (and cross promoting related pieces of NICE guidance on smoking prevention and young people) would also improve the relevance of the draft recommendations.

3.2.2 *The importance of examples drawn from practice and case studies*

The vast majority of practitioners wanted to see the recommendations set out (or accompanied by) specific, detailed examples of 'best practice' interventions to prevent the uptake of smoking in schools⁵. These details or case studies could be more tailored to specific ages or settings, for example lesson plans or project descriptions that would tell practitioners how to 'do' an intervention:

"what would be helpful is to say "here's a resource pack, here's a pack of interventions"

Secondary school PSHE lead

⁵ For instance, the call from practitioners for more detailed information could be reflected in accompanying documents to the guidance to assist with implementation.

For some practitioners – particularly those based in schools – the lack of examples drawn from practice meant that the draft recommendations were not seen as useful:

“There’s so much good work going on in schools and it’s not reflected in here [the draft recommendations]”

Headteacher

3.2.3 Disseminating the recommendations

The vast majority of practitioners thought that close working with DCSF, Ofsted and the NHSP would be helpful in disseminating the recommendations and giving them the opportunity to reach a wide audience. For instance, practitioners said that this could be achieved through joint branding, or promoting the recommendations on the relevant websites. Some practitioners also said that the growing importance of PSHE (it is about to become compulsory) was also an opportunity to disseminate such recommendations.

Some practitioners also stated that a short set of instructions on how to implement the recommendations – not only which agency should lead, but the steps in the process – could accompany the recommendations. For instance, if a school already has a smoke free policy in place, how should it seek to improve and enforce it, and from where should it seek support?

Other agencies could also help to promote the recommendations, as these practitioners illustrated:

“[We] don’t need it [the recommendations] to be a piece of paper that is put in a door. And I think the more people that know about it, the more it is going to be publicised, it will publicise and promote itself”

Local practitioner

“If Ofsted came in and we knew they were going to be looking for certain things otherwise we fail, then that would change the priority”

Headteacher

Some practitioners also mentioned the following routes for dissemination:

- The Director of Public Health, where they are a joint post between the PCT and Local Authority;
- Healthy Schools coordinators / teams;
- Extended schools services; and
- Drugs Education Coordinators / Advisers in Local Authorities.

4 RECOMMENDATION ONE

Recommendation 1 Organisation-wide approaches

Who is the target population?

- Children and young people under the age of 19 who attend school.
- School workforce.
- Parents.

Who should take action?

Head teachers, school governors, teachers, support staff and others who work with primary and secondary schools. This includes: school nurses, counsellors, healthy school leads, personal, social and health education (PSHE) coordinators in primary schools and personal, social, health and economic (PSHE) education coordinators in secondary schools.

What action should they take?

- In consultation with young people and staff, develop an organisation-wide smoke free policy which includes smoking prevention activities (led by adults or young people) and staff training and development. The policy should sit within a wider healthy school policy incorporating wellbeing, relationships and behaviour. It should also take account of children and young people's cultural, special education or physical needs. (For example, Braille versions of information may be needed.)
- Apply the policy to everyone using the school premises, for any purpose. This includes the school grounds as well as buildings. (Any designated smoking areas should be removed from the school grounds.)
- Widely publicise the policy and ensure it is easily accessible (this includes making a printed version available). Everyone using the school facilities should be aware of its content, by providing clear reminders of its key messages throughout school buildings and grounds.
- Schools should offer staff and pupils help to quit smoking, either in-house or by advising them about local NHS Stop Smoking Services.

See also: 'Workplace interventions to promote smoking cessation' (NICE public health guidance 5); 'School-based interventions on alcohol' (NICE public health guidance 7); 'Smoking cessation services' (NICE public health guidance 10); and 'Social and emotional wellbeing in primary education' (NICE public health guidance 12).

4.1 Findings

4.1.1 Practitioners welcomed the overall approach, but were concerned that it should not be perceived as duplication

Practitioners were mostly welcoming of recommendation 1, and as with the draft recommendations as a whole, health professionals thought that it gave them a useful tool to engage with schools and PCT commissioners to raise the profile of smoking prevention in education settings. Likewise, many school based practitioners and Healthy Schools coordinators thought that it would help them to gain greater interest from health professionals and elicit more support.

Many practitioners welcomed the aims of the recommendation and stated the importance of more consistent policies on smoke free environments – especially between different settings, such as PRUs and mainstream schools; as well as a more holistic, 'health'-based approach to smoking prevention in schools.

The vast majority of practitioners were concerned that schools and local agencies might view recommendation 1 as duplicating the criteria for Healthy School status: as one local practitioner stated, "*all teachers will say they do this already*". The Healthy Schools

standard states that schools should use a holistic, whole-school approach to smoking and health, integrating prevention across the curriculum, banning smoking in all buildings and grounds, and that policies should be developed through consultation with children and parents. Therefore some practitioners thought that the recommendation should make it clear that achieving Healthy Schools status (or its enhancement) was one way of meeting the recommendation (or vice versa).

Nevertheless, many practitioners recognised that the recommendation provided a framework and identified the main issue as one of wording – recognising that schools and other education settings may be doing much of this already, but emphasising that the actions relevant to the Healthy Schools standard need to be reinforced and built upon.

As with other recommendations, many practitioners thought that the main barrier was NICE's lack of 'teeth', and stated that Ofsted had to play a bigger role:

"If it linked into, if they implement the guidance then it links into healthy schools or if somehow Ofsted gives them recognition for the fact that they are doing this, I think that is what would make the schools take the recommendation on board"

Stop Smoking Service Coordinator

4.1.2 Current practice is very inconsistent in relation to smoke free schools and grounds

The vast majority of practitioners described the main barrier to implementation as the inconsistent or poor enforcement of current smoke free policies (which already exist in many schools). Some practitioners warned of a 'tick-box' approach to smoking prevention and stated that the recommendation needed to overcome such ways of thinking. Some practitioners also stated that local authorities differ in their guidance on smoke free buildings, and how rigorously they certify Healthy Schools status. Therefore local authorities should also be listed among those agencies who should take action.

Practitioners – both tobacco control professionals and schools staff – often stated that schools sometimes had a poor understanding of smoking, and smoking policies in their school. For example, they may deny that smoking takes place, or tend to overestimate the level of smoking and take a more pessimistic view: 'most of our young people smoke'. Some practitioners thought the language used in the draft recommendations reinforced the latter view by using the term 'prevalence'.

According to many practitioners, implementing smoke free policies seems to be a major challenge for many schools. The vast majority agreed with the recommendation that enforcing (and reinforcing) smoke free policies were important. Currently, schools vary on whether policies are enforced, or enforced to different degrees with pupils, visitors and staff. Some school staff stated that they were not confident in challenging smoking, partly because policies had not been promoted or because it was not a priority for the senior management. The following quotes illustrate some of the challenges:

"The policies are a good idea...but it's all very well having a policy, it's the enforcement of it and the willingness to actually implement it"

Local tobacco control practitioner

"All schools that I know have a smoking policy and apply it as best they can but it is hit and miss"

Tobacco Control Alliance coordinator

"When I was teaching there were constantly kids who were constantly smoking, constantly getting discipline slips, kids in my tutor group. I'd pick them up and I wouldn't have a clue what to do. I was a newly qualified teacher and I wouldn't have a clue what to do with these kids. So I'd find this ancient, old quit leaflet that I'd found tucked at the back of a cupboard and talk to them about smoking and tell them I don't want them to get another discipline slip the following week of them doing it"

again ... and I didn't have any powers to, kind of, call upon. I didn't want to push for them to be suspended, I didn't think that would be particularly helpful"

Local Smoke free coordinator

Some schools also share their site with other facilities (e.g. youth services or adult and community education) who may observe different policies. There may also be problems with contractors on site; and some practitioners stated that some schools have limited control over the use of their own buildings because of PFI (Private Finance Initiative) arrangements. Some practitioners also raised the issue of FE colleges operating under different circumstances, because under 19s may share a site with adults, and they considered that colleges could not implement smoke free policies in the same way; furthermore Healthy Schools staff do not normally work with such institutions. Finally, some practitioners and schools were unclear on how to deal with people who lived on site (such as caretakers or staff / young people in boarding settings). They felt the recommendation needed to give more detail about how such differences could be overcome, and the actions that different types of school might take in order to implement a smoke free policy effectively.

