Executive Summary

Coventry and Warwickshire Smoking in Pregnancy Review

Table of Contents

1. Introduction **2**

1.1 The costs of smoking in pregnancy 2

1.2 Barriers to reducing smoking in pregnancy 3

1.3 National targets to reduce smoking in pregnancy 3

1.4 National guidance 4

1.5 Evidence for interventions to reduce smoking in pregnancy 4

2. Review structure **5**

3. Review Findings: Data Analysis **6**

3.1 Epidemiology of Smoking in Pregnancy Across Coventry and Warwickshire 6

3.2 Access to Specialist Stop Smoking Support 9

3.3 Smoking at Time of Delivery 10

3.4 Birth Outcomes for Smokers vs Non-smokers 11

4. Review Findings: Case Note Audits **12**

5. Review Findings: Staff Engagement **13**

6. Review Findings: Compliance with Guidance **15**

7. What Needs to Change **16**

8. Review Recommendations **18**

Link to the full report **21**

Appendix 1 Estimating the Costs Associated with Smoking in Pregnancy **22**

Appendix 2 Overview of Current Services **25**

Appendix 3 Membership of Smoking in Pregnancy Task and Finish Group **28**

Appendix 4 Warwickshire JSNA Maps **29**

Appendix 5 Details by District and Borough Populations and JSNA Areas **32**

Appendix 6 Key Findings: National Data and Maternity Data Analysis **35**

Appendix 7 Key Findings: Access to SSiP Services and Smoking Outcome **37**

Appendix 8 Key Findings: Smoking at 36 weeks and SATOD **40**

Appendix 9 Key Findings: Case Note Audits **45**

Appendix 10 Key Findings: Staff Engagement **48**

Appendix 11 Overview of Compliance with NICE Recommendations: PH 26 **52**

Appendix 12 Smoking Cessation/Smokefree Policies in NHS Trusts – PH48 Standards **57**

1. Introduction

This summary provides an overview of the findings of a Smoking in Pregnancy Review undertaken across Coventry and Warwickshire. The review was commissioned by the Local Maternity System (LMS) Board in order to provide a detailed picture of the women who smoke during pregnancy, the support they currently receive and to identify any further measures that could be taken to enable them to stop smoking.

Smoking in pregnancy and exposure to second-hand smoke are associated with significant health risks to both mother and baby – including preterm birth, low birthweight (LBW) and stillbirth, as shown in Table 1.

Table 1. Smoking in Pregnancy Impacts of Smoking on Birth Outcomes

	Maternal Smoking	Second-hand Smoke Exposure
Low birth weight	Average 250g lighter	Average 30-40g lighter
Stillbirth	Double the likelihood	Increased risk
Miscarriage	24%-30% more likely	Possible increase
Preterm birth	27% more likely	Increased risk
Heart defects	50% more likely	Increased risk
Sudden Infant Death	3 times more likely	45% more likely

Source: Action on Smoking and Health. Smoking in pregnancy challenge group. Review of the Challenge 2018.

The impact of smoking in pregnancy reaches into childhood and beyond, continuing into the adult life of the child born to a smoker. The child born to a smoker is over twice as likely to become an adult smoker and as such smoking drives health inequalities, reinforcing disadvantage across generations.

1.1 The costs of smoking in pregnancy

Smoking in pregnancy drives up the cost of maternity care, the cost of caring for neonates and the cost of supporting children born to smokers, as they often have additional education and support needs. The costs of providing just the neonatal intensive care (NIC) required by babies born prematurely because of smoking each year across Coventry and Warwickshire is estimated to be between £1m and £1.6m. Further to this the wider societal costs of supporting this cohort of babies between birth

until 18 years of age has been estimated to be £3.4m. Details of the cost estimates associated with smoking related prematurity are shown in appendix 1.

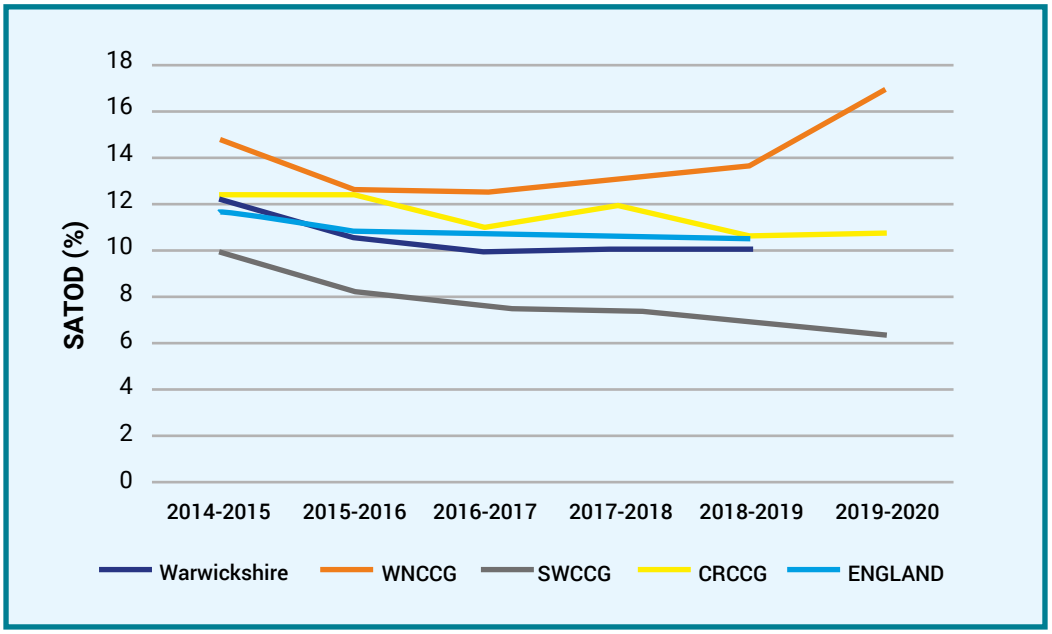
1.2 Barriers to reducing smoking in pregnancy

Given the significant health and cost consequences associated with smoking in pregnancy, reducing it has been a priority over many years. Evidence shows that smoking related risks are significantly reduced if smoking cessation is achieved by 15 weeks' gestation. However, women who smoke face many barriers to quitting including challenging life circumstances, household smoking and living within communities where smoking is 'the norm'. Professionals also face barriers in encouraging smoking cessation including a lack of a training and concerns over their relationship with the pregnant smoker.

1.3 National targets to reduce smoking in pregnancy

The prevalence of smoking in pregnancy is estimated from Smoking at Time of Delivery (SATOD) data that is routinely collected by maternity services. The current national target is to reduce SATOD to 6% by 2022, however, this will be unachievable across Coventry and Warwickshire given current performance, as shown in Figure 1.

Figure 1. Smoking at Time of Delivery 2014/15 to 2019/20



NB: Coventry line not visible as the CRCCG line overlies it (values are the same)

Figure 1 illustrates the wide geographic variability in SATOD and highlights the worsening performance for the WNCCG population where SATOD is increasing counter to the national downward trend. CRCCG rates also appear to be stagnating rather than decreasing.

Failure to reach the SATOD target will undermine other national ambitions, including targets to halve the rates of stillbirths, neonatal and maternal deaths and to reduce the rate of preterm births. However, if the prevalence of smoking among the general population was reduced to 12%, as set out in the national Tobacco Control Strategy, more women would enter pregnancy smokefree making the SATOD target more achievable.

1.4 National guidance

NICE published guidance to support a reduction in smoking in pregnancy in 2010 and more recently their recommendations have been endorsed through NHS 'Saving Babies Lives' (SBL) guidance. This guidance recognises that all professionals, but in particular midwives, should be trained in delivering Very Brief Advice (VBA) and that at maternity booking all women should undergo Carbon Monoxide (CO) testing to help identify smokers. All smokers should then be referred on an 'opt-out' basis to specialist smoking cessation services for support in quitting.

1.5 Evidence for interventions to reduce smoking in pregnancy

There is evidence that interventions to reduce smoking in pregnancy are both cost saving and cost effective[36]. A Cochrane review provides moderate to high quality evidence that psychosocial interventions increased the proportion of women who stopped smoking by 35%, and reduced admissions to NIC by 22%[30].

Further to this, a 'whole system' approach to improving smoking cessation rates (BabyClear) has demonstrated a two-fold increase in quitters[21]. The evidence indicates that success is more likely where there is:

- A maternity services clinical lead dedicated to reducing smoking
- High quality staff training to deliver VBA
- Close partnership working and effective pathways to smoking cessation support

A recent large-scale UK study[39] has also provided evidence that clinic-based support was associated with increased cessation rates and another study[23] has demonstrated increased quit rates where specialist support is provided by maternity support workers and other maternity staff. This evidence should be useful in informing future models of service provision.

There is strong evidence for other interventions such as financial incentives combined with behavioural support being effective particularly for those in low socioeconomic groups, who typically engage less with stop smoking services[25]. In addition, there is a large-scale study underway assessing the impact of e-cigarettes on cessation rates and pregnancy outcomes[35]. Collectively these, together with emerging evidence around the value of self-help support[29] should inform future strategies to reduce smoking in pregnancy.

2. Review Structure

Reducing smoking in pregnancy is a key objective for a wide range of services and agencies. Key services involved across Coventry and Warwickshire include:

- Three maternity services providers; GEH, SWFT and UHCW commissioned by CCGs
- Two Family Nurse Partnership (FNP), two Health Visitor and two Specialist Smoking in Pregnancy (SSiP) services that are commissioned by the Public Health departments

Primary care services play a limited role in maternity care, essentially having an opportunistic role in advising on smoking in pregnancy. An overview of the contribution of current services is provided in appendix 2.

The approach to the review was agreed through the Smoking in Pregnancy Task and Finish group, whose membership is shown in appendix 3. The review included:

- Analysis of relevant routinely available national data
- Analysis of electronic data from maternity and SSiP services for the period 2016/17 through to 2018/19
- Case note reviews by maternity, Health Visitor and FNP services to assess compliance with NICE, SBL and other relevant guidance
- Staff engagement through surveys and discussion groups involving maternity services, Health Visitor and FNP services, General Practice staff and staff working in children's centres/family hubs
- Corporate assessment outlining the compliance of key organisations in terms of meeting NICE recommendations as defined in the CleaR smoking in pregnancy assessment framework and in SBL guidance
- A limited review of the evidence in relation to helping pregnant smokers to quit
- The addition of aggregate data from Trusts demonstrating the impact of smoking in pregnancy on key outcomes – stillbirths, preterm births and LBW babies

3. Review Findings: Data Analysis

The review has provided a detailed picture of both smoking at booking and smoking at time of delivery through analysis of national and local data.

3.1 Epidemiology of smoking in pregnancy across Coventry and Warwickshire

It is estimated that across Coventry and Warwickshire there are approximately 1550 smokers at booking each year although not all smokers are initially identified.

It is clear that smoking is more common among younger women from more deprived areas and there is wide geographic variability in smoking rates, for example:

- At LSOA level (small geographical areas) the proportion of smokers ranges between 0% to 37% of all maternity bookings
- In total across Coventry and Warwickshire there are 37 LSOAs with a proportion of smokers at booking greater then 25%

The higher risk communities are in Coventry and North Warwickshire, with smoking at booking in 2018/19 ranging from 9% for the SWCCG population, to 13% for the CRCCG and 17% for WNCCG population.

Figures 2 and 3 illustrate how the rate of smoking at booking differs by JSNA populations across Coventry (Figure 2) and Warwickshire (Figure 3). Appendix 4 includes more detailed maps for the Warwickshire population and appendix 5 includes additional detail of smoking status at a JSNA level, illustrating differences in both smoking rates and in the proportion of women for whom smoking status is unknown at booking. The main report provides detail of smoking at booking for LSOA populations.

Smokers at booking are more likely to have other health problems, with 55% of smokers having one or more co-morbidity compared to 37% of non-smokers. Twenty-six percent of smokers are recorded as having a mental illness as compared to 13% of non-smokers and 13% are identified as having complex social care needs compared to 7% of non-smokers. Appendix 5 shows details, including co-morbidities of women at booking, for District and Borough populations.

Further details of the key findings from national data and from the analysis of local maternity booking data are included in appendix 6.

