MEETING IN COMMON OF NHS MANSFIELD AND ASHFIELD CCG AND NHS NEWARK AND SHERWOOD CCG GOVERNING BODIES

TITLE: Smoking At Time Of Delivery (SATOD) rates

DATE OF MEETING: 2 August 2018

PAPER REF: JGB/18/91

AUTHOR: Sue Bateman / Rosa Waddingham

PRESENTER: Elaine Moss

PURPOSE OF REPORT:
To provide detail on the SATOD rates and the work being undertaken in relation to maternal smoking rates within mid-Nottinghamshire.

RECOMMENDATION:
☐ To endorse
✓ To approve
☐ To receive the recommendation (see details below)
☐ To discuss

This paper is for information as requested by the Governing Bodies on 5th July 2018, there is also a recommendation to:

Adopt the Local Maternity System (LMS) SATOD targets, and report against the agreed local trajectory moving forwards. The national target is 6% by 2021/22

The Nottingham LMS targets are 10% in Mansfield & Ashfield and 8% in Newark & Sherwood.

EXECUTIVE SUMMARY (OVERVIEW):

In Quarter 1 2017/18, Mansfield & Ashfield CCG SATOD rates were 23.8% making them the third highest CCG nationally. Newark and Sherwood CCG had a better position with a rate of 18.1%.

Improvement has been made with Q1 2018/19 SATOD rates at 20.6% for Mansfield and Ashfield CCG and 17.8% for Newark and Sherwood CCG both remain at a concerning level.

We recognise;

- Smoking in pregnancy is a national priority and for the Nottinghamshire Local Maternity System (LMS) particularly in view of the exceptionally high rates in Mansfield and Ashfield, Newark and Sherwood and Nottingham City.
- Smoking in pregnancy leads to a number of negative effects and it is the single most important modifiable risk factor in pregnancy.
- Reducing smoking during pregnancy is one of the three national ambitions in the Tobacco Control Plan (DOH 2017), with an aim of “reducing smoking amongst pregnant women (measured at time of giving birth) to 6% by the end of 2022”.

In 2017:

- Sherwood Forest Hospitals Foundation Trust was the first trust in the region to introduce the “Risk Perception Model”. This is a hard hitting intervention delivered by a midwife with an individual mother and her family. The intervention graphically explains the effects of smoking on a fetus.
• Public Health supported an evaluation of the risk perception model at Sherwood Forest Hospitals Foundation Trust, which demonstrated that the intervention is effective in reducing Smoking at Time of Delivery; previously only 57% of pregnant smokers had received the intervention.
• All midwives who deliver the Risk Perception needed to be trained and updated annually with adequate staffing in the antenatal clinic to increase coverage.
• Need to integrate work around SATOD into wider population approaches and a Making Every Contact Count (MECC) approach was relaunched.

Building on Actions Into 2018:
• Bi-monthly Mid Nottinghamshire SATOD focus group has been established
• An additional midwife has been trained to deliver Brief Intervention Interviews for women accessing services in Newark.
• All women who are identified as smokers are referred to a smoking cessation service via electronic referral. The service then contacts women by telephone to offer various types of support.
• Smoking status at booking is now communicated to GPs via an electronic letter.
• The smoking cessation provider has undertaken wider work with the early pregnancy unit, ward 24 and the neonatal unit to improve uptake.
• The Local Maternity System (LMS) has set timescales for the development of a community hub model and the revised Nottinghamshire local maternity offer for 2020 will integrate SATOD and maternal smoking into a wider population focussed approach.

REPORT:

Background

In Quarter 1 2017/18, Mansfield & Ashfield CCG SATOD rates were 23.8% making them the third highest CCG nationally. Newark and Sherwood CCG had a slightly better position with a rate of 18.1%.

Improvement has been made Q1 2018/19 SATOD rates 20.6% for Mansfield and Ashfield CCG and 17.8% for Newark and Sherwood CCG both remain at a concerning level.