Some practitioners also stated that engaging parents was very important, and that parents needed information and awareness-raising in relation to why a smoke free environment was desirable. Others said that schools ought to be able to signpost parents to smoke free homes (or other local initiatives) that would help to reinforce the smoke free message, and put the school's actions in a broader health promotion context.

Most practitioners stated that for this recommendation, examples of effective smoke free policies would be useful. Many practitioners were able to give examples of actions that they, or schools that they worked with, had taken to promote their smoke free policy, and felt that the recommendation could go further by using these as illustrative examples:

- writing a no smoking requirement into contractors' contracts;
- newsletters;
- highly visible posters; and
- setting up healthy school / smoking displays so that parents walk past them when they enter school.

4.1.3 Practitioners differed in their views on the links between smoking prevention and other health work in schools

Some practitioners stated that the reference to a 'wider healthy school policy' was confusing. While a smoke free policy is part of the National Healthy Schools criteria, a 'Healthy School' policy is not, and most schools would not have such a policy (nor are there any incentives to create one). However, most practitioners welcomed the aim of the statement and agreed that smoking prevention needed to link up with other interventions on risk-taking behaviour. Some practitioners wanted the recommendation to take this approach further by emphasising that smoking is an addiction, and ought to be primarily addressed using a health model rather than an issue of behavioural control.

Some practitioners also wanted to emphasise the links between tobacco and drugs (for instance, focusing on the harm caused by smoking tobacco and cannabis together), and wanted one policy to cover both issues. However, other practitioners took the opposite view. Most practitioners thought that smoking prevention was not given the same priority as drugs:

"Smoking doesn't really affect behaviour in the same way drugs and alcohol do, so schools are less concerned with smoking than they are with the other two"

Local tobacco control alliance coordinator

4.1.4 Young people's involvement is crucial

The vast majority of practitioners thought that it was important to involve young people themselves in the development and enforcement of the smoke free policy. However, the same issues of confusion and effective leadership are also relevant.

"involving young people creatively in the devising of a policy is important and essential to ensure an achievable policy".

Local tobacco control practitioner

4.1.5 Practitioners identified barriers to creating effective smoking cessation services / referring to smoking cessation services in school

In relation to the last part of recommendation 1 on offering help to staff and students to quit smoking, practitioners pointed out wide variations in current practice. Local stop smoking services can provide brief interventions or training, but they may not be commissioned to provide this, or schools may not be interested in taking this up (see also feedback to recommendation 4).

Practitioners reported wide variations in access to NRT in schools. For example, some schools host drop-ins or buddying groups where smokers can access help, advice and referrals on an ongoing basis (they may also provide letters to the pharmacist so they can access NRT there). However this does not appear to be common practice; much depends on the capacity of local health services and the leadership of heads and school governors, who may not want such a service in their school.

4.2 Discussion

Broadly, the vast majority of practitioners agreed with the aims of the recommendation – for instance on reinforcing smoke free policies, taking a holistic approach to smoking prevention, and involving young people and parents.

However practice varies considerably between schools and local areas, and most practitioners felt that they needed further, more specific help in the recommendation on developing effective smoke free policies (and building up the confidence of school staff to deal with smoking as a health issue). They felt that examples would be particularly helpful.

The fit with the NHSP and the role of Healthy Schools coordinators was also felt to be very important, and practitioners were keen to see the recommendations mention this in both the 'who should take action' and 'what action should they take' sections. Most practitioners wanted to see the recommendation add value to the progress made through the NHSP, because there was still much to do.

There are also wide variations in the availability of and access to help to quit smoking, although practitioners differed in their views on whether a statement on cessation was appropriate here.

5 RECOMMENDATION TWO

Recommendation 2 Adult-led interventions

Who is the target population?

Children and young people under the age of 19 who attend school.

Who should take action?

Head teachers, school governors, teachers, support staff and others who work with primary and secondary schools. This includes: school nurses, counsellors, healthy school leads, PSHE coordinators and PSHE education coordinators.

What action should they take?

- Deliver interventions that aim to prevent the uptake of smoking as part of PSHE, PSHE education, activities related to Healthy Schools status or as part of the core curriculum (for example, science). They should be linked to the school's organisation-wide, smokefree policy. Interventions should be innovative, factual and interactive. They should:
 - be tailored to age and ability
 - be ethnically, culturally and gender-sensitive and non-judgemental about individual children or young people
 - aim to develop decision-making skills and include strategies for enhancing self-esteem and resisting the pressure to smoke from the media, family members, peers and the tobacco industry (this could involve roleplay)
 - include accurate information about smoking including its prevalence and its consequences: tobacco use by adults and family members should be considered and challenged
 - be delivered by trained external professionals such as school nurses, doctors and teachers or support staff who do not smoke and who are confident about dealing with the subject.
- Children and young people should be involved in the design of the interventions.
- Parents should be encouraged to help, for example, by providing them with support materials to use at home.
- Two or more sessions should be delivered over the course of an academic year, supported by additional 'booster' activities throughout every academic year.
- Schools should link with partners involved in smoking prevention and cessation activities in the wider community, such as NHS Stop Smoking Services or regional tobacco policy leads, to deliver the interventions.

See also 'Behaviour change' (NICE public health guidance 6); 'School-based interventions on alcohol' (NICE public health guidance 7) and 'Preventing the uptake of smoking by children and young people' (NICE public health guidance 14).

5.1 Findings

5.1.1 *Practitioners mostly welcomed an approach to smoking prevention which fitted with current thinking in PSHE*

The vast majority of practitioners thought that recommendation 2 emphasised some good principles for effective smoking prevention activities in schools. In general, they welcomed the non-judgemental approach; the emphasis on young people being involved and engaged in the design of activities in school (with many practitioners considering that 'genuine' consultation with young people was not yet common practice); and the links to enhancing decision making skills and self-esteem, particularly when faced with the influence of the tobacco industry, peer pressure, and (sometimes) parental behaviour. Many practitioners

also wanted to emphasise that smoking prevention activities fitted well with approaches to teaching children and young people about risks and decision making. Such an approach, grounded in interpersonal skills and confidence-building, and embedded across all the subjects / curriculum areas taught in education, was felt to fit well with current thinking on PSHE.

"I really liked this part about developing decision making skills and including strategies for enhancing self esteem - that's core in the PSHE policy in which we work and it gives the children the opportunity to say no or make the decision or provides them with alternative strategies. I really like the point that was made there"

Primary school teacher

Some practitioners also identified several areas in PSHE where smoking prevention could be integrated, for example:

- economics (the cost of smoking);
- sexual health (smoking and fertility);
- environment (impact of tobacco and smoke);
- global citizenship (the tobacco industry and media); and
- drug education (the link between tobacco and cannabis was a key concern).

Many practitioners – both those working in health and school-based practitioners – thought the recommendation could also enhance the profile of smoking prevention within PSHE, and raise awareness of the importance of smoking prevention and PSHE more generally, if the recommendation was worded well and disseminated effectively:

"[smoking prevention] needs to be brought to the top of the PSHE agenda"

Local Smoke Free coordinator

5.1.2 Practitioners thought that the draft recommendation helped to promote smoking prevention activities embedded across the whole curriculum, but wanted to a greater emphasis / examples on this aspect

All practitioners were welcoming of the approach of integrating smoking prevention into all areas of the curriculum. However the vast majority of practitioners thought that the recommendation was less clear on how this could be achieved, and that appropriate examples would be helpful. Educational settings generally use the term 'cross-curricular' to describe this approach.

Most practitioners thought that a reference to schemes or programmes of work would help to emphasise that smoking prevention could be delivered as part of many different subjects. Many felt that the reference to science was unhelpful as this reflects a more traditional approach that was based around the delivery of facts alone, whereas giving examples of integrating smoking prevention into other areas of the curriculum could encourage more innovative practice. For example, mathematics lessons could be used to discuss the cost of smoking, while English, drama or geography lessons could discuss the global tobacco industry. Primary school teachers stated that 'circle time' was a good time to discuss health messages. Some practitioners stated that children responded best to messages about the manipulative nature of 'big tobacco' in fostering an addiction, and interpreting messages in the media. The Florida Truth campaign was mentioned on several occasions as a good example of a social marketing / educational campaign involving young people. They welcomed the reference to the tobacco industry and the media in the recommendation.