Figure 2. Smoking at time of booking in Coventry, 2016/17 to 2018/19

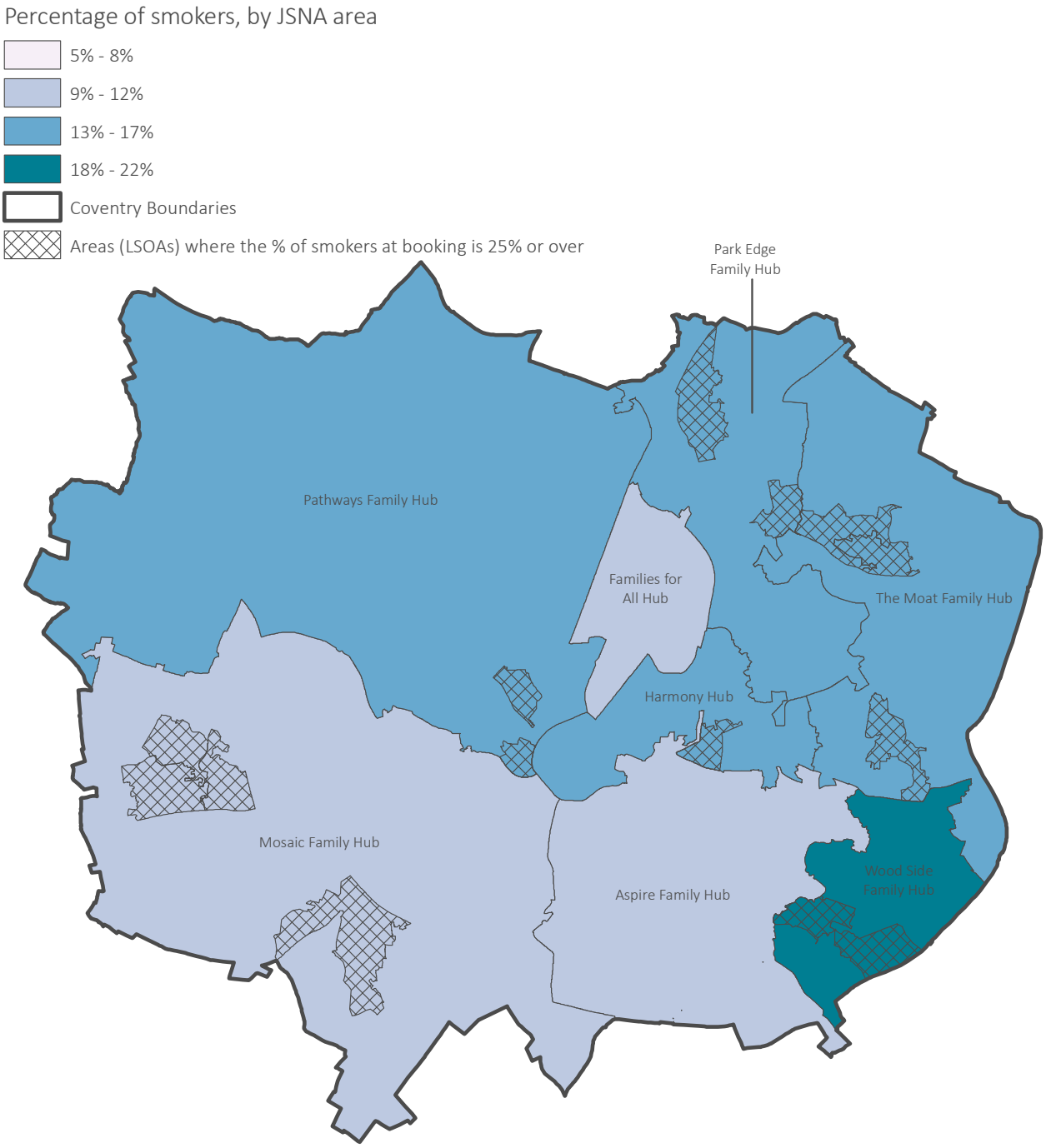
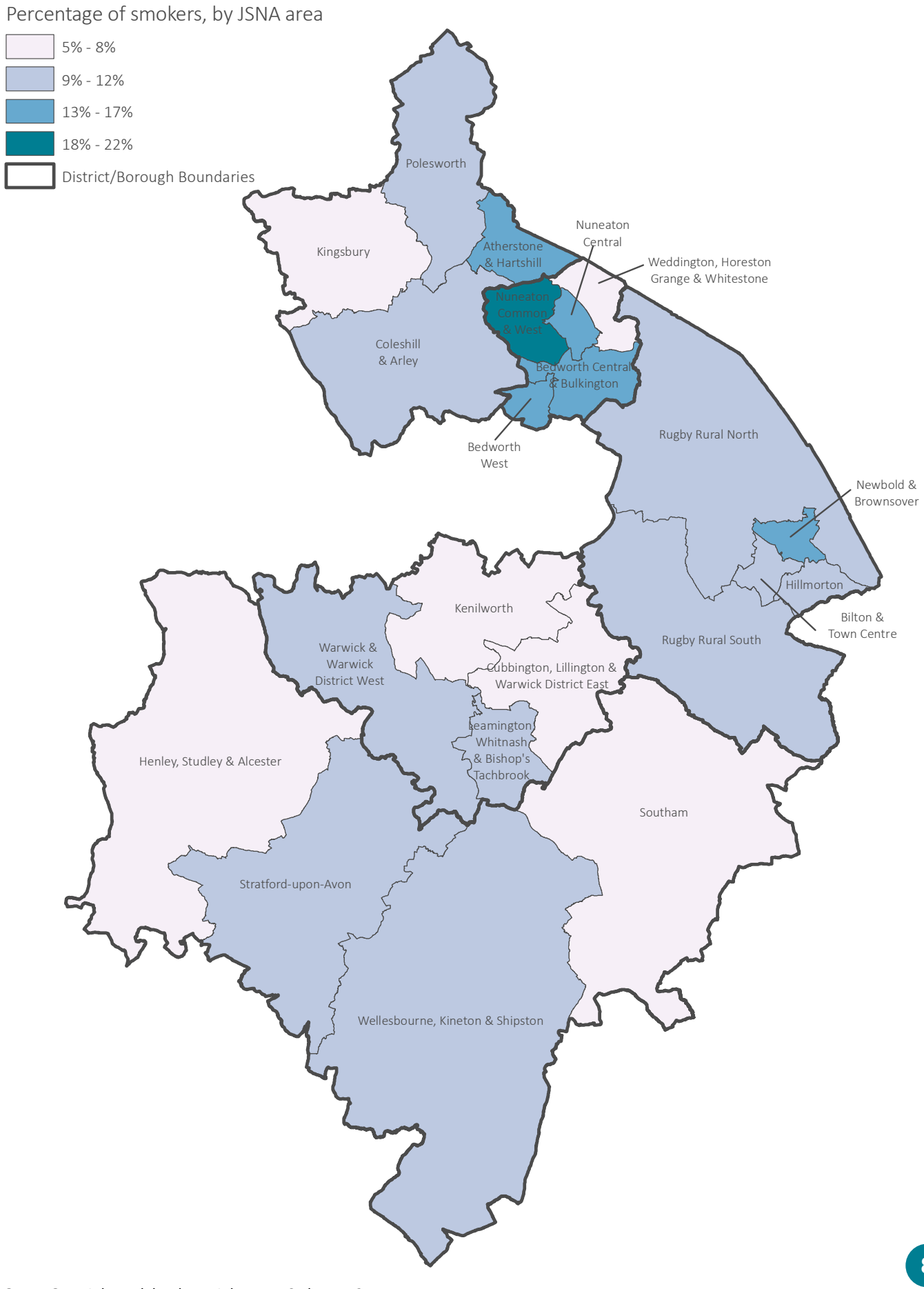


Figure 3. Smoking at time of booking in Warwickshire, 2016/17 to 2018/19

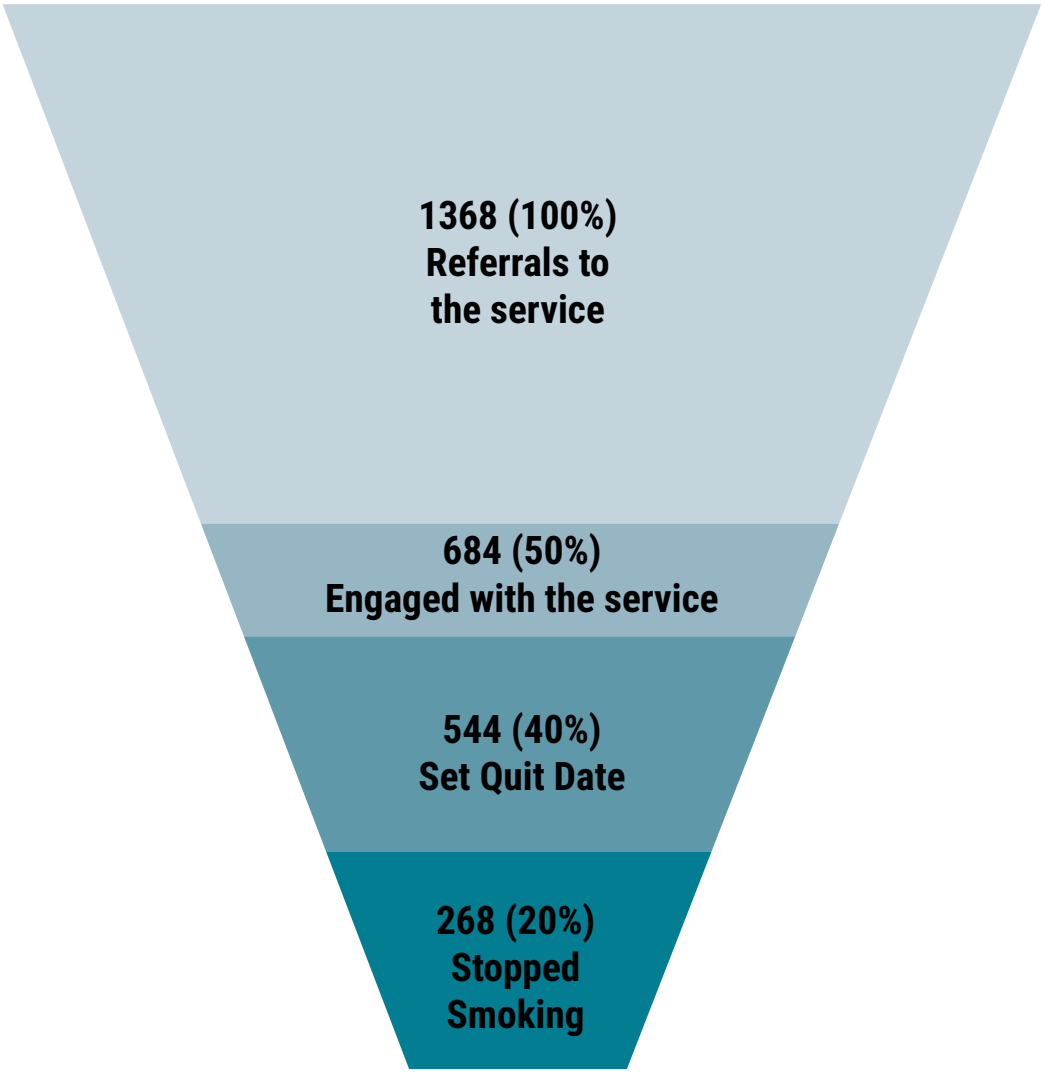


3.2 Access to specialist stop smoking support

There is evidence to indicate that a high proportion of smokers identified at booking are being referred for specialist support. This is particularly true for 2018/19 indicating an improving picture. Each year on average there are 686 referrals to the Coventry smoking service (compared to an average of 645 smokers identified at booking) and 714 to the Warwickshire service (compared to an average of 723 smokers at booking).

The numbers who stop smoking each year (ie. achieve 'a 4-week quit') with SSiP support ranges from 117 to 124 in Warwickshire (16% to 17% of all referrals) and from 135 to 157 in Coventry (20% to 24% of all referrals). The average is 148 quitters per annum for Coventry and an average of 120 quitters each year for Warwickshire. Figure 4 illustrates the pattern of 'drop off' in numbers from referral to smoking quitters across Coventry and Warwickshire.

Figure 4. Smoking Service Referrals, Engagement and Quitters



It is estimated that approximately 73% of women who quit smoking between booking and delivery could be attributed to access to SSiP services. However, there is evidence of considerable delay between maternity booking and access to face to face counselling and support through the provision of Nicotine Replacement Therapy (NRT). The service model includes a number of inefficiencies including a good deal of time spent by specialist advisers in attempting to contact women. Following this, women can face challenges in sourcing NRT as not all pharmacies stock all products. These difficulties are likely to undermine quit attempts.

Further details relating to access to SSiP services and outcomes for different population groups is included in appendix 6. Amongst other things, this illustrates some variation in outcome; for example, just 11% of those referred to SSiP from North Warwickshire achieve a 4-week quit, compared to 23% of referrals from Stratford upon Avon.

3.3 Smoking at time of delivery

Of all of the smokers at booking it is estimated that approximately 365 quit each year, 24% of the total smokers. There is some evidence that those who do not quit book for their maternity care later, are less ethnically diverse and tend to have more co-morbidities. Over recent years there has on average been 1000 smokers at time of delivery (SATOD) across Coventry and Warwickshire. The review findings confirm sustained and comparatively high smoking rates in North Warwickshire.

Further details about the smokers at delivery and the characteristics of those who quit compared to those who do not are included in appendix 8. Alongside other findings, this shows how smoking is related to other maternity outcomes, for example 72% of women who do not smoke were recorded as breastfeeding as compared to just 41% of smokers.