We recognise;

• Smoking in pregnancy is a national priority and for the Nottinghamshire Local Maternity System (LMS) particularly in view of the exceptionally high rates in Mansfield and Ashfield, Newark and Sherwood and Nottingham City.
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SATOD has been a priority for a number of years and some long term improvement has been made, but rates remain higher than the England average.
Local Targets

As part of the Better Births Maternity Transformation the current target is 11%. The Local Maternity System (LMS) has instead developed some local targets, for agreement. These targets remain challenging. The targets have been developed with provider, commissioner, regulator and public health input.

**LMS Nottinghamshire Targets**

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</thead>
<tbody>
<tr>
<td>National IAF Target</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6%</td>
</tr>
<tr>
<td>Mansfield &amp; Ashfield CCG</td>
<td>18.0</td>
<td>15.0</td>
<td>12.0</td>
<td>&lt;10.0</td>
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<tr>
<td>Newark &amp; Sherwood CCG</td>
<td>16.0</td>
<td>13.5</td>
<td>11.0</td>
<td>&lt;8.0</td>
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Actions to Date:

Work between December 2017 and June 2018 has delivered a number of changes:

- SFHFT was the first trust in the East Midlands to roll out the risk perception smoking cessation model following the first dating scan for pregnant smokers. The model is a motivational interviewing consultation focusing on the effects that smoking has on the baby, includes visual aids and a Carbon Monoxide (CO) reading. A mandatory smoking cessation referral is then made following the consultation. However as previously reported, the trust had struggled to offer this intervention to all pregnant smokers due to staffing issues. In the last 6 Months the CCG’s have supported the training of an additional midwife to offer the intervention at Newark Hospital.
- Working with Nottingham University, SFHFT developed and displayed posters at two conferences relating to successes achieved to date with the Brief Intervention model (Annex A)
- SFHFT has implemented the NICE guidance relating to smoking in pregnancy. CO₂ breath testing is offered to all women at pregnancy, 16 weeks if missed or still smoking, and at 36 weeks. Additional ad hoc readings are performed if a woman needs to attend pregnancy day care unit.
- All women who are identified as smokers are referred to a smoking cessation service via electronic referral. The service then contacts women by telephone to offer various types of support.
- Smoking status at booking has been added to the letter sent to GPs following a booking appointment.
- Known smokers are invited to specific scan appointments; smoking cessation advisors are present at these clinics and offer interventions directly to women and their wider families. This is when risk perception is also offered.
• As part of the Saving Babies Lives Care Bundle women who choose to continue to smoke are put onto a care pathway which increases the fetal surveillance.
• The smoking cessation provider offers NRT treatments as well as offering advice and support information relating to e-cigarettes.
• The smoking cessation provider has now undertaken some wider work with the early pregnancy unit, ward 24 and the neonatal unit.

Mid-Nottinghamshire and Greater Nottinghamshire CCGs planned for the development of a website and linked support materials to provide information about the harms of smoking in pregnancy and how to access support. However a decision by Nottingham City Council to decommission all smoking cessation services saw the withdrawal of Greater Nottinghamshire CCGs from the planned scheme and this has currently been suspended.

Next Steps

• A joint trust and CCG audit is planned for July 2018 to gain assurance that midwives are following the Trust’s Smoking in Pregnancy Guidelines.
• Work is underway to improve access to the brief intervention interview by some changes the organisation of staff within the antenatal clinic and pregnancy day care unit.
• Community midwives will be asked to attend a meeting delivered by the smoking cessation service, this will update them on the maternity transformation plans and provide an opportunity for midwifes to feedback their views.
• Two community maternity hubs are currently being scoped for Kirkby-in-Ashfield and Newark. The hubs will incorporate access to smoking cessation support.
• IT developments have been requested to support midwives being able to record CO₂ readings electronically.

QIPP Assurance and connection

Whilst this work will not realise any QIPP in itself it is an enabler to achieve reductions in non-elective admissions and the development of long term conditions in both adults and children.

Financial Impact and Risks

Services are paid for via Maternity Tariff. Payments are made in the antenatal period at three rates:

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Tariff (£)</th>
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<tbody>
<tr>
<td>n/a</td>
<td>Standard</td>
<td>1,019</td>
</tr>
<tr>
<td>n/a</td>
<td>Intermediate</td>
<td>1,630</td>
</tr>
<tr>
<td>n/a</td>
<td>Intensive</td>
<td>2,713</td>
</tr>
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</table>

Smoking in pregnancy triggers an intermediate payment and would be a factor considered in deciding if the intensive tariff applies.

