Quitting smoking in pregnancy and following childbirth

Commissioning guide
Implementing NICE guidance

December 2010
Quitting smoking in pregnancy and following childbirth

This commissioning guide provides support for the local implementation of NICE guidance through commissioning, and is a resource for people involved in commissioning health and social care services and public health programmes within the NHS and partner organisations in England.

All commissioners, including commissioners of children and families services, may find this guide useful to inform partnership working and joint planning.

This commissioning guide should be read together with the following NICE guidance:

- NICE public health guidance PH26. How to stop smoking in pregnancy and following childbirth.

Commissioners should note that the NICE public health guidance PH26 updates the recommendations on smoking in pregnancy in 'Antenatal care: routine care for the healthy pregnant woman' (NICE clinical guideline CG62).

NICE public health guidance PH26 recommends the identification and routine referral of pregnant women who smoke to NHS Stop Smoking Services by midwives and others in the public, community and voluntary sectors. The recommendations will impact on the local commissioning of maternity services, and on resources and capacity within NHS Stop Smoking Services.

When planning quitting smoking in pregnancy services, commissioners may also wish to consider other factors affecting women before, during and after childbirth and refer to the following commissioning guides:

- Weight management before, during and after pregnancy
- Peer support programme for women who breastfeed
- Antenatal and postnatal mental health services.

NICE guidance provides evidence-based recommendations about clinically effective and cost-effective treatments and interventions to improve outcomes for local populations.

Making commissioning decisions based on NICE guidance and accredited information from NHS Evidence can help commissioners of services ensure they are using their resources effectively.

This commissioning guide highlights any recommendations that support cases for disinvestment or decommissioning of services by identifying treatments
and interventions that do not add value. This enables commissioners to release resources or generate savings where appropriate.

Implementation of the guidance noted above is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement this guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in the guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

The guide:

- makes the case for commissioning services for quitting smoking in pregnancy and following childbirth
- specifies service requirements
- helps you determine local service levels
- helps you ensure corporate and quality assurance.

The full text of this commissioning guide can be downloaded or accessed from the navigation menu on the right hand side of the screen. Download the openly available commissioning and benchmarking tool, there is no need to register.

We are keen to improve the commissioning guides in order to better meet the needs of commissioners. Please send us your ideas for future topic-specific guides or other comments.

Read the NICE disclaimer for information on the use and accuracy of content on the NICE website.

- Topic-specific Advisory Group: quitting smoking in pregnancy
Commissioning services for quitting smoking in pregnancy and following childbirth

Smoking in pregnancy is a major public health concern imposing a considerable economic burden on society, and increasing risks to both mother and child.1 Reducing the prevalence of smoking in pregnancy, and among other target groups, contributes to a reduction in infant mortality and health inequalities.

Smoking during pregnancy increases the risk of infant mortality by an estimated 40%.2 It is estimated that about one-third of all perinatal deaths in the UK are caused by smoking.3 Passive exposure to tobacco smoke, both before and after birth, also has a substantial impact on the risks of a range of fetal and childhood health problems.4 Serious pregnancy-related health problems include complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy.5

Children exposed to tobacco smoke in the womb are more likely to experience wheezy illnesses in childhood. There is also evidence that exposure in the womb is associated with psychological problems in childhood, such as attention and hyperactivity problems and disruptive and negative behaviour. In addition, infants of parents who smoke are more likely to suffer from serious respiratory infections such as bronchitis and pneumonia, symptoms of asthma and problems of the ear, nose and throat including glue ear.6 The report passive smoking and children in 2010 highlights that the burden of disease caused by passive smoking in children in the UK is substantial. Passive smoking results in over 165,000 new episodes of disease, 300,000 primary care contacts, 9,500 hospital admissions, at least 200 cases of bacterial meningitis, and about 40 sudden infant deaths each year. In 2009, over 20% of children, or over 2 million of those aged 16 and under in the UK, lived in a household in which they were exposed to smoke.4

The total annual cost to the NHS of smoking during pregnancy is estimated to be as high as £64 million for treating the resulting problems for mothers and as high as £23.5 million for treating infants (aged 0–12 months).1 Estimates have also placed the costs of a complicated delivery by a woman who smokes at 66% higher than that of a woman who does not smoke.7 Cost estimates are limited to NHS costs during pregnancy and the first year of life, but smoking in pregnancy has long-term effects on health and may therefore have wider costs to education, social work and judicial systems. The real costs to society could be much higher.1

Smoking during pregnancy is strongly associated with age and socioeconomic position, and is the single most modifiable risk factor for adverse outcomes in pregnancy. Commissioners can reduce morbidity and cost by ensuring that clear and systematic referral pathways are in place for pregnant women who smoke, and service providers are trained and competent to provide evidence-based interventions.
A range of effective interventions and services, such as NHS Stop Smoking Services, are available to help people stop smoking. Nevertheless, only a small number of women take up the offer of help during pregnancy or after childbirth. NHS Stop Smoking services should be seen as providing the core to a wider network of referrers, and all healthcare professionals (HCPs) can have a positive impact on a person’s decision to stop smoking. Maternity services play a key role in identifying and referring women who smoke and are trying to conceive, or pregnant women who smoke, to NHS Stop Smoking Services.\(^8\)

Encouraging practitioners to refer all pregnant women who smoke – even those who are currently unwilling to consider quitting – may create a need for additional stop-smoking resources. However, higher referral rates are important in tackling smoking in pregnancy. Commissioning maternity and stop-smoking services in line with NICE public health guidance PH26 will help lower smoking prevalence. This in turn will generate health benefits resulting in reduced healthcare costs.\(^9\)

A range of local approaches are needed to increase the number of pregnant women who smoke who are referred to services, and who receive help to stop smoking.