Appendix 8 also includes details of SATOD for District and Borough and JSNA populations. Across Districts and Boroughs, year on year the Nuneaton and Bedworth population has the highest SATOD rates. For JSNA populations over the 3-year period in Warwickshire the proportion of women smoking at time of delivery ranges from 3% in Kenilworth up to 19% in the Nuneaton Common and West JSNA area. In Coventry SATOD ranges from 8% for the Aspire and Mosaic Family Hub populations, up to 18% for Wood Side Family Hub area.

3.4 Birth outcomes for smokers vs non-smokers

In order to enable an estimate of the impact of smoking on birth outcomes UHCW and SWFT provided aggregated data for a total of 30,005 births. The data was separate to the main review data and included smoking status at delivery, birth outcome (stillbirth or live birth) gestation at birth and birthweight. The key findings are:

- The stillbirth rate for smokers was 6.1 per 1,000 births, compared to a rate of 3.2 among non-smokers
- The proportion of preterm births was 15% among smokers, compared to 8% among non-smokers
- The proportion of LBW babies was 16% for smokers, compared to 7% among non-smokers

These findings confirm national evidence in terms of the impacts of smoking in pregnancy and why it must be reduced if lives are to be saved.

4. Review Findings: Case Note Audits

The case note audits were undertaken by staff to assess compliance with NICE and other related guidance. Audits were undertaken by the maternity and health visiting services through reviewing the records of 300 smokers identified at booking and the FNP services each reviewed the records of 50 consecutive clients referred for support to either the Coventry or the Warwickshire service.

The key findings from each of the reviews is enclosed in appendix 9, but in summary whilst the audits confirmed compliance with a number of standards, they also demonstrated scope for improvement. For example, outside of SWFT, at any appointment that followed booking there was little if any enquiry about household smokers or signposting to support for household members who smoke.

5. Review Findings: Staff Engagement

There were 580 staff survey responses and 228 staff involved in discussion groups across different service areas. Through this engagement the following key findings emerged:

- A high proportion of staff believe that smoking in pregnancy is very important, but a relatively small proportion see it as important to their specific role
- Services and professionals tend to see maternity services as being responsible for tackling smoking in pregnancy, but within maternity services the responsibility is seen to lie with community midwives rather than with any other clinicians or midwives working in other clinical areas

In relation to training the following points were identified:

- A high proportion of staff report that they do not feel adequately trained – particularly in relation to delivering VBA
- 25% of maternity staff report not having been trained in relation to smoking in pregnancy and in particular junior doctors (64%), General Practice staff (57%) and sonographers (67%) report a lack of specific training
- 27% of maternity staff expressed a lack of confidence in tackling smoking in pregnancy and 31% of General Practice staff reported having insufficient knowledge around smoking in pregnancy
- The vast majority of staff feel inadequately trained in relation to advising on NRT and there is widespread misunderstanding about e-cigarettes

Staff from different service areas/professional groups identified similar barriers in tacking smoking in pregnancy including time constraints, lack of training, lack of knowledge about the referral process and concern about their ongoing relationship with the woman. These findings mirror national evidence in relation to barriers.

Through discussion groups staff identified specific areas for change including:

- More investment for socially deprived areas – specifically areas in Coventry and North Warwickshire
- The need for a revised model of SSiP provision with 'in maternity clinic support' and more immediate access to NRT

- The need to work with partners/families in reducing smoking given the strong influence of household smoking on likely cessation
- The need to 'cohort' smokers within maternity services so that scarce specialist resources can be targeted on those who most need support

Staff also suggested a number of areas for improvement including:

- Clarifying staff roles and responsibilities and raising awareness of the SSiP service and the referral process
- Expanding the role of maternity support workers so they can provide specialist support to smokers
- Increasing capacity to deliver the Risk Perception Intervention (RPI) so access is equitable across all Trusts

Children centre/family hub staff identified opportunities where more support could be provided, for example through integrating support for smoking cessation/relapse prevention in baby clinics and some GP practice staff highlighted opportunities for pre-conception advice, such as during contraception related consultations and when undertaking cervical screening for example. More details of the findings from the staff engagement processes are included in appendix 10.

6. Review Findings: Compliance with Guidance

Analysis of the electronic data, the case note audits and the staff surveys collectively provided evidence to enable an assessment of compliance with NICE and other relevant guidance. The assessment is enclosed as appendices 10 and 11, but in relation to maternity services key findings include:

- Trusts in general are not fully implementing NICE guidance (PH48) aimed at supporting all smokers to quit, although more progress is being made at UHCW
- There is evidence of improving, but variable implementation of guidance in relation to smoking in pregnancy by maternity staff
- An increasing proportion of women are CO tested at booking – 82% across all Trusts in 2018/19
- Maternity case note audits showed that 60% of women had a documented 36 week CO measurement at UHCW and GEH, as did 72% of women at SWFT
- The proportion of smokers at booking who had a repeat CO measurement (prior to 36 weeks) ranged from 29% of women at UHCW, 53% at GEH up to 94% at SWFT
- Not all smokers are being identified at booking, but of those that are, a high proportion are being referred for specialist support
- Generally, the evidence indicates that SWFT demonstrates higher performance in terms of complying with guidance on a more consistent basis

For Health Visitor and FNP services there is evidence that smoking is addressed during initial visits and that advice in relation to household smoking is provided, although relatively few people are sign-posted to smoking cessation support.

There is evidence that GPs and others in primary care make relatively few referrals and there is a generally low level of awareness about the specialist support available for pregnant smokers.

Thirty percent of survey respondents from children's centres/family hubs reported that they did not use brief advice opportunities to raise the issue of smoking in pregnancy. However, this is likely to be linked to the fact that 60% of the staff reported never having received relevant training.

7. What Needs to Change

It is clear that the national 6% SATOD target will not be met for some years across Coventry and Warwickshire unless there is significant change. Failure to reduce smoking in pregnancy will mean that targets to reduce stillbirths and preterm deliveries are also likely to be unattainable. In order to secure the necessary improvements, the following actions are required:

- An increased system-wide focus on working with higher risk communities to reduce population smoking prevalence, particularly among young people. In this way more women would enter pregnancy smokefree, partners would be less likely to smoke and social norms could change such that smoking in pregnancy is recognised as having a damaging impact
- A greater focus on pre-conception advice and smoking cessation support, with a family/household focus, so women are more supported in their quit attempts
- Increased ownership of smoking in pregnancy across all professional groups/services and across all staff groups in all maternity service settings, so there is increased consistency in messaging in relation to the risks of smoking in pregnancy and the importance of quitting
- Mechanisms to 'cohort' smokers within maternity services need to be introduced so that specialist support and delivery of the Risk Perception Intervention can be provided efficiently
- A 'levelling up' of resources and support such that the systems and processes adopted in SWFT (where there is some dedicated Public Health and smoking cessation midwife time, and where there is a larger budget per birth) can be emulated in UHCW and GEH
- Increase in antenatal notifications from maternity staff to health visiting and FNP services, to include details of smoking status, SSiP referral and take-up
- Improved training for staff groups, but in particular improved training for midwives enabling them to be more confident in engaging women in challenging conversations
- A revised model of specialist support is required whereby women have more rapid access to specialist advice and NRT to enable their quit attempt

It is recognised that additional resources will be required to address the issues identified above together with the recommendations detailed below. It is also acknowledged that there are many competing priorities

for investment. However, in part, the anticipated investment in smoking cessation identified in the NHS Long Term Plan should offer some opportunity to secure improvements in the way that smoking in pregnancy is managed.

Whilst this investment could make a valuable contribution the expectation is that more substantial investment would be required across the system to secure meaningful and sustainable change. If such change was achieved, it would generate very welcome longer-term system-wide savings and would in turn reduce the morbidity and mortality burden associated with smoking in pregnancy.

8. Review Recommendations

These recommendations are informed by the review findings and reflect national evidence in terms of what works in reducing smoking in pregnancy. The recommendations are structured as follows:

- Key recommendations that provide a high-level summary of the priorities for change.
- Specific recommendation relating to identified stakeholders/ services – outlining their contribution to the key recommendations, as detailed below.

Key Recommendations

1. Develop an innovative and comprehensive Coventry and Warwickshire wide Tobacco Control Plan, that includes a focus on targeted activity with 'higher risk' communities. The plan should seek to promote smokefree homes and communities drawing on the contribution of a wide range of services and partner agencies. It should build on evidence of what works in reducing smoking in the general population and among higher risk groups.
2. Implementation of a systematic approach to smoking cessation within maternity services and across the local maternity system based on the evidence based 'BabyClear' approach – including dedicated leadership within maternity services, enhanced staff training and revised pathways including delivery of the Risk Perception Intervention.
3. Co-produce a new model for Specialist Smoking in Pregnancy Services, providing more rapid 'in clinic' access to specialist advice and NRT.

Specific Recommendations

Relevant to LMS/System

1. In the context of wider LMS opportunities to address health inequalities and inequities in service provision strengthen the LMS role in relation to smoking in pregnancy promoting consistency across Trusts and the sharing of expertise. In particular to:
    - Constitute a smoking in pregnancy steering group with accountability to the LMS Board and through to the wider Health and Care Partnership Board

- With Public Health support, lead development of a revised smoking in pregnancy service model (reflecting implementation of a 'BabyClear' approach)
- The new model needs to be informed by the views of pregnant smokers – in particular those who do not currently access specialist support
- Working with CCGs develop a revised service specification for maternity services, addressing training needs and agreeing monitoring requirements.
- Working with maternity services to ensure staff training needs are identified and met

2. Work with CCGs in ensuring GPs refer pregnant smokers to SSiP services rather than to general cessation services.

3. With CCG and Public Health colleagues organise smoking in pregnancy Protected Learning Time (PLT) event for staff working in primary care.

For additional detail see note 1 in appendix 36 *(in main report)*.

Relevant to Maternity Services

1. Work through the LMS and with other partners to implement a revised model for smoking in pregnancy support, based on the evidence based BabyClear approach. To include:

- Appointment of a smoking cessation lead midwife post within each Trust
- A programme of training for all maternity staff to include skills in delivering VBA
- An enhanced role in smoking in pregnancy for Maternity Support Workers
- Rapid access to NRT (ie at booking clinics wherever possible)
- Full implementation of NICE PH26, SBLCB and Smoking in Pregnancy Challenge Group guidance/recommendations.
- Introduction of the Risk Perception Intervention (subject to business case approval) for GEH and UHCW and revise/enhance provision in SWFT

For additional detail see note 2 in appendix 36 *(in main report)*.

2. Ensure smoking in pregnancy is a priority for ALL maternity staff in all clinical settings, working with the smoking cessation lead midwife to identify and support smoking in pregnancy champions, identifying and meeting training needs, so that all staff can undertake CO monitoring, deliver VBA and make electronic referrals to SSiP services.

3. Develop mechanisms to cohort smokers so that specialist support can be targeted on those with the greatest need of support.

4. Ensure that the midwife notifications to Health Visitors from Trusts includes smoking status (non-smoker, quit in pregnancy, still smoking, referral to SSiP services), and that those still smoking should be highlighted as requiring an early antenatal contact.

5. Ensure full compliance with SBL guidance in relation to smoking in pregnancy, including the provision of growth scans.

For additional detail see note 3 in appendix 36 *(in main report)*.

Relevant to Specialist Smoking in Pregnancy Service

1. Working with PH commissioners and LMS partners seek to secure efficiencies in the SSiP model, improving timely access to specialist support, working to improve the skills of specialist advisors and working wherever possible with 3rd sector partners to improve the reach of pre-conception, antenatal and post-natal support to women and 'higher risk' communities.

For additional detail see note 4 in appendix 36 *(in main report)*.

Relevant to HVs/FNP

1. Identify and train 'Smokefree Champions' as High Impact Area leads within Health Visitor and FNP services. In addition, identify locality level smoking in pregnancy champions to work across all service areas. Collectively these posts should ensure that:

   - All 0-5 Public Health Nursing Staff (HVs, community nursery nurses, FNP staff) are trained and competent to use motivational interviewing techniques to deliver brief advice for smoking cessation

   All staff should then promote an increase in the use of universal contacts to:

   - Provide smoking cessation advice and make referral to SSiP services for pregnant smokers
   - Provide advice and support on relapse prevention among women who quit smoking in pregnancy
   - Enhance the sign-posting of partner/household smokers to mainstream smoking cessation support
   - Promote relapse prevention among pregnant women who quit smoking
   - Continue to promote smokefree homes and cars.

   For additional detail see note 5 in appendix 36 *(in main report)*.

2. Working with commissioners consider the introduction of targeted CO monitoring to aid the identification and management of smokers within Health Visitor services.

3. Improve recording/documentation of smoking and working with PH commissioners and wider LMS partners agree enhanced monitoring requirements so the longer-term impacts of smoking in pregnancy can be evidenced.

For additional detail see note 6 in appendix 36 *(in main report)*.