Additional payment is made for the care given during the birth, costs increase if the birth is complicated. A fetus that is compromised by maternal smoking is more likely to require and emergency, and complex, delivery.

Reducing maternal smoking would have a positive impact in reducing costs for maternity services.

Risk Implications, Assessment and Mitigations

Consultation, Involvement and Engagement

Not applicable
### Equality Impact
Not applicable

### Evidence and Research (include where this informs why the paper is presented to Governing Bodies)
Not applicable

### HOW DOES THIS CONTRIBUTE TO THE OUTCOMES AND OBJECTIVES OF THE CCG:
- Quality [✓]
- Health [☐]
- Financial [☐]
- Clinical [☐]
- Performance (tick as appropriate) [☐]

### CONFLICTS OF INTEREST:
This is a recommended action to be agreed by the Chair at the beginning of the item.
- [✓] No conflict identified
- [☐] Conflict noted, conflicted party can participate in discussion but not decision (see below)
- [☐] Conflict noted, conflicted party can remain but not participate (see below)
- [☐] Conflicted party is excluded from discussion (see below)

### CONFIDENTIALITY:
Is the information in this paper confidential?
- [✓] No
- [☐] Yes
Background
Smoking in pregnancy is a major public health concern and the current national ambition rate has been set to reduce smoking at time of birth to ≤6% at time of birth by 2020.

Smoking is a modifiable risk factor in pregnancy. It is known that smoking or smoke exposure during pregnancy can cause serious health problems and has further implications throughout childhood. Smoking is strongly associated with several adverse socio-economic and educational indicators.

NHS England recently set a national ambition to halve the rates of stillbirths by 2030, with a 20% reduction by 2020. ‘Saving Babies’ Lives’ will help maternity services meet this aspiration. Reducing the incidence of maternal smoking during pregnancy forms one of the evidence-based four elements of the NHS England ‘Saving Babies’ Lives’ care bundle.

The total annual cost to the NHS of smoking during pregnancy is estimated to range between £3.1 and £54 million for treating the resulting problems for mothers and between £12 and £23.5 million for treating infants (aged 0–12 months).

Smoking cessation pathway development

2011 Community midwives had Brief Intervention education
2013 University of Nottingham ‘Opt out’ study: introduction of a CO reading at 12 weeks of pregnancy
2014 Risk Perception Intervention commenced (Motivational Interviewing based intervention)
2017 CO readings at first contact commenced

Care pathway for women who smoke 2017
1. CO reading at first contact
2. Risk Perception with a repeat CO reading for women continuing to smoke
3. Discussion about smoking raised at every subsequent antenatal contact
4. Serial growth scans for women who continue to smoke at 28, 32, 36, 39 and 41 weeks to detect fetal growth restriction and small for gestational age babies to reduce the term still birth rate: NHS England Saving Babies’ Lives (2016)
5. Smoking status recorded at 25 weeks and 34 weeks and % stillbirth for the full period. There was a score of 0.75 for Q1 16/17 onwards, indicating the two variables are strongly related in the latter quarters. The small numbers associated with still births contributed to the volatility in the data.

Reflection and Discussion
Seeing the baby for the first time and receiving CO readings coupled with learning that high CO levels are harmful to the fetus, could have been an additional motivator for the women. At SFHT ‘opt-out’ referrals were implemented by a small group of healthcare staff who were trained to national standards and received support afterwards; staff training and ongoing support may be necessary to ensure that new referral processes are effectively introduced. The ‘opt out’ pathway was implemented in addition to existing ‘opt in’ referrals, repeated referrals may have enhanced smokers’ motivation leading to improved cessation outcomes (Campbell et al 2017). SFHT redesigned the smoking in pregnancy pathway, embedding intensive specialist smoking cessation advice into routine antenatal care.

Motivational Interviewing is a powerful technique and must be conducted by appropriately qualified personnel to achieve a consistent outcome that empowers women to quit smoking.

References