PHE Smoking in Pregnancy Mapping Project
Medway

Project Title: Reducing Smoking in Pregnancy

Project Lead: Fareeda Williams

Project Lead Contact Details:
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Target Population:
(e.g. nationality, age bracket, socioeconomic status, geographic area, fathers etc. Please also discuss any local insight research which was used or commissioned)

Locality:
(include all known details about where the project is located - hospital/local authority/community centre/Sure Start/neighbourhood/town/region)

Aims and Objectives of the Project:
(*SMARTT targets, KPIs, those set by commissioners and providers, please include informal aims as well*)

Smoking in pregnancy rates in the Medway towns have traditionally been high and currently sit at around 19%. The county is a diverse mix with pockets of very high deprivation and a growing Eastern European population who have not been responsive to behaviour change interventions.

Although there had been an "opt out" system of referring women for stop smoking support in place for some years, the number of women who went on to quit was low so in 2013 that Medway implemented the BabyClear programme to better engage with pregnant women, with some minor tweaks to suit local need. It was felt that the Risk Perception intervention would reduce the number of women who dropped out and increase the quit rate.

Prior to the introduction of the Risk Perception initiative, around 60% of women who were referred entered the programme for stop smoking support although not all went on to quit smoking. It is hoped that this new initiative will increase the number of quitters.

- Continued engagement with stakeholders to ensure the programme continues to develop.
- for stop smoking support for pregnant women to become embedded in the care pathway and that all healthcare professionals who work with pregnant women engage with this work.
- for the CO test to be offered to pregnant women during all antenatal visits and at delivery.

Brief Description of the Project and how it operates:
(*please include background to how the project was initiated, obstacles faced during setup and throughout and how/if they were overcome, training arrangements for staff)*

The programme for supporting pregnant women who smoke to quit has been developing and growing over many years. CO monitoring had been available to pregnant women in the Medway area since 2012 but not all midwives were willing to offer it, citing fears about the client relationship. To address this concern, the Stop Smoking Pregnancy team set up an initiative of attending a clinic in the hospital and offering a free CO test to 1000 women to ascertain attitudes to the test. Perhaps because it was introduced as part of routine antenatal care no women refused the test. A case was then made to midwives that pregnant women were willing to engage with the test and happy for it to be offered. In addition to identifying smokers, a number of cases of exposure to carbon monoxide from faulty boilers were discovered which further cemented the value of offering the test as part of standard pre-natal care.

Training was given to all midwives via team meetings – there are four teams in total - and refreshments were provided by the Stop Smoking Team. Training covered not only the use and maintenance of the monitors but techniques for engaging in a meaningful dialogue with the women about the impact of tobacco use on their baby. Numbered CO monitors were issued at these meetings which enabled midwife activity to be monitored. Yearly update training is mandatory for all community and hospital-based midwives and offered on a monthly basis.

Smokers who are identified as a result of the CO test are referred to the Stop Smoking Service. A paper referral form is completed by the midwife and faxed to the Stop Smoking Service. The women are then contacted within 48 hours (although usually on the same day the fax is received) and offered an appointment with an advisor the same week. The team of two full time specialist pregnancy advisors and one part time advisor is headed up by a former midwife. The standard service is 1:1 advice in a community setting although in July of 2014 an advisor was recruited to offer home visits. Despite this being a recent initiative, a positive impact is already being seen both in engagement with the women but with their partners as well. Home visits are offered in the day or evening between Monday and Saturday (the advisor offers evening visits one week; Saturday visits the next). To promote engagement with women from Eastern Europe, the initial phone call is made by an interpreter who then attends the first appointment.

Support for this work amongst senior managers in the maternity service has been variable and so, following extensive negotiation with the maternity service, a decision was made to set a CQUIN for working with pregnant women who smoke. The CQUIN includes recording smoking status, offering a CO test at booking, referring smokers for stop smoking support, recording SATOD data accurately and training for midwives.

Outcomes:
(provide baseline, please also include formal and informal outcomes - e.g. a drop in the number of pregnant smokers, changing attitudes amongst clinical staff,)

This project has only recently been implemented and, as such, there are no results yet.

Relationship to current evidence base:
(in particular which evidence was drawn on during the project design?)

Evaluation:
(formal and informal, was it published, if an evaluation has not been carried out please explain why not - funding?)

Costs:
(revenue and capital, include detail about equipment costs - CO monitors etc)

Commissioning arrangements and timescale
(is there long term sustainability or was this a short project, please also say who has commissioning responsibility for the project)

This work is funded and commissioned by the Public Health Department in Medway Council.

Any other points the interviewee wishes to make:
(any learning, advice for colleagues setting up a similar project)

1. An adequate level of staffing is necessary to carry this work out effectively.
2. Maintaining stakeholder relationships will ensure continuity of standards.
3. Sufficient time for training and support of the midwives should be allocated.
4. Engaging with the midwives of the future while they are in training is key to a long term change in the attitudes towards discussing tobacco use with pregnant women.
5. Streamlining bureaucratic procedures is helpful so midwives are not duplicating paperwork.
6. Frequent audits of patient notes provide useful information about activity and identify training needs.