The vast majority of practitioners stated that there was a lack of resources in schools to take forward such adult-led recommendations; many wanted to see the recommendation give some examples or signpost to useful external resources, which were relevant and differentiated by age group and setting. Some healthy schools coordinators had developed

lesson plans for smoking prevention, and wanted to see the recommendations reference them as a specific source of curriculum support for school staff. The following quote summarises this attitude:

“not really anything new [in recommendation 2] I don't think, my gut feeling is it's a little bit woolly... [it] needs some examples... it has some good ideas, yes we should be delivering innovative, factual interventions but let's have some examples then”

Local authority practitioner

Many practitioners also wanted to see more in recommendation 2 about who ought to take the lead in schools and local authorities in developing lesson plans, and specific ideas for implementing a cross-curricular approach to smoking prevention.

“Maybe local authorities or local alliance group could put together a fact file or lesson plans for teachers”

Local practitioner

Practitioner examples of teaching smoking prevention across the curriculum

One Healthy Schools coordinator described their lesson plans for primary and secondary schools:

“We've done it, in our primary schools... we've tried to do it cross curricular. So do it across geography, across PE, across drama. You've got PSHE, got Maths. The Maths is looking at the costing of it all. So it's a simple activity where you say 'right over a year, you'll save about £1000. There's an Argos catalogue – tell us what you can buy and in some schools they've opened it and they're being, like, fences and sheds but some are buying, you know, plasma TV's and stuff like that”

“In Geography they look at smoking rates around the world, so they talk about different smoking rates around the world. Look at England, it's what, about 24/25% - who is the largest, who's the smallest, can you find those countries and then looking into the economics of those countries... you can run through your maths, you can do your creative writing, you can look at smuggling rates and you can say 'right it starts in Russia and ends up in England – how does it get there?'... It's essentially a file that I've put together with lesson plans for each year from Year 1 to Year 11.”

Healthy Schools Coordinator

A primary school teacher described the importance of repeating the message often, in many different forms:

“One of the recommendations I thought was really good was the part where it encourages the opportunity for cross-curricular links. It really is, you need to repeat it. It's about embedding so it becomes second nature really, so that you don't have to think twice, so that you just know it's the right thing. By having the cross-curricular links between PSHE and Science – we've tried to group all the curriculum areas – the children are getting a repeated programme”

Primary School Teacher

5.1.3 A majority of practitioners found the reference to 'two or more sessions' unhelpful and unclear

The vast majority of practitioners expressed an unfavourable view of the reference to 'two or more sessions' in the draft recommendation, considering that it went against the general direction of the recommendation, or was overly prescriptive and unrealistic. In general, a cross-curricular approach was felt to be more effective in communicating a message about smoking, whereas dedicated sessions about smoking were felt to be backward-looking and reflective of a 'tick-box' approach to health education.

Current practice in many schools appears to be to 'condense' PSHE delivery into very narrow chunks of time – for instance two days in the whole school year. From that point of view, trying to include smoking prevention into these fixed time periods would be counterproductive.

“there is no way with two sessions, and the wider PSHE curriculum that this suggestion is achievable. For example, one school that I know only delivers 10 PSHE sessions in a whole year and they have to cover all the subjects in that. That is the reality for a lot of schools”

Local tobacco control practitioner

Many practitioners also found this bullet point in the recommendation confusing, because they were unclear as to whether the two sessions were spread over all the school years or each school year; while others were confused over the meaning of a ‘session’ (one lesson? one hour? one day?). Local recommendations in some parts of England appear to go further or have a more nuanced approach, for example one regional tobacco control group recommends activities on smoking at every key stage, but more importantly this should be focused on the transition between different schools or parts of school as children and young people are more likely to change their behaviour at these times. In general, practitioners felt that a more flexible approach was required.

5.1.4 Practitioners believed that a reliance on trained external professionals alone was unrealistic and unsuitable

The vast majority of practitioners could describe difficulties in achieving effective relationships between schools and external partners around the smoking prevention agenda. While in some cases this might be due to the attitude of particular schools, practitioners also highlighted the difficulty in getting ‘mainstream’ health professionals to engage with health promotion activities; which was seen as being dependent on local PCT commissioners. Many practitioners felt that it was unrealistic to get school nurses and doctors to lead such activities in schools, due to capacity constraints. Therefore they wanted an approach that emphasised training and empowering school staff to be more confident and competent in leading smoking prevention in their own settings. Some practitioners also said that young people do not generally place a high degree of trust in GPs or doctors (who tend to be perceived as older, ‘authority’ figures).

Some practitioners emphasised that external professionals had to be handled carefully: they need to be briefed on the circumstances of the school and the needs of the children that they speak to, and the fit with the curriculum. They could also be expensive, and schools would have to think very carefully about devoting a larger chunk of resources to such activities. In general, practitioners thought that Healthy Schools coordinators and Local tobacco control alliance / stop smoking service staff were best placed to come into schools and assist with setting up prevention or cessation activities, provided that they were equally supported by the school leadership.

“They [the Healthy Schools staff] engaged the children, they did a lot of practical activity and things like the cigarette cocktail”

Teacher in a PRU

Most practitioners said that the recommendation ought to emphasise that while external practitioners have a role, it should be left to the school to decide what support is appropriate and how to deploy it in the context of cross-curricular smoking prevention. Some schools such as PRUs may need more tailored external support.

Many practitioners cited examples where external professionals were not specialists in smoking prevention, but where their interventions worked well as part of a wider strategy. In one example, a school described how the community development arm of their local football club had come into the school to deliver lessons on health.

5.1.5 The majority of practitioners thought that the competence of trainers was much more important than trainers’ smoking status

The vast majority of practitioners did not understand why interventions ought to be led by non-smokers. Some practitioners gave examples where some of their best advocates

against smoking were those that were smokers (with health problems, for instance) and ex-smokers. Both health professionals and schools staff stated that this requirement was unnecessary and that 'competence' was more important than 'confidence'.

In particular, many school staff were critical of this aspect of the recommendation because they thought it could lead to confusion about the responsibility of all adults to help to prevent the uptake of smoking among young people (i.e. did it mean that smokers cannot take part in any activity connected with prevention?). Teachers thought this was discriminatory as some teachers would be doing a certain task that others could not.

5.1.6 *Many practitioners advised caution in how schools engage parents in smoking prevention activities*

Many practitioners agreed with the statement about involving parents, and recognised they are key influences on their children's behaviour. However they were also cautious about activities that might negatively influence the relationship between children and their parents. Both health practitioners and school staff would have liked to have seen more detail on how best to engage with parents, and how they can be involved in smoking prevention in a way that is not seen as threatening or encroaching on parental responsibilities.

One school had a good experience of implementing joint parent and student sessions on smoking prevention where the issue could be discussed openly. In one region, Healthy Schools and smoking cessation services could signpost parents to the Smoke Free Homes Initiative. The Smoke Free Homes Initiative encourages people to keep their homes smoke free by offering advice on how to achieve this, giving ideas of activities parents can do with their children and providing educational resources for families. This was viewed by local practitioners as a way of engaging parents in positively promoting their children's health in a manner that was seen as encouraging.

5.1.7 *Practitioners identified some issues with clarity and important gaps in 'who should take action' (and how)*

Some practitioners identified other gaps and clarity issues in recommendation 2:

- the recommendation did not state whether schools ought to have an identified lead on smoking prevention – this was felt by external agencies to be a problem when trying to engage with schools;
- the recommendation did not mention the specific nature of smoking cessation for young people, and were concerned that the recommendation might lead to adult models of smoking cessation being adopted in schools;
- youth workers were a key group missing from 'who should take action'; and
- the term 'counsellors' was thought by some groups to be confusing (psychological support / elected officials).

5.2 Discussion

This recommendation generally provoked the most debate and interest among practitioners; the vast majority of them thought that it was reflective of an approach to cross-curricular learning that fitted well with best practice in PSHE delivery in schools. However, practitioners think that a major barrier to implementing such an approach in respect of smoking prevention is the lack of resources, including external support; and many of them thought that the recommendation could have highlighted innovative examples of practice that would help them to develop lesson plans and schemes of work. Nevertheless, practitioners were able to highlight examples of lessons built around an anti-smoking message.

