North East and Cumbria LMS Boards Regional Smoking in Pregnancy Audit

Purpose

Smoking in pregnancy is driven by a complex range of factors. There are many examples of good work in local areas, with very successful outcomes. However, the picture is complex; women and their families come into contact with many different parts of the health and social care system before, during and after a pregnancy. Each part of that system has varying potential to impact on reducing rates.
This whole systems toolkit is designed to support areas to examine their impact upon reducing smoking in pregnancy across the whole system. The tool will help to identify which areas within their local system have the potential to make the most impact.

Background

Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK.
Smoking rates not only vary by local authority area, but also by age and social group: pregnant women from unskilled occupation groups are five times more likely to smoke than professionals, and teenagers in England are six times more likely to smoke than older mothers.

Infants born to smokers are much more likely to become smokers themselves which perpetuates cycles of health inequalities. Giving every child the best start in life must be made a priority and this must include protecting babies from the damage of tobacco smoke, both before and after birth.

Process

The focus of the maternity self- assessment element of the toolkit were discussions with each of the heads of Midwifery (HOM) in each of Foundation Trusts within the North East region .
It was felt that it was important in securing the commitment of the right people at the start of the process and will help you to get the best out of the tool, and will provide a broad understanding of local policies and relationships that relate to smoking in pregnancy work locally.

Foundation Trusts Visited

- County Durham and Darlington
- Carlisle and North Cumbria
- Royal Victoria Infirmary
- James Cook

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- North tees and Hartlepool
- Queen Elizabeth Gateshead
- South Tyneside
- Northumbria and North Tyneside
- Sunderland

Emerging themes

Training and equipment

All trusts delivered some level of training and refreshment updates. A mixed model of delivery was evident with some training being delivered by stop smoking services and some locally by trusts by a training midwife or public health midwife. Not all training was mandatory and the frequency and content was variable. Much of the focus was on community midwifery and support staff being the key providers of much of the interventions and support. Very few trusts supported training for medical staff.

All of the trusts indicated that community staff both midwives and maternity support workers had their own CO monitors with funding for replacement and maintenance variable however more than half of trusts replaced and maintained their own equipment. The provision and use of co monitors in other areas e.g antenatal clinics, assessment units, antenatal inpatient wards and delivery suites of maternity services was again viable.

Data and governance

Almost all trusts recorded booking information e.g smoking status electronically for all women however the actual recording of the CO reading was variable. Most trusts did not have robust process in place for review and validation of data. Not all trusts carried out CO monitoring on all women focusing only on those who had identified they had or were smoking. Recording of CO monitoring at every contact was inconsistent with no process for validation and few audits being carried out as part of any governance or assurance framework. Most trusts still operated a paper based hand held records system for most of the antenatal period so CO readings if taken would be recorded in the paper records and not electronically. Data display and analysis was variable with few reporting via any governance process.

Smoking at time of delivery (SATOD) data in all trusts was recorded electronically. Very few trusts validate this using CO monitoring relying on midwives asking the

women. However 1 trust carried out CO monitoring on admission to delivery suite and on postnatal ward which supported the validation process. The process for reporting of and displaying data as part of any metrics dashboard again was variable.

Pathways and collaboration

Nicotine replacement therapy in the form of patches was available in the maternity wards in almost all trusts, with prescribing and access available on the maternity wards. Some trusts did proactively manage this process to encourage women to use NRT however this was not consistent and proactive in all trusts.

Referral process for quit support again was inconsistent with not all trusts having stop smoking services and support available. One trust just offering support via community pharmacies. Most trusts did operate an opt approach to referrals with 2 referring only those women who identified they wish to quit and 1 having no process in place at all.

Audit of data and feedback again was variable depending on the relationship and collaboration with stop smoking services and Local Authorities.

Where relationships with stop smoking services and LA teams had been fostered feedback and collaboration with regular contact to improve pathway processes and uptake of services was very positive. Information sharing on any new updates and new initiatives was either shared if joint meetings did take place or information was cascaded e.g if HOM received anything new would cascade to all teams.

Most trusts operated the risk perception process, with 2 trusts having no process in place at all. Capacity issues and training were identified as reasons. Who actually delivered the risk perception was variable with some using midwives who had received training and others had support from stop smoking advisors. Some offered NRT during that process but most referred on to arrange appointments with the appropriate ongoing support. One trust who have introduced the " doll and placenta" discussion on CO and oxygen exchange and effects on the fetus early on in the antenatal period have seen a decline in the need for women to attend risk perception as these women have often already opted into the quit programme. This is being monitored.

With regard to the DOH/PHE plans for all trusts to be completely smoke free by 2019 some trusts did have groups/committees set up with midwifery participation in progress this and in 1 trust the public health midwife is vice chair of the trust wide committee. All trusts had smoke free signage and some had a tannoy type system but in all trusts smoking by individuals including pregnant women was observed. This

process is not proactively managed or policed. Some HOM/midwives were not aware of any groups committees within their own trust.

What works well

- Letters sent to all patients who register for care within the trust including maternity care regarding the trust being smoke free and availability of NRT.
- Where collaboration of all services SSS, LA and maternity is in place there is improved processes and approach to training.
- Use of “dolls and placentas” out with risk perception process seems to have had a positive impact.
- Carrying out CO monitoring on admission to delivery suite and on postnatal wards.
- Where is effective leadership with the authority to act, implementation of initiatives to support SIP appears to be more positive.

Where are the challenges

- Differing funding streams and fragmentation of services.
- Inconsistent approach to training.
- Workforce differences including MCA roles and banding
- Pathways and guidelines are not consistent
- Medical staff training and engagement.
- Implementing robust Governance and assurance frameworks and linking SIP processes into clinical safety forums.
- Data reporting inconsistencies
- Wider context of the smoke free trusts moving towards completely Smokefree by 2019.

Lessons learnt

- On hindsight would have been preferable to have met with more staff involved in the managing of the SIP process rather than the HOM
- Requesting current pathways and guidelines before discussion

<u>Key Learning/recommendations</u>

- Core pathways including training and refreshment expectations.
- Single format of data presentation
- Accurate data collection and governance processes in analysis and reporting of data linking it to clinical outcomes and patient safety.
- Core specification and collaboration of services.
- Leadership and job roles.
- Promotion of PHE agenda from a trust wide perspective.

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