Relevant to Public Health

1. Spearhead a system-wide commitment to achieving a 'smoke free generation' raising the profile of smoking with Health and Wellbeing Boards, the Health and Care Partnership and other partners, securing investment that will deliver a saving to the system.

For additional detail see note 7 in appendix 36 *(in main report)*.

2. In relation to wider population smoking- lead development of comprehensive Tobacco Control Plans (or a joint TCP) for Coventry and Warwickshire, working with all partners to support a reduction in population smoking, particularly in 'higher risk' communities, using innovative techniques and incentives as appropriate. This should include full implementation of PH guidance (PH48 (NHS Trusts), PH23 (Young People), PH14 (Preventing uptake) and PH 26 (Smoking in Pregnancy) and opportunities for pre-conception smoking cessation support. The TCP should be supported with a population wide communications campaign.

For additional detail see note 8 in appendix 36 *(in main report)*.

3. In relation to smoking in pregnancy– consider the role of innovative and/or evidence-based approaches – including incentives and the contribution that wider partners can make to reduce smoking in pregnancy, particularly among 'higher risk' communities. Additionally, enhance the contribution of all PH commissioned services, in particular HVs and Children and Family Centres/Family Hubs and work with SSiP services to revise service specifications as appropriate.

For additional detail see note 9 in appendix 36 *(in main report)*.

Link to the full report

The full report can be accessed here: https://www.happyhealthylives.uk/our-priorities/maternity-and-paediatrics/pregnancy-smoking/

Readers are encouraged to access the full report if they are interested in seeing more detail, for example more information illustrating differences by Trust and by geographical area.

The full report includes a full list of references and a glossary of the terms used in this summary.

Appendix 1

Estimating the Costs Associated with Smoking in Pregnancy

Neonatal Intensive Care Costs

This analysis is restricted to estimating the impact of smoking on the annual number of preterm births across Coventry and Warwickshire and uses national data sources /published data to estimate Neonatal Intensive Care (NIC) costs (based on estimated cot/bed days required by babies born to mothers who smoke).

This analysis will produce an under-estimate of smoking related NIC costs as there will also be full-term babies (ie babies born after 37 weeks gestation) who will have a low birth weight as a consequence of smoking and who will also need specialist support for a period of time. They are not accounted for in this analysis.

The ONS Birth Characteristics data set 2018[1] indicates that 7.8% of all births across England and Wales were preterm. For the West Midlands 8.7% of births were preterm[2]. The data set does not provide information at a Local Authority level and so for Coventry and Warwickshire the England and Wales preterm birth rate has been applied to local births.

The 2016 ONS data set 'Live births by mothers' usual area of residence' reports that there were 10,482 live births across Coventry and Warwickshire. The proportion of all preterm births attributable to smoking has been estimated to range from 5.3 to 7.8% (in a population where the prevalence of SiP was 11.5%)[3]. Thus, for this analysis it is assumed that 6.5% of all preterm births could reasonably be estimated to occur as a consequence of smoking in pregnancy.

On this basis it is estimated that there would be **818 preterm births** (babies born before 37 weeks gestation) across Coventry and Warwickshire, and that of these births **53 (6.5%)** were due to smoking.

The number of Coventry and Warwickshire preterm births by gestational age was estimated by using the national profile as indicated in the ONS Birth Characteristics data set 2018[1]. Table 1.1a shows the national profile of preterm births by gestation applied to the estimated number of preterm births across Coventry and Warwickshire.

Table 1.1a. Estimated Number of Preterm Births by Gestation Across Coventry and Warwickshire.

Gestation at birth	Proportion of all preterm births (England and Wales)	Applied to estimated Number of C&W preterm births (n=53)
Less than 24 weeks	0.9%	0.5 baby
24 to 27 weeks	4.16%	2.2 babies
28 to 31 weeks	9.95%	5.3 babies
32 to 36 weeks	84.9%	45 babies
Total		**53 babies**

National data on NIC length of stay by gestational age[4] was applied to the number of C&W preterm births as shown in Table 1.2a. The cost of an NIC cot day was estimated to be £1,000 based on national cost data (the range of cot day costs is from £493 (special care with external carer) to £1531 (intensive care))[5]. On this basis **the annual NIC cost attributable to preterm births caused by smoking is estimated to be £1,021,000.**

Table 1.2a. Estimated Number of NIC Cot Days for Preterm Births Due to Smoking

Gestation at birth	Average number of cot days	Applied to estimated Number of C&W preterm births (n=53)	Estimated annual cot days[4]
Less than 24 weeks	92 days	0.5 baby	46 days
24 to 27 weeks	92 days	2.2 babies	202 days
28 to 31 weeks	44 days	5.3 babies	233 days
32 to 36 weeks	12 days	45 babies	540 days
Total		**53 babies**	**1021 days**

1. ONS Birth Characteristics data set 2018 (Table 8)
2. ONS Birth Characteristics data set 2018[1] (Table 9)
3. Infant Morbidity and Mortality Attributable to Prenatal Smoking in the U.S. Patricia M. Dietz, Dr PH, Lucinda J. England, MD et al. American Journal of Preventive Medicine 2010;39(1)45–52

4. BLISS Statistics 2016 (https://www.bliss.org.uk/research-campaigns/campaigns/neonatal-care-statistics/statistics-about-neonatal-care)
5. National Cost Collection data. National Cost Collection: National Schedule of NHS costs - Year 2018-19 - NHS Trust and NHS foundation Trusts (https://improvement.nhs.uk/resources/national-cost-collection/#ncc1819)

Wider Societal Costs

This cost estimate is based on included the 2012 Chief Medical Officers (CMO) report[10] which focused on prevention and included the cost-consequences of failing to prevent preterm births.

Table 1.3a. Estimated Additional Costs Associated with an Annual Cohort of Preterm Births Caused by Smoking

	Mean additional cost	Estimate for 53 preterm births 2012 costs	Costs Uplifted for inflation to 2020/21
Delivery of preterm infant	£360	£19,080	£23,250
Neonatal care	£24,000	£1.3m	£1.6m
Health costs discharge to age 2	£1000	£53,000	£64,500
Societal costs up to 18 years	£51,656	£2.8m	£3.4m

The costs in Table 1.3a were uplifted for inflation based on NHS guidance[11] that indicates annual inflation to be between 2% and 3.1%. Therefore, an annual inflation figure of 2.5% has been applied to the cost estimates published by the CMO in 2012 to provide a more realistic estimate of the current (2020/21) cost-consequences of preterm births attributable to smoking across Coventry and Warwickshire. These estimates align with other information, such as the additional complications for smokers during delivery and the impacts of smoking in terms of increased risk of cerebral palsy and increased educational support needs. It is therefore reasonable to assume that the additional societal costs of an annual cohort of preterm babies due to smoking in pregnancy is £3.4m.

Appendix 2

Overview of Current Services

Maternity Services

The LMS has three maternity providers George Eliot Hospital (GEH), South Warwickshire Foundation Trust (SWFT) and University Hospitals Coventry and Warwickshire (UHCW) which collectively deliver approximately 10,500 births per annum. There are differences in the midwifery workforce at the respective Trusts and differences in the level of investment that do not necessarily reflect population need, as shown in appendix 8 *(see main report)*. SWFT benefits through having a larger budget per birth and from having a dedicated Public Health midwife plus some additional dedicated smoking in pregnancy midwife time. It is reasonable to assume that these differences will give an improved ability of the maternity service to address smoking as well other issues related to promoting a healthy pregnancy.

Community midwives who see pregnant women for their 'booking appointment' are expected to refer all smokers on an 'opt-out' basis at this time. Over recent years there has been considerable progress in implementing NICE and SBL guidance, including work to ensure all women receive CO monitoring at booking and are referred to the SSiP services on an opt-out basis.

Each Trust includes smoking in pregnancy within their mandatory training programmes and this consists of a 45 minute to one-hour update for staff once every two years. A small number of midwives in each Trust have received additional training in order to be able to provide a 'Risk Perception Intervention', although delivery of the intervention has only been sustained within SWFT and here delivery is to an extent dependent on their being no other workload pressures.

Maternity services work in close partnership with other services. There are two specialist stop smoking in pregnancy (SSiP) providers; a Coventry and a Warwickshire service, two Family Nurse Partnership (FNP) services and two Health Visitor services. All of these services are commissioned by the local Public Health departments and are provided by SWFT.

Specialist Stop Smoking in Pregnancy (SSiP) Services

The Coventry SSiP service is an integral part of the Family Health and Lifestyles service and for Warwickshire the service sits within the contracted 0-5 Public Health Nursing service. Both services are relatively small (2.8 WTE in Coventry and 4.5 WTE in Warwickshire) and they are commissioned in line with NCSCT guidance. Appendix 9 *(see main report)* provides a checklist of provision by each service in terms of meeting

NCSCT recommendations. In summary, both services:

- Compare favourably against national performance of SSiP services in terms of % of quitters and % of quitters that are CO verified (as detailed through routine reports published by NHS digital)
- Operate from more than one base
- Provide flexible appointment venues
- Operate Monday to Friday (Coventry 9 to 5, Warwickshire 8am to 8pm)
- Now use 'quit manager' as their referral management system
- Receive electronic referrals (although this was only established for the Coventry service in January 2020) and whilst GEH make electronic referrals to the Warwickshire service these are not direct from the midwife (ie the midwife passes referrals to administrative staff, so building the potential for delay)
- Do not have activity targets, but have target response times of contact within 2 days of receipt of the referral (NICE recommendation is one day) and the offer of an appointment within 2 weeks (NICE recommendation is within one week)
- Spend significant time in attempting to contact smokers who have been referred
- Provide access to combination NRT through a 'letter of recommendation' (ie similar to a prescription that must be redeemed at a pharmacy) and provide support through using a combination of recommended behaviour change techniques.
- Are e-cigarette 'friendly'
- Incorporate relapse prevention strategies into the support provided and offer a postnatal visit but cannot issue NRT unless the woman actually relapses and becomes a smoker in the postnatal period.
- Deliver regular updates to midwives through providing updates on their mandatory training programmes

The Warwickshire service has a specific website to aid communication/ provision of information whilst for the Coventry service information can be accessed via the Family Healthy Lifestyles website. Both services are able to provide support to partners/other household smokers, but only if this can be delivered at the same time as the support provided to the pregnant woman. As such this is very limited provision and in the main family smokers are sign-posted to mainstream services.

Family Nurse Partnership (FNP) Services

The Coventry and the Warwickshire FNP services provide dedicated support to vulnerable expectant/new parent teenagers, mostly single women and the aim is enrol clients before the 16th week of pregnancy.

A high proportion of FNP clients smoke, often misuse other substances and frequently have chaotic lives. Commissioners expect FNP services to refer smokers to SSiP services and to support them in their quit attempts. National data from the FNP programme indicates that Warwickshire North and Coventry clients tend to report higher smoking rates during pregnancy and at the end of pregnancy than the average for all FNP sites nationally, whilst the South Warwickshire service (which includes Rugby) reports comparably lower values for these measures.

The national programme is in the process of rolling out an enhanced approach to smoking in pregnancy as part of the 'Personalisation Programme'. This will include adopting a family/whole household approach to smoking cessation, the introduction of new resources, the use of CO monitoring, enhanced staff training in advanced communication skills and mindfulness techniques, and revised pathways.

Health Visitor (HV) Services

The Coventry and the Warwickshire Health Visitor (HV) services are commissioned to provide an antenatal visit (around 28 weeks) but can only do so when they are notified of the pregnancy by midwifery services. Whilst the Coventry HV service was under capacity during the transition of the service to SWFT antenatal visits were provided on a targeted basis only. However, increasing the number of ante-natal contacts delivered is a priority for the Family Health and Lifestyles service and work to develop the increase offer is underway.

When provided the antenatal visit provides an opportunity to encourage quitting among smokers (making referrals to SSiP services) and to advise quitters on relapse prevention, although in practice this may not happen. HVs also provide a 'new birth' visit (14- 28 days post-natal), 6 to 8-week postnatal review, 9-12 months and 2-2.5 years contacts that also provide opportunities to encourage quitting among smokers (and their families) and this is often addressed through conversations focussed on promoting 'smokefree' homes.

Primary Care Services

Whilst NICE guidance does specify that GPs, Practice Nurses and other health care professionals have a role to play in supporting a reduction in smoking in pregnancy, in practice they make a relatively small contribution on the basis that women receive the bulk of their maternity care from midwives and opportunities to intervene are perceived to be few.

There is however evidence that in Warwickshire a small number of women (approximately 37 per annum) are receiving SSiP support through their GP or pharmacy but among these women there is a lower quit rate (21% vs 46%) and as such all pregnant smokers should be directed towards the specialist provider.