Given the general tone of this recommendation, many practitioners were surprised to see references to 'two or more sessions... delivered over the course of an academic year, supported by additional 'booster' activities', and the emphasis placed on external clinicians

to lead their delivery. It seems that even where PHSE delivery is concerned, many practitioners thought this was not delivered according to best practice (cross-curricular delivery) and therefore this recommendation was unrealistic to fit into a timetable that was already perceived as being squeezed. Most practitioners thought that external professionals could bring valuable insights and much-needed support, but ultimately for cross-curricular approaches to be sustained, school staff needed to carry out most of the delivery. The statement recommending that those delivering smoking prevention ought to be non-smokers also confused many of the practitioners, who did not understand its relevance to a practitioner's competences.

Finally, practitioners showed an interest in engaging parents in smoking prevention through the home-school relationship, but would have liked to have received more advice on the most effective ways to involve them.

6 RECOMMENDATION THREE

Recommendation 3 Peer-led interventions

Who is the target population?

Children and young people under the age of 19 who attend secondary school.

Who should take action?

- Head teachers, school governors, teachers and support staff in secondary schools and others who work with them. This includes: school nurses, counsellors, healthy school leads, PSHE education coordinators.
- Young people.

What action should they take?

- Secondary schools should consider offering peer-led interventions to support their smokefree policy. The interventions should link to relevant PSHE education programme activities and any other relevant adult-led interventions.
- They should ensure the interventions can be delivered both in class and informally, outside the classroom.
- Young people should nominate the peer leaders.
- Peer leaders should receive training outside school delivered by adults who are experts. They should be in regular contact with the peer leaders while they are performing this role.
- The interventions should be set up to ensure young people consider and, if necessary, challenge peer and family norms in relation to smoking, discuss the risks associated with it and the benefits of not smoking (environmental and economic).

See also 'School-based interventions on alcohol' (NICE public health guidance 7).

6.1 Findings

6.1.1 Practitioners thought that 'peer' interventions were a good idea, but wanted more information and clarity

Most practitioners thought that peer-led intervention was a good idea in principle, but many were unsure as to the best approaches, and did not feel that the recommendation met their needs for information and clarity. Nevertheless, at many focus groups there was an enthusiasm for peer approaches that suggested practitioners would welcome further engagement and clarity from NICE in this area.

Those practitioners that had implemented, or were in the process of implementing, 'peer' approaches were often enthusiastic about them, but thought there were many difficulties to overcome and still much to learn about what worked best. They thought the recommendation would be a useful tool to take to commissioners. In general, school staff were the most positive about peer approaches, with some finding them "*powerful and persuasive*". Many practitioners did not think that the term 'peer-led' sufficiently described the approaches that they were familiar with:

"I think to some extent, peer-led interventions could work, but I would like to see more pupil voice interventions....peer-led sounds like someone knows more than others [implies that one peer is more knowledgeable than those they are 'leading']"

LA drug coordinator

"We will be looking with our youth advocacy project... at a range of tobacco issues that look at tobacco industry tactics. Then they run a campaign"

Although the draft recommendation only addressed secondary schools, some practitioners wanted to know whether peer approaches could effectively be used in primary schools or for transition programmes (where an older student would mentor a primary school student, for instance).

The vast majority of practitioners thought that youth workers / youth services and Connexions were key groups that were missing from this recommendation. Many practitioners also wanted to know more about how to target peer-led interventions, so young people who could form effective relationships with their peers could be persuaded to take part (rather than relying on those young people who were the most keen). Some were also unsure of the meaning of young people 'nominating' the peer leaders. Some practitioners said that offering qualifications for young people taking part could help to implement peer-led approaches. Other practitioners wanted to know how to identify 'experts' who were expected to assist them with the programmes. In addition, some practitioners thought that 'outside the classroom' should have read 'outside the curriculum' because it would be difficult to use facilities outside school for training.

6.1.2 Practitioners thought that there were many barriers to implementing peer-led interventions, including a lack of evidence

Many practitioners – both health practitioners and schools staff – identified barriers to implementing peer-led interventions and other peer education approaches. The latter would include pupil voice, where pupils become partners in designing and delivering each stage of an intervention, but do not necessarily act as 'leaders' for other pupils. Some practitioners mentioned the social marketing campaign D-MYST in Liverpool or other local variants of this, as an alternative approach to 'peer-led' (see example box below).

Some practitioners felt that peer approaches were time consuming, labour intensive and expensive, especially where external training was required. The cost was an important barrier, as many schools would not be able to deliver peer-led approaches to smoking prevention without externally commissioned support:

"A commissioner would need to commission this to ensure there is dedicated support to help with this recommendation. Schools will not have the money themselves to do this themselves, other than at a very basic level"

Local tobacco control practitioner

Also, as pupils enter and leave school every year, an ongoing effort is needed to train and retrain others in order to sustain the intervention – and it was at this stage that peer approaches (not only those concerning smoking prevention) often failed to continue:

"I think it's a really good idea. I think the only thing it might fall down on is the support that the young people then get"

Local health practitioner

"Peer led education requires time and resources, and follow through and action which is important. It requires ongoing support – it's an ongoing process"

Local tobacco control practitioner

Many practitioners therefore thought that peer interventions would be difficult and wanted to read more in the recommendations about how to address the most important challenges:

"It's another tool in the box, but I don't think it should be singled out as a recommendation. It's not realistic"

Local health practitioner

As local tobacco control experts, many of the consultees were familiar with the evidence underlying peer-led interventions and expressed uncertainty about the availability of

evidence to support recommendation 3. There were many debates about this during the focus group consultations. Some health professionals stated that with the current evidence, commissioners would always prioritise those interventions with proven impacts, such as smoke free environments, where resources were scarce. Other practitioners said that it was important that the recommendation should emphasise the importance of learning from what has been seen to work already, and give guidance on 'how to build an evidence base' and monitor outcomes at a local level, so that practice could be 'evidence-informed' rather than 'evidence-based'. Some practitioners also suggested that in designing smoking prevention interventions, they could draw on evidence and lessons learned from implementing peer approaches elsewhere, for instance in social and emotional wellbeing. Other practitioners wanted the recommendation to mention specific programmes that have been evaluated (for example, the ASSIST programme).

An example of a young person-led social marketing campaign

D-MYST: Direct Movement by the Youth Smokefree Team

D-MYST is youth movement run by and for young people in Liverpool. The group aims to de-normalise and de-glamorise smoking amongst their peers through education, advocating smokefree work environments for everyone and speak out against and challenge the ways in which tobacco is marketed at young people through product placement, particularly in the media. D-MYST is a smokefree movement led by and for young people in Liverpool.

D-MYST provides young people with an opportunity to air their views and concerns on tobacco and to take action to de-normalise and de-glamorise smoking by:

- Raising the awareness of the dangers of tobacco and exposure to second-hand smoke amongst other young people
- Campaigning for and promoting smokefree environments for all
- Campaigning to get rid of smoking and the placement of tobacco products in the media that is predominantly targeted at young people.

[As the campaign describes:] *"Our campaign is pro smokefree, anti-tobacco and not anti-smoker".*

Liverpool PCT website

6.2 Discussion

Practitioners were generally welcoming of peer-led approaches, but there is a great deal of variation in current practice; confusion over the definition of a peer-led approach; and concerns over the barriers which need to be overcome for schools to deliver such interventions.

Practitioners also thought that key groups of professionals, such as youth workers, were missing from the recommendation. Alongside Healthy Schools coordinators, practitioners stated that they could provide the external support and resources that schools would need to implement peer approaches.

Perhaps most importantly, practitioners wanted to see more guidance on how to measure the effectiveness of peer-led interventions at the local level, so that an evidence base could be built up over time.

7 RECOMMENDATION FOUR

Recommendation 4 Training and development

Who is the target population?

Teachers, support staff and others with a remit for improving the health and wellbeing of children and young people in schools. This includes school nurses, counsellors, healthy school leads, PSHE coordinators and PSHE education coordinators.

Who should take action?

Head teachers, school governors, commissioners, teacher training bodies and providers of continuing professional development.

What action should they take?

- Provide training for all those working in schools to prevent the uptake of smoking by children and young people.
- Work with key partners (for example, the school nursing service, voluntary sector organisations and universities) to design and deliver training and smoking prevention interventions.

See also: 'Brief interventions and referral for smoking cessation' (NICE public health guidance 1); 'Behaviour change' (NICE public health guidance 6) and 'Smoking cessation services' (NICE public health guidance 10).

7.1 Findings

7.1.1 *Practitioners recognised the importance of training to make smoking prevention happen in schools, but there are many barriers*

All practitioners agreed on the importance of high quality training so that school staff and their partners could deliver, plan and evaluate interventions to prevent the uptake of smoking. In this respect, the idea of having a recommendation on training was welcomed and felt by practitioners to be necessary. Furthermore, the idea that all staff should be trained (to varying degrees) so they could be confident in dealing with smoking prevention and cessation was welcomed.

However, practitioners identified many barriers or negative perceptions of training that needed to be overcome: many thought that the draft recommendation would not have much impact because it did not give enough detail on who ought to receive what kind of training; who should lead its development and fund it; and how it could best be integrated or prioritised against many competing demands for continuing professional development (CPD) in schools. For instance, a specific remit for preventing the uptake of smoking or promoting good health in general is absent from most schools staff's job descriptions. These comments echoed the general perception of all the recommendations as a low priority:

"We can live without Healthy Schools, but we have to answer to Ofsted"

Headteacher

The main barriers identified by practitioners reflected wider concerns about what were perceived to be additional demands on CPD. Some health practitioners said that getting school staff to find the time to carry out training was the most important barrier (for example, where training on brief interventions for smoking cessation was made available for free, there was little take up from schools). Therefore some practitioners suggested that the best approach to training would be to target specific leads within each school, and make it their remit to 'cascade' the training to other staff within their setting. In addition such

efforts needed to be ongoing, in order to mitigate for staff turnover. Some practitioners said that this could be supported by online training.

Some health practitioners would have liked to have seen a reference to making training on smoking prevention compulsory for key groups of professionals; however many others said that such ideas were unrealistic (or that it would be better to set a target, for example, that 50% of staff must be trained). There were, however, other practitioners who argued that a more flexible approach would work better in engaging teachers.

The availability of external resources and training in smoking prevention was also highlighted by some practitioners as a key concern. While stop smoking services have implemented training programmes for brief interventions on smoking cessation, relatively few described providing specific training on how to prevent the uptake of smoking in schools. Similarly, some practitioners said that much of the current knowledge around smoking prevention is based on adult models that are not suitable for young people (hence there was a knowledge gap in how best to train professionals that work with young people). Quality assurance of CPD was another issue identified by some practitioners: they wanted to know how they could determine what constituted 'quality' training in their local area.

Other practitioners said that the main issue was not the lack of resources, but a lack of joined-up thinking among partner services:

"All the funding for training for the various workers involved comes from different places. School Nurses come from NHS budgets. Healthy Schools comes from education budgets, Teachers comes through individual schools budget"

Stop Smoking service coordinator

In this respect, they welcomed the references in the recommendation that aimed to encourage services and commissioners to work together, although they doubted that this alone would have an impact. They welcomed any initiatives that would help to get smoking prevention into core CPD, and some thought that the NHSP and local authorities needed to take this consideration on board.

The vast majority of practitioners stated that they would have like to have seen greater detail in the draft recommendation about how training needed to be tailored to the circumstances of each school, and the different methodologies that could be used with different target groups, or the skills that different types of professional might need:

"Training is important, I train a lot on tobacco for young people and it's very much about using different methodologies to use with young people...it needs to be more explicit and say that. It's very scientific and teachers can easily take this [fixed] approach which makes the subject dull and uninteresting for young people"

Local tobacco control practitioner

7.1.2 Practitioners thought that the recommendation ought to give more detail on the roles of key partners

In general, all practitioners were welcoming of the emphasis on agencies working together on training. Many practitioners stated that the Healthy Schools coordinators in local authorities or local tobacco control alliances ought to be emphasised as key contacts for schools, so that the latter had more encouragement to approach these external agencies for advice on training and resources that could help. In particular, the lack of a reference to local tobacco control alliances in this recommendation was felt to be detrimental to its potential impact.

Many practitioners also mentioned the PSHE CPD qualification and network as a key resource (see below). This covers how to deliver smoking, drugs and alcohol education and is highly commended, as it allowed for cross curricular and cross-level education. The link to raising the quality of PSHE delivery, and the profile of smoking prevention as part of that

agenda, was perceived as essential by many school staff, as teachers reported that stand-alone training would not be prioritised as it would be perceived as 'staff training' rather than training linked to improving students' learning.

Some practitioners found the reference to universities confusing: they thought it might be better to replace this term with 'teacher training institutions'.

The National PSHE CPD programme

This programme, jointly funded by the Department for Children, Schools and Families and the Department of Health, aims to improve confidence and effectiveness in the delivery of PSHE. The programme has been running for four years and to date 3,208 teachers and 604 community nurses have gained certification.

This programme of continuing professional development (CPD) has been developed to enable teachers, schools staff and other professionals to gain recognition of their experience in delivering personal, social and health education. The programme also allows professional to join a PSHE network.

Local authorities have differing criteria on which groups of professionals they fund in each year, but the overall idea is to allow teachers to mix with other professionals.

"The CPD network is brilliant – primary, secondary, special, Pupil Referral Units so cross fertilisation is great!"

"The programme has created mutual respect between teachers and nurses."

"There are very few opportunities for nurses and teachers to come together and talk about how they work with young people. By linking the two groups together, you get two sets of expertise and I think that's of real value."

DCSF Teachernet website (accessed 04/10/09)

7.2 Discussion

Among the vast majority of practitioners, the recommendation on training was welcomed, as well as the emphasis on partnership working. However the recommendation was generally not thought to address many of the key barriers faced by schools and other practitioners.

In particular, important CPD programmes or sources of external advice were not given a prominent enough position within the recommendation, nor did it mention the kind of methodologies required or the skills needed by different types of practitioner working in different settings or with differing age groups.

8 RECOMMENDATION FIVE

Recommendation 5 National context

Who is the target population?

Children and young people under the age of 19 who attend school.

Who should take action?

Government departments, school inspectorates, school governing bodies, children's trusts, school commissioners and local authorities (in particular, children and young people's services).

What action should they take?

- Ensure school-based interventions to prevent smoking and to encourage young people to quit are part of a community-wide tobacco control strategy, with clear outcome indicators and involving key partner organisations.
- Ensure schools deliver evidence-based smoking prevention interventions which are linked to their smokefree policy and consistent with regional and national tobacco control strategies. The interventions may be delivered as part of PSHE, PSHE education and work associated with Healthy Schools status, as well as being integrated within relevant curriculum subjects (for example, science).

See also 'Behaviour change' (NICE public health guidance 6).

8.1 Findings

8.1.1 ***Practitioners were welcoming of the emphasis on local partnerships, but wanted to know more detail, especially on outcome measures***

Most practitioners were very positive about recommendation 5, and found it to be relevant and relatively uncontroversial. Practitioners found the emphasis given to local partnerships to be "reassuring" and some thought that it would help to create an environment where schools would feel confident in working with external agencies to work on smoking prevention (and cessation). They also felt that national support was essential to help local areas build on social marketing campaigns aimed at preventing both children and adults from taking up smoking.

While the recommendation was mostly thought to be clear, many practitioners wanted to know more detail about 'clear outcome indicators' at a local level. While this part of the draft recommendation was welcomed – because currently, the outcomes of smoking prevention activities were not considered to be measured effectively – many practitioners wanted the recommendation to describe what was meant in greater detail. For instance, much of the current work commissioned by PCTs relates to smoking quitters and meeting targets for quitting smoking; while this will move towards an approach based on measuring prevalence, many practitioners wanted to know what an appropriate model for measuring change with children might look like. For instance, in relation to cessation, some practitioners said that young people need more attempts to quit smoking than adults. The term 'evidence-based' was also criticised by some practitioners, who questioned whether evidence-based interventions were available across each and all of the recommendations.

Some practitioners wanted the recommendation to mention how outcome indicators for smoking prevention among young people could be included in a Local Area Agreement (LAA), which brings together all local agencies around a set of joint targets.

Additionally, some practitioners thought that the term 'community-wide' was confusing and wanted more clarity on this (i.e. did it refer to a local authority area, the neighbourhood of a school?).