Appendix 3

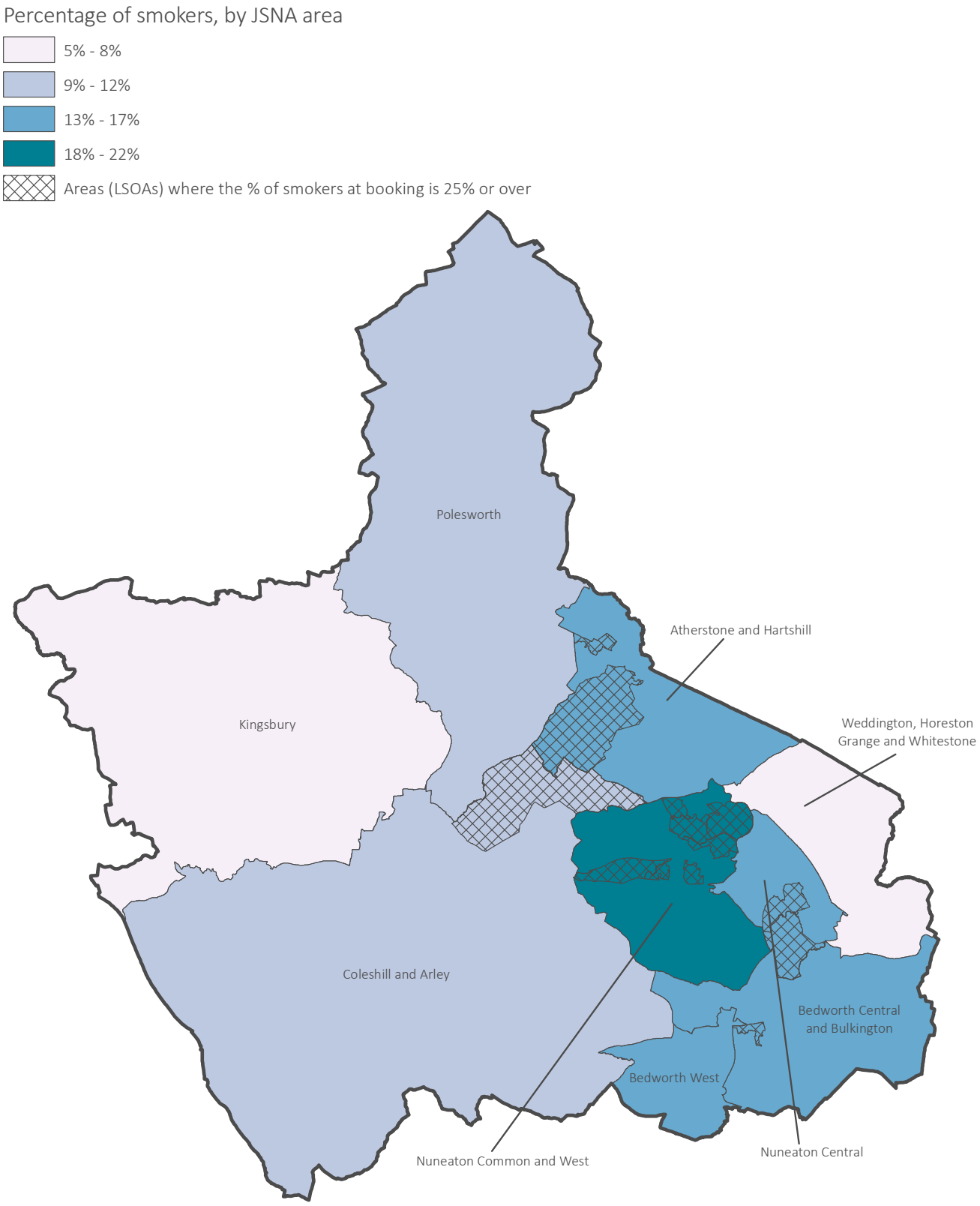
Membership of Smoking in Pregnancy Task and Finish Group

Dawn Fuller	GEH Midwife
Sophy Forman Lynch	WCC PH Commissioner
Dawn Powers	SWFT Warwickshire Specialist Stop Smoking Service
Rachel Harrison	SWFT Midwife
Lorna Coyle	UHCW Midwife
Majella Johnson	SWFT Coventry Specialist Stop Smoking Service
Liann Brookes-Smith	WCC/WNCCG PH Consultant
Anne Morcombe	UHCW Midwife
Angela Doherty	UHCW Midwife
Sally Talbot	SWFT Midwife
Harbir Nagra	CCC PH Commissioner
Sarah Griffiths	Coventry University Qualitative Analyst
Carmen Baskerville	SWFT Specialist Stop Smoking Service
Berni Lee	Review Lead

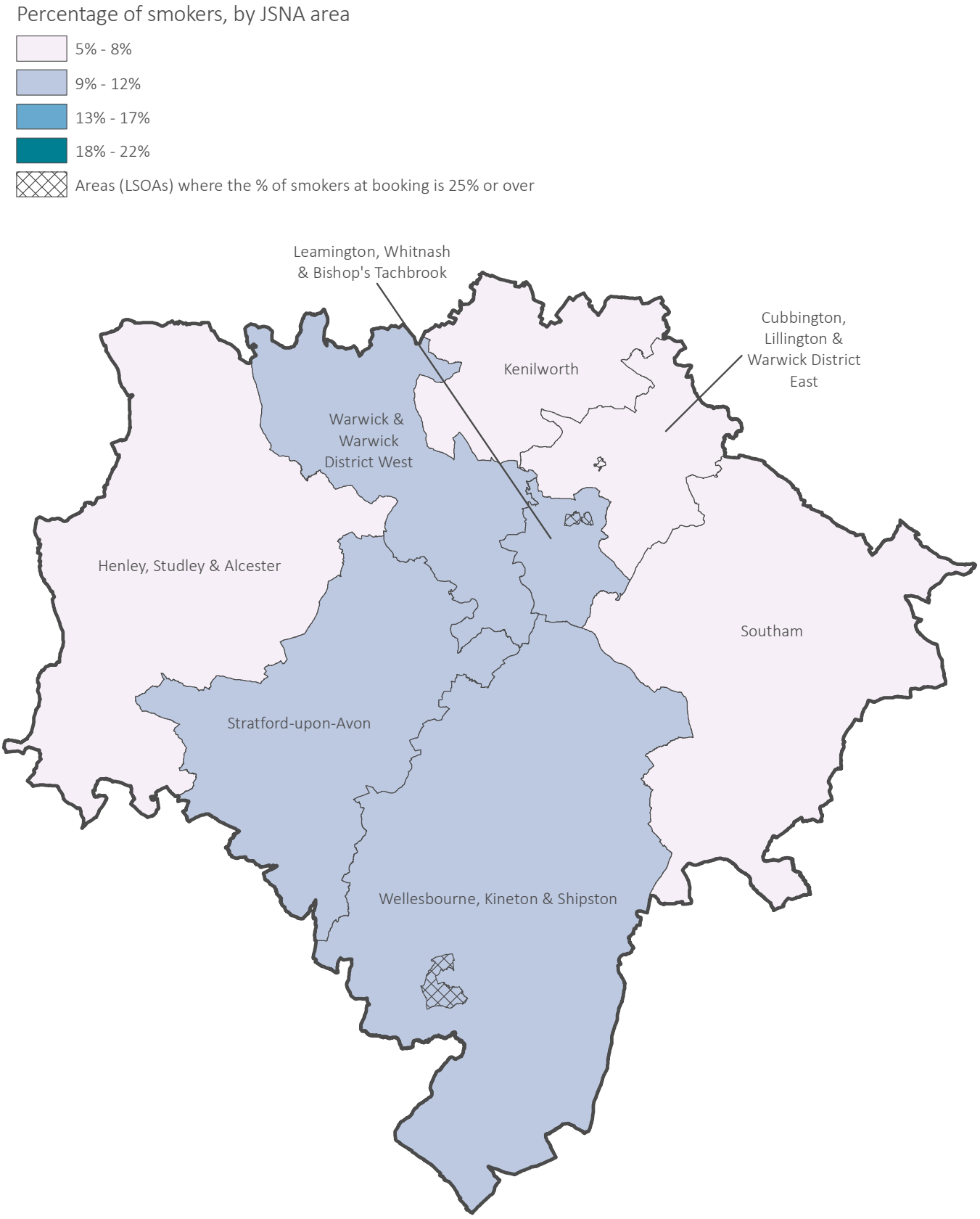
Appendix 4

Warwickshire JSNA Maps

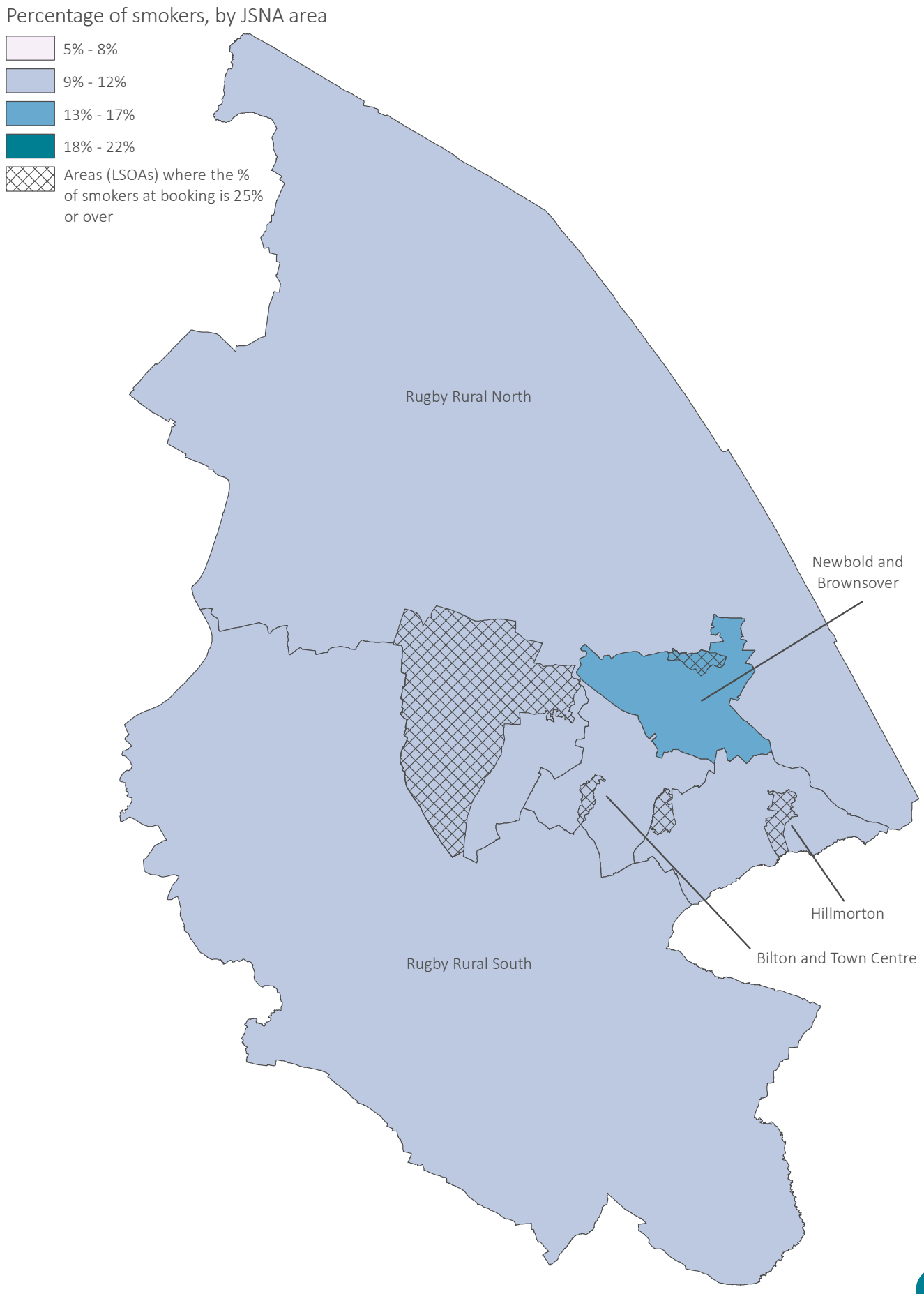
Smoking at time of booking in Warwickshire North, 2016/17 to 2018/19



Smoking at time of booking in South Warwickshire, 2016/17 to 2018/19



Smoking at time of booking in Rugby, 2016/17 to 2018/19



Appendix 5

Details by District and Borough Populations and JSNA Areas

Table 4.1a. Coventry and Warwickshire Maternity Bookings by Districts and Boroughs – All Years Combined

Population	Bookings	Smoker	BME	Obese	MH	Gestation	Deprivation Decile=1	Complex Social Care
Coventry	12183	1619 (13%)	5990 (49%)	2877 (24%)	1098 (9%)	10.2	2597 (21%)	1614 (13%)
North Warwickshire	1915	220 (11%)	133 (7%)	401 (21%)	204 (11%)	10.9	51 (3%)	76 (4%)
Nuneaton and Bedworth	5214	825 (16%)	935 (18%)	1297 (25%)	544 (10%)	10.5	523 (10%)	355 (7%)
Rugby	3471	415 (12%)	983 (28%)	748 (22%)	389 (11%)	10.6	0%	117 (3%)
Stratford-on-Avon	2937	265 (9%)	393 (13%)	606 (21%)	923 (31%)	10.3	0%	9 (0%)
Warwick	4280	351(8%)	973 (23%)	687 (16%)	1141(27%)	10.5	0%	14 (0%)
Warwickshire	17817	2076 (12%)	3417 (19%)	3739 (21%)	3201 (18%)	10.5	574 (3%)	571 (3%)
C&W Total	**30000**	**3695 (12%)[1]**	**9407 (31%)**	**6616 (22%)**	**4299 (14%)**	**10.4**	**3171 (11%)**	**2185 (7%)**

[1] Smokers as a proportion of all bookings as opposed to the number of bookings with known smoking status. Rates among those with a 'known' smoking status will be slightly higher.