8.1.2 Practitioners thought that Ofsted and local tobacco control alliances are key agencies that should be included

As with previous recommendations, many practitioners thought that local tobacco control alliances and youth workers were important partners that were missing from 'who should take action'; and that Ofsted should have been mentioned by name:

"I'm amazed that a DH document [this recommendation] has ignored one of its key partners [local tobacco control alliances] in this whole process actually"

Local tobacco control coordinator

Ofsted was thought to be important because some practitioners reported that its practice on the importance of health promotion in schools varies from place to place – some schools are designated 'outstanding' but do not have National Healthy Schools status; other schools receive a clear message that they need to become 'healthy schools' in order to improve.

8.2 Discussion

Recommendation 5 was broadly welcomed by practitioners as giving an important push for agencies to work together more effectively at a local and national level to prioritise and improve smoking prevention in schools.

The main query of most practitioners was in relation to local outcome indicators, and they wanted to see more detail on what was expected, as they were concerned that current models did not allow sufficient room to prioritise prevention (alongside cessation). Some practitioners wanted to see a greater reference to key partners in this process, including local tobacco control alliances, Ofsted and LAAs, which could be an important incentive for agencies to cooperate.

9 CONCLUSIONS

9.1 Overview

This section provides the conclusions drawn from the fieldwork consultation with practitioners.

9.1.1 ***Practitioners were broadly welcoming of the recommendations on preventing the uptake of smoking among children and young people in school***

Most practitioners (both tobacco control professionals and others) thought that the recommendations were addressing an important, and sometimes neglected, area of work: that of preventing smoking among children and young people. In particular, many health practitioners thought that recommendations would be useful in making the case to commissioners for focusing more resources on primary prevention.

The general tone of the recommendations was felt by many practitioners to echo other national guidance from the National Healthy Schools Programme, and DCSF best practice guidance on PSHE (although the terminology used was not always common).

9.1.2 ***Practitioners were unsure that the draft recommendations would have much impact on schools and local agencies***

Coupled with the general welcome of the principles behind the draft recommendations, there was widespread scepticism as to whether they would have a great impact, particularly in schools. There were many reasons for this, not least because the recommendations were thought by many practitioners to lack 'teeth' in the same way as Ofsted inspections, because of a perceived lack of recognition within the recommendations that they could not apply to such a diverse range of settings with different local circumstances, or because of a lack of detailed, clear examples or instructions within the recommendations that could assist local agencies to implement them.

Practitioners identified many barriers to the take up of smoking prevention activities, including the attitudes of some senior managers in schools (recommendation 1); the patchy implementation of smokefree policies and National Healthy Schools status (recommendation 1); a lack of time, capacity or external support to take up peer-led interventions (recommendation 3) or CPD (recommendation 4); and poor understanding of how outcome measures could be used to measure the effectiveness of prevention with young people (recommendation 5).

Practitioners also stated that the recommendations were sometimes confusing on the relationship between prevention and cessation (recommendations 1, 2, and 5). A wider glossary of terms could be one way to clarify the document, particularly for non-specialists.

9.1.3 ***Practitioners wanted to see more examples and detail on how best to implement different aspects of the recommendations***

Particularly in relation to recommendations 2 and 3, many practitioners stated that they would have liked to have seen more detailed examples of how smoking prevention interventions could work in a school setting. These included examples of how effective smoke free policies could be enforced (recommendation 1); how smoking prevention could be integrated across the curriculum (recommendation 2); how parents could be engaged in interventions (recommendation 2); and examples of peer-led or other 'peer' approaches that could be attempted (recommendation 3).

Examples could also help to persuade a wider group of practitioners who do not have a sole remit for tobacco control to see the relevance of the recommendations to them. These examples could be embedded within the recommendations, or be included with the guidance as part as of the implementation process.

9.1.4 Practitioners felt that there was too much emphasis on the role of health professionals, and too little emphasis on empowering school staff

In general, the vast majority of practitioners felt that there was an overemphasis on the role of health and other external professionals throughout the draft recommendations. Many practitioners, including those in local tobacco control services, strongly believed that school nurses, doctors, or other external professionals would not want to engage deeply in the smoking prevention agenda because of other commitments (recommendation 2).

Most practitioners thought that trained schools staff, supported by outside agencies where needed, would be best placed to take forward smoking prevention in their own settings, whilst recognising the challenges that would bring – such as the need for training or persuading school leaders to integrate smoking prevention activities across the curriculum (recommendation 4).

9.1.5 There are important gaps in the coverage of ‘who should take action’ throughout the draft recommendations

Practitioners identified other gaps throughout the draft recommendations in the target audience for ‘who should take action’. The most commonly mentioned groups were:

- Local Tobacco Control Alliances (or equivalents);
- Healthy Schools Coordinators, Drug Education Coordinators and Local Authorities in general;
- Youth workers / youth services;
- Connexions;
- Ofsted (which was not mentioned by name in the draft recommendations);
- Trading Standards officers; and
- Children’s Centres (mainly in relation to primary schools, with whom they may share facilities)

Some practitioners also questioned whether the new NHS National Centre for Smoking Cessation and Training ought to be mentioned, and whether it would have a role in disseminating best practice in smoking prevention.

9.2 Summary of suggested changes

This section consolidates the main changes suggested by practitioners to the text.

Recommendation	Suggested changes to the text
General comments	<ul style="list-style-type: none"> ▪ Examples may be helpful as part of the recommendations or accompanying implementation material, to illustrate how the recommendations could be implemented ▪ Giving each recommendation a lead agency may help with implementation ▪ Consider a greater emphasis on the role that school staff can play in smoking prevention ▪ Clarify the relation between prevention and cessation in the text ▪ The meaning of specialist terms such as ‘tobacco control’ need to be explained for lay readers (for example using a glossary) ▪ Mention of Ofsted, youth workers and local tobacco control alliances (in particular) under ‘Who should take action’ ▪ Consider replacing ‘schools’ with ‘all educational settings’

	<ul style="list-style-type: none"> ▪ Consider replacing 'parents' with 'parents or carers' throughout ▪ The recommendations could be more flexible so that they take account of schools in different circumstances and working with different populations
Recommendation 1	<ul style="list-style-type: none"> ▪ Clarify how the full implementation of National Healthy Schools status links with the recommendation ▪ Schools need more guidance on what constitutes best practice in enforcing and communicating smoke free policies (bullet point 1) ▪ More information about how to consult and involve parents (and young people) in an organisation-wide approach to smoking prevention (bullet point 1) ▪ Some parts of the recommendation may need to be tailored so they are relevant to different settings (for instance PRUs or FE colleges)
Recommendation 2	<ul style="list-style-type: none"> ▪ Clarify 'counsellors' (who should take action) ▪ Consider a greater emphasis on cross-curricular smoking prevention activities e.g. by stating that smoking prevention can be included in lesson plans across many subjects (including greater explanation as to how this can be 'innovative' and 'interactive') (bullet point 1) ▪ Consider a greater emphasis on interventions delivered by school staff, supported by external professionals (bullet point 1) ▪ Consider removing the reference to 'staff who do not smoke who are confident...' and replace with 'staff who are competent' (bullet point 1) ▪ Consider giving more advice on how to engage with parents effectively (bullet point 3) ▪ Consider removing or clarifying the reference to 'Two or more sessions should be delivered over the course of an academic year...' (bullet point 4) ▪ Healthy Schools coordinators can assist with the production of resources and lesson plans (bullet point 5)
Recommendation 3	<ul style="list-style-type: none"> ▪ Clarify what is meant by 'peer-led interventions' (throughout) ▪ Consider giving more emphasis to how evidence on peer-led interventions can be gathered and evaluated at local level ▪ Consider giving greater emphasis to the role of youth workers, Connexions and other relevant external agencies in supporting and establishing such programmes (throughout) ▪ Clarify the terms '<i>nominate</i> the peer leaders' (bullet point 3) and 'outside school' (bullet point 4) ▪ Consider giving greater emphasis to ongoing support for young people involved in peer activities so that they are sustained (bullet point 4)
Recommendation 4	<ul style="list-style-type: none"> ▪ More detail on how to overcome the barriers to accessing high quality training would be helpful to practitioners (throughout) ▪ Give more emphasis on how frontline practitioners can be trained, including different methodologies that are appropriate to different settings (bullet point 1) ▪ Mention of how Healthy Schools coordinators and local tobacco control alliances can help develop appropriate training (bullet point 2)
Recommendation 5	<ul style="list-style-type: none"> ▪ Consider giving more information on what 'clear outcome indicators' might include (bullet point 1)

	<ul style="list-style-type: none">▪ Clarify 'community-wide' (bullet point 1)▪ Consider mentioning local tobacco control alliances and Ofsted by name, as well as Local Area Agreements (bullet point 2)
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ANNEX A – FINAL DISCUSSION GUIDE

Discussion Guide

5 m	Introduction
	<p>Introduce GHK, the facilitator (and scribe).</p> <p>Introduce NICE and why the focus group / interview is taking place:</p> <ul style="list-style-type: none"> - why the recommendations on school-based prevention of smoking are being produced - why the audience's input is important and valued <i>'this is your opportunity to influence national recommendations on the prevention of smoking...'</i>, and how it helps in the development of the final recommendations - explain if necessary how NICE's work links with the national agenda on promoting good health and wellbeing in schools, preventing children and young people from taking up smoking, and improving public health more generally - also be prepared to explain a little about the process by which the recommendations were developed and the evidence (explain if necessary that practitioners are being consulted on the recommendations only, rather than the whole draft guidance document) - explain that NICE wishes to learn from practitioners' / school staff's experience and current good practice ... <i>'we would like you to give examples throughout and draw our attention to any good practice that you feel that other practitioners could learn from...'</i> <p>Introduce consent and confidentiality</p> <ul style="list-style-type: none"> - focus groups will be recorded for audit purposes - all views will be treated in confidence and anonymised, neither individuals or their organisations will be named <p>Remind respondents that they must fill in the sign in sheet and give consent if they wish to take part (if they have not already done so)</p> <ul style="list-style-type: none"> - offer respondents the opportunity to ask questions at any point <p>Ask whether participants have read draft recommendations</p> <ul style="list-style-type: none"> - If most have not, explain that each recommendation will be introduced to the group as the focus group progresses (ensure that copies of individual recommendations are on hand)
5 m	Warm up
	<p>Respondents to introduce self, role and responsibilities</p> <p>Have you heard of NICE and what would you expect NICE's involvement in this area to achieve?</p> <p>What do you currently do to prevent the uptake of smoking in schools? How optimistic do you feel that smoking interventions in your school can be improved?</p> <ul style="list-style-type: none"> - prompt (for example) for work taking place in the context of Healthy Schools status; PSHE and promoting physical wellbeing using a whole-school approach; smokefree policies; awareness of national and local strategies; do they know how many people smoke in their school / local schools? <p>In relation to the following sections, ask respondents to think about examples when feeding back on the individual recommendations.</p>
20 m	Recommendation 1 Organisation-wide approaches
	[Be prepared to start with a general question and follow up respondents' feedback

	<p>throughout]</p> <p>Will this recommendation help you in your efforts to develop school-based approaches to smoking prevention and tobacco control?</p> <ul style="list-style-type: none"> - is this recommendation useful to you and colleagues in the services you work for? - what is your opinion on how effective it might be? - do you think that all the key issues in relation to organisation-wide approaches are covered? - what impact might it have on current of future services or policy? - what factors might influence its implementation or effectiveness? - what barriers might there be to implementing it? Are there any barriers to schools developing an organisation-wide / whole school smokefree policy? <p>To what extent do schools currently have organisation-wide smokefree policy which includes smoking prevention activities, and how might this recommendation impact on future practice in this area?</p> <p>What do these policies include and how are they communicated to those people using schools & their grounds. How are policies applied, and enforced? (N.B. it is illegal to smoke in school buildings)</p> <p>To what extent is preventing smoking among young people a priority for schools in your region / area (prompt for both primary and secondary schools, and within the context of wider health promotion activity)? Who is responsible for this work? (prompt for the role of different local agencies and how they work together on the ground)</p> <p>What support do schools need in order to create an environment that helps prevent the uptake of smoking? (prompt for key factors such as leadership, external support, access to specialist input from health or other services)</p> <p>How is help currently offered for staff and pupils to quit smoking? If so, how?</p> <p>Who should take action on this recommendation? (prompt for views on whether the 'who should take action' list is comprehensive)</p> <p>Is the recommendation easily understood and clearly worded?</p>
20 m	<p>Recommendation 2 Adult-led interventions</p>
	<p>Will this recommendation help you in your efforts to develop school-based approaches to smoking prevention and tobacco control?</p> <ul style="list-style-type: none"> - is this recommendation useful to you and colleagues in the services you work for? - what is your opinion on how effective it might be? - do you think that all the key issues in relation to adult-led interventions are covered? - what impact might it have on current service or policy? - what factors might influence its implementation or effectiveness? - what barriers might influence how this recommendation is implemented? What support might school staff and local practitioners working with them need to implement this recommendation? <p>What smoking prevention interventions are currently being delivered in schools and how do these differ from what the recommendations propose? (prompt for both primary and secondary). Now just focusing it on the ones that are adult led, what are their advantages / shortcomings?</p> <ul style="list-style-type: none"> - (prompt for: links to the curriculum and schemes of work in schools; links to healthy schools policies; parental and children's involvement in design and delivery of interventions; approaches to improving children and young people's decision making; provision of

	<p>information)</p> <p>How can interventions be sensitively delivered and in a non-judgemental way?</p> <p>Who should take action on this recommendation? (prompt for views on whether the 'who should take action' list is comprehensive)</p> <p>Is the recommendation easily understood and clearly worded?</p>
20 m	Recommendation 3 Peer-led interventions
	<p>Will this recommendation help you in your efforts to develop school-based approaches to smoking prevention and tobacco control?</p> <ul style="list-style-type: none"> - is this recommendation useful to you and colleagues in the services you work for? - what is your opinion on how effective it might be? - do you think that all the key issues in relation to peer-led interventions are covered? - what impact might it have on current service or policy? - what factors might influence its implementation or effectiveness? - what barriers might there be to implementing it? <p>Some schools use peer-led interventions or approaches to preventing the uptake of smoking in schools. Thinking of the interventions discussed previously as part of our earlier discussions, do any of the interventions you offer fit this description? (prompt for work undertaken in a wider health promotion context, and not only specific to smoking; prompt for both primary and secondary)</p> <p>If so, how are these delivered? Have the peer-led interventions that you have employed locally been effective? Why / why not? (prompt for local evidence)</p> <p>How difficult do you think it would be for young people be trained to challenge peer and family norms in relation to smoking, and raise awareness among their peers of the consequences of starting to smoke?</p> <p>Do you think this recommendation might change your current practice in relation to peer-led interventions?</p> <p>Who should take action on this recommendation? (prompt for views on whether the 'who should take action' list is comprehensive)</p> <p>Is the recommendation easily understood and clearly worded?</p>
15 m	Recommendation 4 Training and development
	<p>Will this recommendation help you in your efforts to develop school-based approaches to smoking prevention and tobacco control?</p> <ul style="list-style-type: none"> - is this recommendation useful to you and colleagues in the services you work for? - what is your opinion on how effective it might be? - do you think that all the key issues in relation to training and development are covered? - what impact might it have on current service or policy? - what factors might influence its implementation or effectiveness? - what barriers might there be to implementing it? <p>How are teachers, school staff and other practitioners working with children and young people currently trained in order to prevent the uptake of smoking? (prompt for both primary and secondary)</p> <p>What skills do all practitioners need to have (the widest possible range of professionals working with young people)? What ongoing development support, or</p>

	<p>continuous professional development, is required?</p> <p>What can be done to improve the quality of continuous professional development in preventing the uptake of smoking? What support do trainers need?</p> <p>Who should be take action on this recommendation? (prompt for views on whether the 'who should take action' list is comprehensive)</p> <p>Is the recommendation easily understood and clearly worded?</p>
15 m	Recommendation 5 National context
	<p>Will this recommendation help you in your efforts to develop school-based approaches to smoking prevention and tobacco control?</p> <ul style="list-style-type: none"> - is this recommendation useful to you and colleagues in the services you work for? - what is your opinion on how effective it might be? - do you think that all the key issues in relation to national context are covered? - what impact might it have on current service or policy? - what factors might influence its implementation or effectiveness? <p>What are the barriers to achieving this and how can they be overcome? (what conditions are needed?)</p> <p>How are school-based interventions (and activity) integrated into community-wide tobacco control strategies? (prompt for local and regional levels)</p> <p>Are there variations between different schools and local authorities that you are aware of? How can these variations in standards be addressed at a strategic level?</p> <p>How can progress in preventing smoking in schools be monitored? (prompt for governing bodies, local authorities, commissioners, Ofsted etc)</p> <p>Who should take action on of this recommendation? (prompt for views on whether the 'who should take action' list is comprehensive)</p> <p>Is the recommendation easily understood and clearly worded?</p>
15 m	General overview
	<p>How relevant are these recommendations to your day to day practice? Why?</p> <p>To what extent will these recommendations influence your practice or the practice of your organisation? Why?</p> <p>How practical is it to implement these recommendations overall? Is it realistic to implement them – are you confident that they would work?</p> <p>What are the biggest barriers likely to be? How can these be overcome?</p> <p>Do you think there are any gaps in the coverage of these recommendations? What are they?</p> <p>How clear is the wording of the recommendations? How easy are they to understand?</p> <p>Are you aware of any duplication or overlap with any existing guidance aimed at schools or professionals that work with schools?</p> <p>Are there any potential negative impacts of these recommendations? Why?</p> <p>Would you say that you have trust in these recommendations? Why?</p> <p>Did anything surprise you in relation to the content of the guidance?</p> <p>What could NICE do to raise awareness of the recommendations and communicate them to</p>