Smoking at Booking Warwickshire JSNA Areas– 3 years data combined

JSNA Area	Non-smokers		Unknown Status		Smokers		Total
Atherstone and Hartshill	393	74%	47	9%	90	17%	530
Bedworth Central and Bulkington	775	67%	211	18%	169	15%	1155
Bedworth West	372	62%	155	26%	77	13%	604
Bilton and Town Centre	707	81%	58	7%	108	12%	873
Coleshill and Arley	314	56%	189	34%	55	10%	558
Cubbington, Lillington and Warwick District East	963	87%	50	5%	94	8%	1107
Henley, Studley and Alcester	600	89%	20	3%	54	8%	674
Hillmorton	449	86%	21	4%	55	10%	525
Kenilworth	520	89%	35	6%	27	5%	582
Kingsbury	167	45%	182	49%	23	6%	372
Leamington, Whitnash and Bishop's Tachbrook	1330	87%	53	3%	139	9%	1522
Newbold and Brownsover	812	81%	50	5%	138	14%	1000
Nuneaton Central	962	75%	116	9%	212	16%	1290
Nuneaton Common and West	972	70%	111	8%	307	22%	1390
Polesworth	315	69%	88	19%	52	11%	455
Rugby Rural North	499	79%	67	11%	64	10%	630
Rugby Rural South	361	83%	30	7%	46	11%	437
Southam	499	84%	50	8%	45	8%	594
Stratford-upon-Avon	895	85%	53	5%	99	9%	1047
Warwick and Warwick District West	912	85%	64	6%	91	9%	1067
Weddington, Horestone Grange and Whitestone	614	80%	94	12%	59	8%	767
Wellesbourne, Kineton and Shipston	527	85%	28	5%	67	11%	622
Unknown JSNA area	8	50%	3	19%	5	31%	16
Grand Total	**13966**	**78%**	**1775**	**10%**	**2076**	**12%**	**17817**

Smoking at Booking Coventry JSNA Areas – 3 years data combined

JSNA Area	Non-smokers		Unknown Status		Smokers		Total
Aspire Family Hub	1263	84%	105	7%	133	9%	1501
Families for All Hub	846	81%	67	6%	127	12%	1040
Harmony Hub	802	79%	57	6%	162	16%	1021
Mosaic Family Hub	1987	85%	110	5%	235	10%	2332
Park Edge Family Hub	1224	78%	97	6%	253	16%	1574
Pathways Family Hub	2158	81%	144	5%	354	13%	2656
The Moat Family Hub	1117	79%	67	5%	222	16%	1406
Wood Side Family Hub	476	74%	37	6%	132	20%	645
Unknown JSNA area	5	63%	2	25%	1	13%	8
Total	**9878**	**81%**	**686**	**6%**	**1619**	**13%**	**12183**

Appendix 6

Key Findings: National Data and Maternity Data Analysis

Analysis of routinely available national data

- Data from GP practice survey indicates that general population smoking prevalence is lower in SWCCG (11.4%) than for CRCCG (15.7%) or WNCCG (13.6%)
- The likelihood of being a current smoker is highest in younger age groups with adults aged 25 to 34 being the most likely to smoke (19%)
- Smoking at Time of Delivery for 2018/19 gives the following values: CRCCG 10.6%, SWCCG 6.8% and WNCCG 13.7%
- SATOD has been increasing for WNCCG over recent years with a value for 2019/20 (data to December 2019) of 16.8%
- National SSiP data reports for the period 2015/16 to 2018/19 indicate that the number of women setting a quit date each year ranged from 297 to 347 for Coventry and from 235 to 384 for Warwickshire residents
- There are between 265 and 334 4-week quitters among pregnant women across Coventry and Warwickshire each year

Analysis of maternity data: smoking at booking – numbers and geography

- Across Coventry and Warwickshire each year an average of 885 women have an unknown smoking status at booking
- GEH has the highest proportion with unknown status (15% in 2018/19), but unknowns have increased from 3% to 8% over the time period at UHCW
- Of those with known smoking status an average of 1368 women are smoking at booking each year, decreasing from 14% to 13% of total bookings over the review period
- Each year Coventry has an average of 645 smokers identified at booking and Warwickshire an average of 723

- The highest proportion of smokers at booking live in Nuneaton and Bedworth (16%)
- At JSNA level smoking rates vary between 5% to 22% across Warwickshire JSNA areas and between 9% and 20% for Coventry JSNA areas
- At LSOA level the proportion of smokers ranges between 0% to 37%. In total across Coventry and Warwickshire there are 37 LSOAs with a proportion of smokers at booking greater then 25%
- A higher proportion of bookings in the lowest IMD quintile in Warwickshire (53%) are smokers, than in Coventry where 35% of smokers are from the lowest quintile
- The % of women at booking who smoke is 5 to 6 times higher in the most deprived deciles compared to the least deprived deciles

Analysis of maternity data: characteristics and co-morbidities of smokers at booking

- A higher proportion of smokers have a post-code in the most deprived decile (19%) than non-smokers (10%)
- Of all bookings aged under 18, 29% smoke as do 27% of those aged 18 to 24
- The majority of smokers – 91% - come from 'white' ethnic groups
- 26% of smokers are recorded as having a mental illness as compared to 13% of non-smokers
- A higher proportion of smokers have co-morbidities, with 55% of smokers having one or more co-morbidity (not including smoking) compared to 37% of non-smokers

Appendix 7

Key Findings: Access to SSiP Services and Smoking Outcome

- Whilst it cannot be confirmed there is evidence to indicate that a high proportion/all smokers identified at booking are being referred for specialist support. This is particularly true for 2018/19 indicating an improving picture. However, this may not be the case for Rugby smokers at booking
- There appears to be a high level of referrals from the GEH CMWs relative to the number of smokers at booking, potentially reflecting a high level of re-referral, and/or smokers being identified at a later point in the antenatal pathway
- Each year on average there are 686 referrals to the Coventry smoking service (this compares to an average of 645 smokers at booking) and 714 to the Warwickshire service (this compares to an average of 723 smokers at booking)
- There is a longer average time to first appointment in Warwickshire (17 days) than in Coventry (11 days) and to 'quit date set' (23 days for Warwickshire service and 18 days for Coventry service)
- The proportion of those who engage with smoking services ranges from 53% to 60% of Coventry referrals and from 40% to 42% of Warwickshire referrals
- The proportion of those engaging with services who go on to set a quit date are similar across the two services ranging from 67% to 82% for the Warwickshire service and 81% to 82% in Coventry
- The numbers who achieve a 4-week quit each year ranges from 117 to 124 in Warwickshire (16% to 17% of all referrals) and from 135 to 157 in Coventry (20% to 24% of all referrals). The average is 148 quitters per annum for Coventry and an average of 120 quitters each year for Warwickshire
- A high proportion of quitters are prescribed NRT (93% in Warwickshire, 100% Coventry)
- A high proportion of quitters are CO verified across both the Coventry and the Warwickshire services
- It is estimated that approximately 73% of those who quit smoking between booking and delivery could be attributed to access to SSiP Services

- For Warwickshire there is evidence of variation in engagement with services by district and borough populations with just 25% of those referred from Nuneaton and Bedworth and from Rugby setting a quit date, as compared to 40% from Warwick
- Just 11% of those referred from North Warwickshire achieve a 4-week quit, compared to 23% of referrals from Stratford upon Avon
- The Coventry service tends to receive all referrals (99%) from midwives, whereas in Warwickshire 16% of referrals are from other professionals such as Health Visitors
- Coventry clients have a higher average number of appointments – both for quitters (8 appointments) and non-quitters (3.3 appointments) than in Warwickshire (4.9 for quitters, 2.1 for non-quitters)
- The average cost per 4-week quitter ranges from £811 per quitter in the Coventry service to £1667 in the Warwickshire service
- For Warwickshire the deprivation profile of referrals for smoking cessation support matches the profile of smokers at booking
- There are differences in engagement and outcomes associated with the smoking service by deprivation decile with a tendency for better engagement and outcomes in the less deprived deciles – but this is not a strictly linear relationship, with those in decile 1 'out-performing' those in deciles 2., 3 and 4
- The RPI offered to 'resistant smokers' at SWFT makes a small but important contribution to smoking cessation
- The full value of the smoking services cannot be quantified in terms of the quitters achieved alone as the availability of the service is likely to encourage the delivery of VBA by midwives

Table 6.1a. Warwickshire Smoking Referrals and Outcomes by District and Borough and CCG Populations

2016/17 to 2018/19 (October 2016 to March 2019)							
	Number of referrals	Number[1] (%) Engaging	Number set Quit Date (%) of all referrals	Quit Date % of those Engaging	Number quit (%) of all referrals	% of those setting quit date	Number (%) quitters CO verified
By District/Borough:							
North Warwickshire	214	91 (43%)	72 (34%)	80%	24 (11%)	33%	18 (75%)
Nuneaton & Bedworth	696	247 (35%)	174 (25%)	70%	104 (15%)	60%	84 (81%)
Rugby	307	99 (32%)	78 (25%)	79%	43 (14%)	55%	36 (84%)
Stratford-on-Avon	282	150 (53%)	109 (39%)	73%	66 (23%)	61%	53 (80%)
Warwick	342	172 (50%)	137 (40%)	80%	75 (22%)	55%	66 (88%)
Warwickshire	1,841	759 (41%)	570 (31%)	75%	312 (17%)	55%	257 (82%)
By CCG:							
Warwickshire North CCG	910	338 (37%)	246 (27%)	73%	128 (14%)	52%	102 (80%)
Coventry & Rugby CCG[2]	307	99 (32%)	78 (25%)	79%	43 (14%)	55%	36 (84%)
South Warwickshire CCG	624	322 (52%)	246 (39%)	76%	141 (23%)	57%	119 (84%)

[1] Engagement was defined on the basis that 'decliners' were those with a 'blank' 'First session date' and a 'blank' 'Quit Date'. Excluding these records gave the number engaging with the service. [2] Rugby only

Appendix 8

Key Findings: Smoking at 36 weeks and SATOD

- Over the 3-year period, of the women who were identified as smokers at booking, 27% were recorded as non-smokers at delivery. However, 1% of those recorded as non-smokers at booking and 8% of those with an unknown smoking status at booking were also recorded as smokers at delivery
- The proportion of women with a known SATOD status varied by Trust, with 2% of deliveries having an unknown status at UHCW and SWFT, compared to 14% at GEH. The proportion with unknown SATOD status has decreased over time at GEH and all records in the cohort for 2018/19 had a SATOD value
- The difference in the number of smokers at booking compared to smokers at delivery has been reducing over the time period; there was an 18% reduction in 2017/18 and the difference was 14% in 2018/19
- Whilst technical difficulties affected the provision of 36-week data for the review, there is some evidence from GEH that more women may be smoking at delivery than are currently being recorded as a higher number of the cohort were recorded as smokers at 36 weeks
- The SATOD rates as a proportion of those with a known SATOD status in 2018/19 was 6.6% at SWFT, 10.7% at UHCW and 14.7% at GEH
- Each CCG has seen a small decrease in SATOD over the period, with the exception of WNCCG where there was a slight increase in 2018/19 to 13.7%
- There is a clear relationship between smoking and breastfeeding with 72% of women not smoking at delivery being recorded as breastfeeding as compared to 41% of smokers

Key Findings: Quitters vs non-quitters

- There is some evidence that those who do not quit smoking during pregnancy book for maternity care later, are less ethnically diverse and tend to have more co-morbidities

Key Findings: Estimated number of quitters per annum

- It is estimated that there are approximately 1549 Smokers at Booking across Coventry and Warwickshire each year (ie those identified as smokers and those recorded as non-smokers or with an unknown status)

- Applying the review findings, it can be estimated that approximately 365 of those smoking at booking quit before delivery

Table 7.1a. SATOD Status by District and Borough Populations 2016/17

Authority	Number with outcome	SATOD =Yes	% Smoker	SATOD =No	% Non-Smoker	Unknown SATOD	% Unknown	Total SATOD Known	% SATOD Known
Coventry	1832[1]	239	13%	1543	84%	50	3%	1782	13%
North Warwickshire	399	27	7%*	202	51%	170	43%	229	12%
Nuneaton & Bedworth	1296	126	10%*	653	50%	517	40%	779	16%
Rugby	553[1]	56	10%	465	84%	32	6%	521	11%
Stratford-on-Avon	978	68	7%	873	89%	37	4%	941	7%
Warwick	1372	94	7%	1230	90%	48	3%	1324	7%
Total	**6430**	**610**	**9%**	**4966**	**77%**	**854**	**13%**	**5576**	**11%**

***NB High level of unknowns. [1]6 months data**

Table 7.2a. SATOD Status by District and Borough Populations 2017/18

Authority	Number with outcome	SATOD =Yes	% Smoker	SATOD =No	% Non-Smoker	Unknown SATOD	% Unknown	Total SATOD Known	% SATOD Known
Coventry	4202	453	11%	3695	88%	54	1%	4148	11%
North Warwickshire	472	63	13%	409	87%		0%	472	13%
Nuneaton & Bedworth	1450	196	14%	1251	86%	3	0%	1447	14%
Rugby	1174	118	10%	1043	89%	13	1%	1161	10%
Stratford-on-Avon	947	73	8%	848	90%	26	3%	921	8%
Warwick	1449	98	7%	1324	91%	27	2%	1422	7%
Total	**9694**	**1001**	**10%**	**8570**	**88%**	**123**	**1%**	**9571**	**10%**

Table 7.3a. SATOD Status by District and Borough Populations 2018/19

Authority	Number with outcome	SATOD =Yes	% Smoker	SATOD =No	% Non-Smoker	Unknown SATOD	% Unknown	Total SATOD Known	% SATOD Known
Coventry	4209	464	11%	3621	86%	124	3%	4085	11%
North Warwickshire	434	40	9%	391	90%	3	1%	431	9%
Nuneaton & Bedworth	1465	219	15%	1236	84%	10	1%	1455	15%
Rugby	1174	107	9%	1036	88%	31	3%	1143	9%
Stratford-on-Avon	980	65	7%	897	92%	18	2%	962	7%
Warwick	1382	85	6%	1274	92%	23	2%	1359	6%
Total	**9644**	**980**	**10%**	**8455**	**88%**	**209**	**2%**	**9435**	**10%**

Table 7.4a. SATOD for Warwickshire JSNA Populations 2016/17-2018/19

JSNA	Number in Cohort	Total SATOD Known	SATOD =Yes	% Smoker
Atherstone and Hartshill	446	377	60	**16%**
Bedworth Central and Bulkington	887	785	115	**15%**
Bedworth West	444	408	63	**15%**
Bilton and Town Centre	739	722	76	**11%**
Coleshill and Arley	341	307	31	**10%**
Cubbington, Lillington and Warwick District East	1090	1061	70	**7%**
Henley, Studley and Alcester	669	651	43	**7%**
Hillmorton	447	440	42	**10%**
Kenilworth	559	547	19	**3%**
Kingsbury	180	154	12	**8%**
Leamington, Whitnash and Bishop's Tachbrook	1496	1464	122	**8%**
Newbold and Brownsover	828	807	88	**11%**
Nuneaton Central	1073	920	137	**15%**
Nuneaton Common and West	1186	1025	195	**19%**
Polesworth	338	294	27	**9%**
Rugby Rural North	522	495	42	**8%**
Rugby Rural South	361	357	31	**9%**
Southam	581	564	35	**6%**
Stratford-upon-Avon	1041	1017	77	**8%**
Warwick and Warwick District West	1056	1031	66	**6%**
Weddington, Horestone Grange and Whitestone	617	539	30	**6%**
Wellesbourne, Kineton and Shipston	614	592	51	**9%**
Not Known	10	10	3	**30%**
Total	**15525**	**14567**	**1435**	**10%**

Table 7.5a. SATOD for Coventry JSNA Populations 2016/17-2018/19

JSNA	Number in Cohort	Total SATOD Known	SATOD =Yes	% Smoker
Aspire Family Hub	1232	1199	95	**8%**
Families for All Hub	883	857	86	**10%**
Harmony Hub	871	857	118	**14%**
Mosaic Family Hub	1907	1874	158	**8%**
Park Edge Family Hub	1340	1308	193	**15%**
Pathways Family Hub	2225	2176	244	**11%**
The Moat Family Hub	1204	1180	161	**14%**
Wood Side Family Hub	576	559	99	**18%**
Not Known	5	5	2	**40%**
Total	**10243**	**10015**	**1156**	**12%**

Appendix 9

Key Findings: Case Note Audits

Maternity case note audit

- At booking, between 67% (UHCW) to 85% (SWFT and GEH) had a documented CO measurement
- Smoking advice at booking was documented for between 43% of smokers at GEH up to 85% at SWFT and between 61% at UHCW. At SWFT, 82% had smoking referral documented
- There is a low level of documentation regarding the provision of written information at GEH (2%) and UHCW (12%) as compared to SWFT (87%)
- There is a relatively high level of documentation at booking in relation to partner smoking, ranging from 65% at GEH to 83% at SWFT, but there are low levels of signposting of partners to smoking cessation support
- At subsequent appointments, smoking status was documented on at least one more occasion (prior to 36-weeks) for 74% of records at UHCW through to 100% of records at SWFT, and it was documented on average between 2 to 3.1 occasions across the Trusts
- The proportion of smokers at booking who had a repeat CO measurement (prior to 36 weeks) ranged from 29% of women at UHCW to 94% at SWFT
- Outside of SWFT, at subsequent appointments there was little if any enquiry about household smokers, or signposting to support for household members who smoke
- Between 3% and 17% of the smokers at booking were documented as using an E-Cigarette at some point in their antenatal pathway
- Serial growth scans were provided to a high proportion of smokers at booking at GEH (85%) and at SWFT (98%), whilst none were recorded for the women audited at UHCW
- On average, 4.6 growth scans were provided per woman at SWFT and 2.1 per woman at GEH
- In terms of 36-week data, between 84% at UHCW and 95% of women at SWFT had 36-week data recorded
- At UHCW, 30% of the records had a 36-week smoking status recorded – as did 89% at SWFT and 34% at GEH
- Of those with a smoking status - between 74% at GEH and 82% at UHCW were recorded as smokers

- Between 60% of records at GEH and UHCW and 72% of the records at SWFT had a CO measurement at 36-weeks. Of these, the range was between 34% at UHCW and 42% at GEH having a value >=4ppm

Key Findings: Health Visitor case note audit

- There is an apparent variation in the proportion of birth notifications being received by Health Visiting services and generally low levels of information about smoking status included with the notifications received with none including any information about prior referrals to smoking services made by midwifery services
- A high proportion of antenatal visits were offered where notifications had been received, but a lower proportion (42% to 77%) actually received a visit
- Recording of smoking status at antenatal visits was generally high (71% to 100% of visits) and a high proportion (72% to 100%) had advice documented
- The recorded evidence indicates generally low levels of referral by health visitors to smoking services for pregnant smokers (with the exception of South Warwickshire – 56%) and low levels of documentation relating to the provision of written information
- There was documentation of enquiry about household smoking in a substantial proportion of the antenatal visits (63% to 86%, with the exception of Rugby records (29%)) but low levels of evidence of sign-posting to smoking cessation support for household smokers
- There were generally high levels of documentation of smoking status at the New Birth Visit (41% to 84%) as opposed to at the 6-8-week review (34% to 60% for the services providing 6-8-week information)
- Between 10% to 23% of the smokers at the NBV and 8% to 24% of the 6-8-week smokers had been recorded as 'quitters' in the maternity data set (ie these women had relapsed)
- A higher proportion of women at the NBV (38% to 100%) than at the 6-8-week review (20% to 50%) had smoking advice documented
- With the exception of Coventry there were generally low levels of referrals to smoking service's documented at either the NBV or the 6-8-week review, and also generally low levels of documentation that written information had been given
- There is moderate evidence of enquiry about household smoking at the NBV (18% to 63% of records) but less so at the 6-8-week review (8 to 18% of records)

- There was no evidence of documented discussions about relapse prevention for the women who had quit smoking during pregnancy and a number of the women who had quit were documented as post-natal smokers

Key Findings: FNP case note audit

- There is apparent variability in the level of recording of smoking related issues across services with less recording undertaken within the North Warwickshire service (NB. This may be a consequence of the way the audit was undertaken TBC)
- Between 33% and 45% of the FNP population are identified as smokers at first assessment, and up to 68% were recorded as 'ever smokers'
- Smoking status is documented for between 75% to 100% of clients at first FNP assessment
- Among smokers, with the exception of North Warwickshire, there was a high level of smoking advice documented at first assessments, and a high percentage of clients given information and referrals made to specialist support
- There were generally low levels of referral to specialist support beyond the first assessment, although it was documented that advice was given
- There were generally low levels of signposting of partners to stop smoking support
- In South Warwickshire a significant proportion of the smokers at first assessment were noted to have quit by the 36-week assessment (50%)
- Seven of the 9 smokers who quit following the first FNP assessment had re-started smoking during the post-natal period (78%)
- Just one of the 10 South Warwickshire smokers at first assessment (10%) and one of the 18 Coventry smokers (5%) quit and remained quit
- Nine of the collective 44 non-smokers at first assessment (20%) from the Coventry and South Warwickshire services had become smokers by one-year post-natal (most likely to be those recorded as previous smokers at first assessment)
- There is little evidence of a focus on relapse prevention with 2 documented conversations
- There appears to be a good deal of positive practice providing a platform for future enhanced prevention of smoking related harm

Appendix 10

Key Findings: Staff Engagement

- Smoking in pregnancy is generally **recognised as a very important issue** with 70% of all survey respondents identifying it as such. This did vary across professional groups with 85% of community midwives, 85% of GPs and 73% of Health Visitors seeing it as a very important part of their role, while 58% of the sonographers responding said smoking was not important to their role
- Relapse prevention advice was reportedly always given by 33% of health visitor service staff, but there was some variation by geography with higher proportions reporting providing such advice in Coventry and North Warwickshire
- Between 75% and 82% of HV service staff considered providing advice about second-hand smoke exposure to be very important
- When asked if they had all **the knowledge required to talk to pregnant women** about smoking in pregnancy only 52% of midwifery staff agreed or strongly agreed with the statement. 58% of sonographers and 46% of support workers strongly disagreed with the statement – so feel they lack the required knowledge
- For the health visiting service, 51% agreed that they did have enough knowledge required, although this was lower for Coventry (33%) than Rugby (64%), South Warwickshire (69%) and North Warwickshire (45%)
- In terms of expressing **confidence in engaging pregnant women** with discussion about smoking, 11% of maternity staff strongly agreed that they had all the confidence they needed, 40% agreed, 18% disagreed and 9% strongly disagreed (ie 27% of maternity lack confidence to have the conversation)
- There is widespread uncertainty about E-Cigarettes with 62% of staff across groups being unsure about their harm reduction potential, with in particular 41% of junior doctors feeling that they could be less safe than smoking tobacco
- **Not all staff feel well trained** in relation to smoking in pregnancy for example:
    - Across the maternity services 25% of respondents reported that they had never been trained, as did 37% of antenatal staff, 64% medical professionals, 67% of sonographers, 69% of support workers, 57% of GP practice staff and 60% of children and family centre staff

- 42% of health visiting staff appeared to have received training within the last year This was higher in South Warwickshire at 75%, compared to 45% in North Warwickshire and only 2% in Coventry
- Staff would value additional training with some health visitors and hospital midwives favouring additional face-to-face training, whilst junior doctors also felt motivational interviewing training would help
- All staff groups expressed **a need for increased knowledge around E-Cigarettes** and NRT; less than 5% of staff had sufficient knowledge about NRT and only 3% of staff felt well confident to advise about e-cigarettes
- Other staff groups expressed a need for training in relation to post-natal relapse and cannabis use in pregnancy
- The proportions of maternity staff trained to undertake CO monitoring ranged from 90% of those working in the community to 46% of antenatal staff and 48% of postnatal staff
- There was some indication from survey responses that **all staff do not know all of the actions that should be taken when a CO value level is raised in a non-smoker**
- There were mixed views among health visitors about the value of CO monitoring with some thinking it could prompt discussion of smoking, but the majority feeling it would be difficult to implement
- In terms of familiarity with the SSIP referral process while 70% of midwives said they were clear about the process this varied with 91% of community staff answering positively compared to 45% of antenatal and 47% of postnatal staff
- 72% of health visiting staff indicated that they knew the referral process
- Only 7% of GP practices staff said they would refer to the SSIP service
- Health visiting staff highlighted the issue that notifications they receive from midwifery generally do not report a woman's smoking status
- **In terms of barriers in dealing** with smoking in pregnancy
    - Time constraints were the largest barrier for maternity staff (29%) and health visitors (29%), although this was less of a barrier for children and family centre staff (6%). Lack of training was the biggest barrier for children and family centre staff (28%), the second highest barrier for maternity staff (19%) and third highest for health visiting staff (13%)
    - Lack of knowledge about the referral process was a considerable barrier for both maternity staff in general (15%) and for health visiting staff (9%)