	<p>your professional group?</p> <p>Do you have any more comments about the recommendations?</p>
5 m	Close and thank respondents for their time
	<p>Remind participants to leave sign in sheets and consent forms behind and make sure these are collected at the exit.</p> <p>Give participants notice that we will send them a draft report at the start of October, for them to comment on if they wish to do so.</p> <p>Ensure that the event organiser is thanked and that any expenses for catering are collected.</p>

ANNEX B – CONSENT LETTER

GHK Consulting Ltd
67 Clerkenwell Road
EC1R 5BL
Tel: 020 7611 1100
Fax: 020 3368 6900
[insert researcher email]

[date]

Dear [insert name]

Re. NICE Fieldwork on School-based prevention of smoking

Consent to Participate in Research

[Insert location and address of focus group]

[Date and time of focus group / interview]

As part of the NICE fieldwork process, we are carrying out research in [insert name of region or LA area] in order to find out your views as a practitioner so that NICE's recommendations on School-based prevention of smoking are relevant, appropriate, useful, feasible and implementable. NICE is an independent organisation, created by central government, to be responsible for providing national guidance on promoting good health and preventing and treating ill health. The objective of NICE's public health guidance is to bring about social, economic, organisational, community and individual change to improve health and reduce inequalities in health. Consulting practitioners through fieldwork is an integral part of the process in which NICE guidance is produced

The interview / focus group [delete as appropriate] will last no longer than [time], but you have the right to end early if it is inconvenient or talk for longer.

If you agree to participate in the fieldwork, you will be asked to take part in an interview / focus group [delete as appropriate], which will be recorded by a digital recorder. The recordings will be handled in accordance with standard NICE research practice, and transcripts will be held securely and destroyed after five years, according to NICE procedures and requirements.

In early October, following the consultation, we will circulate the draft report to all participants to ensure factual accuracy. There is no obligation to comment at that stage unless you wish to raise specific issues.

The final research report produced as a result of the analysis will be used by NICE to produce a final version of its recommendations to practitioners, and the research report may be published on the NICE website.

Your true identity will not at any point be revealed in the research or any final products and although GHK may quote you, all comments will be confidential and will not be identifiable to yourself or your organisations within the research report.

GHK will provide you with a copy of the draft NICE guidance closer to the interview / focus group.

If you have any questions regarding this research or your rights as a research subject, you can contact Aidan Moss (Project Manager) at aidan.moss@ghkint.com or by telephone 020 7611 1100.

Your signature indicates that you have read and understood the information provided above, that you willingly agree to participate, that you understand your right to discontinue participation without penalty, and that you have received a copy of this form.

Printed Name _____ Organisation _____

Signature _____ Today's Date _____

Phone Number _____ Email _____

Please fax or post this form to the address given above.

ANNEX C – PRIOR READING TASK

Please read through the draft recommendations attached. NICE are concerned about how useful, relevant and appropriate these recommendations are for a wide variety of professional groups working with young people, as well as the barriers that might prevent them from being implemented.

The following task will help you to structure your feedback. We would be grateful if you could complete this and bring it with you to the meeting.

Which of the recommendations do you think are most useful to you and why?
Do you think these recommendations will change the way that you, your organisation or professional group deliver services? Why / why not?
Do you think that the recommendations are practical and realistic? Why / why not?
Do you think there are any gaps in these recommendations? What needs to be added to them to make them comprehensive?
Are you aware of any good practice in your local area in school-based approaches to the prevention of smoking that you would like to draw to NICE's attention?

ANNEX D – SIGN IN SHEETS

Sign in sheet – Practitioners

Please fill in the following sheet in order that we can know a little more about the background of people attending today:

Your name: _____

Your role: _____

Your organisation: _____

Email: _____

Q1. Please tick the following boxes if your main job role includes a responsibility for working with any of the following groups:

Young people from disadvantaged households	
Children from Black and Minority Ethnic backgrounds (BME)	
Children with disabilities	
Looked after children	
Children with special educational needs	
Children with mental health conditions	
I work with all children (no specific groups)	
None of the above	

Q2. Please tell us if your role covers the following responsibilities (**choose ONE only**):

Senior management or leadership role, or a role that mainly involves coordinating other services	
Practitioner – tobacco control or other public health specialist	
Practitioner – mainly looking after young people's physical health	
Practitioner – mainly looking after emotional or mental health / well being	
Practitioner – mainly delivering positive activities for young people	
Practitioner – mainly working with parents	
Advice and guidance services to young people	
Oversight or quality assurance role	
Other not mentioned above (please give brief description of your role below)	

Q3. Do you have a particular responsibility for the prevention of smoking in schools?

Yes		No	
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Sign in sheet – Schools Staff

Please fill in the following sheet in order that we can know a little more about the background of people attending today:

Your name: _____

Your role: _____

Your organisation: _____

Email: _____

Q1. Please tick the following boxes if your main job role includes a responsibility for working with any of the following groups:

Young people from disadvantaged households	
Children from Black and Minority Ethnic backgrounds (BME)	
Children with disabilities	
Looked after children	
Children with special educational needs	
Children with mental health conditions	
I work with all children (no specific groups)	
None of the above	

Q2. Please tell us the type of school that you work in:

Secondary school – under LA supervision	
Secondary school – non-maintained (e.g. Academy, CTC)	
Primary school	
Pupil Referral Unit (PRU)	

Q3 Please tick the age groups that you work with:

Foundation Stage	
Key Stage 1	
Key Stage 2	
Key Stage 3	
Key Stage 4	
Tertiary education (16-19 year olds)	

Q4. Do you have a particular responsibility for the prevention of smoking in your school?

Yes		No	
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ANNEX E – EQUALITIES MONITORING FORM AND DATA

E1 Equalities Monitoring Form

What is your ethnic group?

White - British	
White – Any Other White background	
Mixed - White and Black Caribbean	
Mixed - White and Black African	
Mixed - White and Asian	
Mixed - Any Other Mixed background	
Black or Black British - Caribbean	
Black or Black British – African	
Black or Black British – Other Black background	
Asian or Asian British - Indian	
Asian or Asian British - Pakistani	
Asian or Asian British - Bangladeshi	
Asian or Asian British – Any Other Asian background	
Chinese or other ethnic group - Chinese	
Chinese or other ethnic group – Any Other ethnic group	

Do you consider yourself to have a disability?

Yes	
No	

E2 Equalities monitoring data for Fieldwork on Smoking Prevention in Schools

This table gives a breakdown of the participants' ethnic groups and disability status.

Ethnic group

White - British	111
White – Any Other White background	5
Mixed - White and Black Caribbean	0
Mixed - White and Black African	1
Mixed - White and Asian	0
Mixed - Any Other Mixed background	0
Black or Black British - Caribbean	1
Black or Black British – African	3
Black or Black British – Other Black background	0
Asian or Asian British - Indian	3
Asian or Asian British - Pakistani	1
Asian or Asian British - Bangladeshi	0
Asian or Asian British – Any Other Asian background	1
Chinese or other ethnic group - Chinese	1
Chinese or other ethnic group – Any Other ethnic group	0
Declined to answer	10
<u>TOTAL</u>	<u>137</u>

Disability status

Yes	125
No	2
Declined to answer	10
<u>TOTAL</u>	<u>137</u>