- Junior doctors and hospital-midwives often assumed that community midwives would have made the referral earlier in pregnancy
- Concern about the future relationship with the patient was more of a barrier for health visiting staff (12%) than maternity staff (10%), although 18% of community midwifery staff felt this to be a barrier
- Some midwives and health visitors questioned the ethics of referring women without their consent, which means they may not always refer them

- Staff identified specific **areas for change** including:
  - More investment is required in more socially deprived areas – specifically areas in Coventry and North Warwickshire
  - The complex issues affecting many women who smoke need to be recognised through the provision of additional support
  - A revised model of SSiP provision is needed with 'in maternity clinic support' and immediate access to NRT
  - More work is needed with partners/families through increase service capacity so advisors can work evenings and weekends.
  - GP practice staff discussed needing to know where and what services were available
- Staff identified where either they themselves could do more, or where other **services and professional groups could play an enhanced role,** suggestions included:
  - Schools, colleges, Looked After Children services and youth workers could all help tackle to tackle pre-pregnancy smoking
  - Sonographers using their limited involvement with women could reinforce messages about the risks of smoking
  - Children and family centre staff could use baby weigh-in clinic and antenatal and postnatal clinics to offer advice
  - GP practice staff using contraception appointments/family planning clinic, fertility discussions, smear tests, vaccination appointments and health checks as opportunities to discuss smoking
- Staff suggested a number of **areas for improvement** including:
  - clarifying staff roles and responsibilities and raising awareness of the SSiP service and the referral process
  - expanding the role of the maternity support worker within maternity services so they can provide specialist support to smokers

- increased risk perception capacity so the intervention can be delivered equitably in all Trusts,
- providing immediate access to NRT for pregnant smokers
- focusing cessation support on the wider household of the pregnant smoker
- providing additional visual resources including hard-hitting images

Appendix 11

Overview of Compliance with NICE Recommendations: PH 26

PH 26 Standard	Review Evidence
Recommendation 1: Identifying pregnant women who smoke and referring them to NHS Stop Smoking Services – action for midwives	
Identify women who smoke	Maternity data analysis indicates that overall for 92% of bookings smoking status was recorded, although 2% of those either identified as a non-smoker or as having unknown smoking status at booking, went to be recorded as smokers at time of delivery (estimated to be approximately 198 women each year). In 2018/19 there was a higher proportion of women with an unknown smoking status at booking at GEH (14%), compared to UHCW (8%) and the lowest level was at SWFT (2%). It is however notable that the proportion of women with unknown smoking status at UHCW has increased over the review period from 3% to 8%.
Undertake CO testing	Evidence from electronic data indicates that a high proportion of women are CO tested, with improvement towards 100% over time. For 2018/19 the maternity booking records showed that 82% of UHCW records, 84% of SWFT's and 79% of GEH bookings had a CO measurement. Through the case note audit between 67% (UHCW) to 85% (SWFT and GEH) had a documented CO measurement at booking.
Provide information (for example, a leaflet)	There was a low level of documentation of provision of stop smoking in pregnancy written information in the case note audit at booking at both UHCW and GEH – at GEH (2%) and UHCW (12%) as compared to SWFT (87%)
Advise stopping – not just to cut down	Mixed evidence - Smoking advice at booking was documented for between 43% of smokers at GEH, 64% at UHCW and up to 85% at SWFT. In discussion groups it was reported that some staff do support cutting down but on balance the majority of staff do recommend complete cessation.

Refer all women who smoke (opt-out)	Evidence from electronic data indicates opt-out referrals are being made (ie number of referrals received by smoking services roughly equates with smokers at booking, although this may not be the case in Rugby) The case note audit showed that 61% of records at UHCW, 71% at GEH and 82% at SWFT had smoking referral documented. Through the staff survey 88% of community midwives reported consistently making referrals at booking. However, within discussion groups, some midwives and Health Visitors questioned the ethics of referring women without their consent (so may not be making 'opt-out' referrals).
Refer those with a CO reading of 7 ppm or above. (NB: threshold now changed to 4ppm)	The local guideline is to refer where the CO is 4ppm or above if the woman is thought to be a smoker and not if she strongly denies smoking and on balance is thought not to be a smoker. The maternity staff survey and discussions indicate that referrals at a threshold of 4pmm are being made.
Where high CO reading (more than 10 ppm) in non-smoker, advise on possible CO poisoning to call HSE gas safety advice line	There was some indication from maternity survey responses that all staff do not know all of the actions that should be taken when a CO value level is raised in a non-smoker – for example through the staff survey only 40% of midwives reported providing the gas safety number (see appendix 20 for detail – *in main report*).
Enquire and advise re: household smokers, signpost to NHS Stop Smoking Services	There is a relatively high level of documentation at booking in relation to partner smoking ranging from 65% at GEH, 79% at UHCW to 83% at SWFT but low levels of signposting partners to smoking cessation support.
Re-refer at subsequent appointments and re-measure/record CO reading	Evidence from the case note review indicates that this is happening but not consistently - at subsequent appointments smoking status was documented on at least one more occasion (prior to 36-weeks) for 74% of records at UHCW, 83% at GEH through to 100% of records at SWFT and it was documented on average between 2 to 3.1 occasions across the Trusts. The proportion of smokers at booking who had a repeat CO measurement (prior to 36 weeks) ranged from 29% of women at UHCW, 53% at GEH and 94% at SWFT.

Recommendation 2: Identifying pregnant women who smoke and referring them to NHS Stop Smoking Services – action for others in the public, community and voluntary sectors – action for GPs, practice nurses, Health Visitors and family nurses. obstetricians, paediatricians, sonographers and wider maternity team. Staff in youth and teenage pregnancy services, children's centres and social services.	
Use any appointment to advise women if they smoke	For HVs there is evidence that advice was given at antenatal visits There were generally high levels of documentation of smoking status at the New Birth Visit (41% to 84%) as opposed to at the 6-8-week review (34% to 60% for the services providing 6-8-week information)A higher proportion of women at the NBV (38% to 100%) than at the 6-8-week review (20% to 50%) had smoking advice documented. In FNP services smoking status is documented for between 75% to 100% of clients at first assessment.
Refer all women who smoke to SSiP services.	For HVs the recorded evidence indicates generally low levels of referral by Health Visitors to smoking services for pregnant smokers (with the exception of South Warwickshire – 56%). In FNP services there was generally low levels of referral to specialist support beyond the first assessment, although it was documented that advice given. SSiP service data indicates that HVs do make referrals in Warwickshire, but 99% of Coventry SSiP referrals are from midwives. This conflicts with the case note review evidence indicating that Coventry HVs do refer to SSiP services. Only 16% of Children's Centre staff reported that they would refer to SSiP services, but they would sign-post smokers to their GP or midwife.
Provide information (for example, a leaflet)	There were generally low levels of documentation relating to the provision of written information by HVs but through the FNP case note audit it was documented that written information was provided for 94% to 100% of first assessment visit records and 60% to 94% of subsequent visits.
Enquire and advise re: household smokers, signpost to NHS Stop Smoking Services	There was documentation of enquiry about household smoking in a substantial proportion of the antenatal visits (63% to 86%, with the exception of Rugby records (29%)) but low levels of evidence of sign-posting to smoking cessation support for household smokers. In FNP services there were generally low levels of signposting of partners to stop smoking support. The staff survey indicated that between 75% and 82% of HV service staff considered providing advice about second-hand smoke exposure to be very important.
Recommendations 3 to 7 apply to NHS Stop Smoking Services	
Compliance with standards is detailed in appendices 9, 29 and 30 *(in main report)*	In summary standards are met with the exception of referrals actioned within 24 hours of receipt and face to face appointment offered within 7 days. Local standards are response within 2 working days and appointment within 2 weeks. The services are not commissioned to provide support to women with infants up to one year – (ie appointments up to 3 months postnatal only).

Recommendation 8: Training to deliver interventions (provided to all midwives GPs, practice nurses, Health Visitors, obstetricians, paediatricians, sonographers, midwives (including young people's lead midwives), family nurses and children's centre staff among others Action by Commissioners of NHS Stop Smoking Services, Maternity services. Other bodies with training responsibilities.	
Ensure midwives are trained to assess smoking status and readiness to quit	Across the maternity services 25% of respondents reported that they had never been trained, as did 37% of antenatal staff, 64% medical professionals, 67% of sonographers, 69% of support workers, 57% of GP practice staff and 60% of children and family centre staff. 42% of health visiting staff appeared to have received training within the last year This was higher in South Warwickshire at 75%, compared to 45% in North Warwickshire and only 2% in Coventry. Staff would value additional training with some Health Visitors and hospital midwives favouring additional face-to-face training, whilst junior doctors also felt motivational interviewing training would help.
Provide information (for example, a leaflet)	There were low levels of recording that written information was given, although in discussion groups staff did indicate that they provide leaflets.
Enquire and advise re: household smokers, signpost to NHS Stop Smoking Service	As above there is variable evidence in relation to household smoking and sign-posting across services and staff groups, indicating a need for additional training.
Understand barriers to quitting how to refer them to local services for treatment	In the staff survey when asked if they had all the knowledge required to talk to pregnant women about smoking in pregnancy only 52% of midwifery staff agreed or strongly agreed with the statement. 58% of sonographers and 46% of support workers strongly disagreed with the statement – indicating that they lack the required knowledge and most likely do not have a good appreciation of the barriers. 25% of Children Centre staff reported a lack of confidence to discuss smoking, as did 26% of General Practice staff. Furthermore 31% of General Practice staff reported having insufficient knowledge to advise on smoking in pregnancy.
Know how to refer to SSiP services	In terms of familiarity with the SSIP referral process while 70% of midwives said they were clear about the process this varied with 91% of community staff answering positively compared to 45% of antenatal and 47% of postnatal staff. 72% of health visiting staff indicated that they knew the referral process but only 7% of GP practices staff said they would refer to the SSIP service. Lack of knowledge about the referral process was reported in the staff survey as a considerable barrier for both maternity staff in general (15%) and for health visiting staff (9%). Only 16% of Children's Centre staff report referring to SSiP services.
Be able to advise on the treatments to aid quitting	All staff groups expressed a need for increased knowledge around e-cigarettes and NRT; less than 5% of staff had sufficient knowledge about NRT and only 3% of staff felt confident to advise about e-cigarettes.

Be trained in brief skills to initiate a referral	In terms of expressing confidence in engaging pregnant women with discussion about smoking, 11% of maternity staff strongly agreed that they had all the confidence they needed, 40% agreed, 18% disagreed and 9% strongly disagreed (ie 27% of maternity lack confidence to have the conversation. Those confident would be assumed to have the required skills.
Be trained in the use of CO monitors	The proportions of maternity staff trained to undertake CO monitoring ranged from 90% of those working in the community to 46% of antenatal staff and 48% of postnatal staff. By profession, 92% of sonographers, 89% of other medical staff and 62% of support workers reported not receiving CO training. Overall 30% of all survey respondents said they would not be confident to discuss a CO reading, indicating a need for training.
Trained to understand the barriers professionals may face in tackling smoking (eg damage to relationship)	In the staff survey concern about the future relationship with the patient was more of a barrier for health visiting staff (12%) than maternity staff (10%), although 18% of community midwifery staff felt this to be a barrier – indicating that more training is required in relation to this.

Appendix 12

Smoking Cessation/Smokefree Policies in NHS Trusts – PH48 Standards

PH 48 Standard	Evidence through review
Clinical or medical director lead identified for Smoking Cessation/Smokefree policy development	Yes, at UHCW. Understood to be no at GEH and SWFT.
Smokefree policies in place	Yes, at UHCW and SWFT. Policy agreed at GEH but understood to be out of date.
An Annual Improvement Plan relating to smoking cessation (eg by clinical area) is developed	No.
On-site smoking cessation service provided	Yes, at UHCW but limited service for Coventry residents only. Individual outside of Coventry are appropriately signposted. Understood not to be in place at SWFT and GEH.
Electronic referral system in place from Trust to local smoking cessation provider(s)	Yes, at UHCW. Understood no at SWFT and GEH.
Provision of full range of NRT/ pharmacotherapies (short and long-acting NRT products plus bupropion and varenicline)	At UHCW only nicotine patches currently available for inpatients. Vouchers are offered on discharge for other NRT products. Very limited provision understood to be in place at SWFT and GEH with limited prescribing of products.
Provision of staff training in smoking cessation and/or MECC	Yes at UHCW via cascade trainers. Plans to include this in induction programmes going forward. No information provided by SWFT and GEH.
Are staff provided with support/access to Stop Smoking Services?	Yes, at UHCW 1:1 support offered where possible. Understood to be no (or very limited provision) at SWFT and GEH.
Is information and advice in relation to smoking/smoking cessation available to patients, carers, families and others in the hospital environment	Yes, at UHCW there are posters and business cards in all areas. No information provided by SWFT or GEH.

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