**Benefits**

The potential benefits of robustly commissioning effective services for quitting smoking in pregnancy and following childbirth include:

- **reducing morbidity and infant mortality** by helping women to stop smoking before or during pregnancy
- **raising awareness of the harm** caused to women, the unborn child and children by passive smoking
- **reducing inequalities and improving access** to NHS Stop Smoking Services by increasing referral routes from maternity services and others in the public, community and voluntary sectors
- **improving engagement with NHS Stop Smoking Services** by increasing the number of pregnant women receiving specialist support while attempting to stop smoking
- **improving outcomes** by increasing the numbers of pregnant women who stop smoking during pregnancy and after childbirth
- **increasing choice for pregnant women** by improving partnership working and offering access to a range of services across a number of settings
- **reducing costs** associated with smoking-related complications for mothers during pregnancy and babies following birth
- **contributing to national targets** to reduce smoking prevalence, infant mortality and health inequalities
• **increasing clinical and cost effectiveness** by making commissioning decisions based on NICE guidance and accredited information from NHS Evidence.

**Key clinical issues**

Key clinical issues in providing effective services for quitting smoking in pregnancy and following childbirth are:

• **accurately identifying and referring** pregnant women who smoke

• **increasing the routine use of carbon monoxide tests** in maternity services

• **providing the best possible health outcomes** for individual pregnant women, their babies, families and local communities

• **providing effective interventions** through initial and ongoing support by specialist advisers

• **providing a quality assured service.**

**National drivers**

National priorities and initiatives relevant to commissioning services for quitting smoking in pregnancy and following childbirth include:

• **Equity and excellence: liberating the NHS: Transparency in outcomes – a framework for the NHS** (draft for consultation)

• **Revision to the operating framework for the NHS in England 2010/11**

• **The new performance framework for local authorities and local authority partnerships:** single set of national indicators

• **Quality, innovation, productivity and prevention**

• **Using the commissioning for quality and innovation (CQUIN) payment framework (with addendum for 2010/11)** makes a proportion of providers’ income conditional on quality and innovation.

• **Maternity and early years: making a good start to family life**

• **Fair society, healthy lives** strategic review of health inequalities in England post-2010

• **Healthy lives, brighter futures – The strategy for children's and young people's health**

• **Towards better births: a review of maternity services in England**

• **Health inequalities: progress and next steps**

• **Maternity matters: choice, access and continuity of care in a safe service**
• Cancer Reform Strategy
• Implementation plan for reducing health inequalities in infant mortality: a good practice guide
• No ifs, no buts: improving services for tobacco control
• Choosing health: making healthy choices easier
• National service framework for children, young people and maternity services: maternity services
• The NHS Cancer plan: a plan for investment, a plan for reform
• The Care closer to home initiative outlined in chapter 6 of the white paper Our health, our care, our say
• Commissioning framework for health and well-being
• Considering the impact of patient choice
• A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services
• Implementation of NICE clinical and public health guidelines. These are currently core standards, and performance against these standards will be assessed by the Care Quality Commission.

Although many or all of these priorities may be relevant to the services nationally, your local service redesign may address only one or two of them.

References


Specifying services for quitting smoking in pregnancy and following childbirth

Service components

The key components of services for quitting smoking in pregnancy are:

- identifying and referring all pregnant women who smoke
- contacting women who have been referred and offering initial and ongoing support from specialist advisers
- developing high-quality services for quitting smoking in pregnancy and following childbirth.

Identifying and referring all pregnant women who smoke

Commissioners should note that service components will impact on working practice within maternity services and other services (identifying and referring) as well as on NHS Stop Smoking services (contacting women). Therefore, service components apply to more than one service specification and a range of providers.

Commissioners should work with a range of service providers including midwives, GPs, practice nurses, health visitors and family nurses as well as obstetricians, paediatricians, sonographers and other members of the maternity team, those working in youth and teenage pregnancy services, children's centres and social services, fertility clinics, dental practices and community pharmacies to ensure that all women who smoke are identified and referred to NHS Stop Smoking Services. Commissioners may also wish to consider including referral procedures in all provider contracts for pregnant women who smoke. Commissioners should ensure that pregnant women who smoke have access to services and are referred in accordance with the referral recommendations in NICE public health guidance PH26.

NICE recommends that midwives take action at first maternity booking and subsequent appointments to assess the woman’s exposure to tobacco smoke through discussion and through use of a carbon monoxide (CO) test. This is because people can get a high CO reading simply from being around other people that smoke. Midwives should explain that the CO test will allow her to see a physical measure of her smoking and her exposure to other people’s smoking. Commissioners should take note that the aim of the test is not to check whether women are telling the truth – or to make them feel guilty if they smoke. Rather, it is to see if carbon monoxide is an issue for them (and, as a result, their unborn child).

NICE also recommends that midwives explain that it is normal practice to refer all pregnant women who smoke for help to quit and that a specialist
A midwife or adviser will phone and offer her support. Therefore commissioners need to ensure that the appropriate referral pathways are in place and there is sufficient capacity within NHS Stop Smoking Services to receive and follow up all women referred by midwives at first maternity booking and subsequent appointments, and where appropriate, at any earlier initial meetings.

**Contacting women who have been referred and offering initial and ongoing support from specialist advisers**

When commissioning NHS Stop Smoking Services, commissioners need to ensure that there are sufficient resources to enable specialist advisers to contact women who have been referred into the NHS Stop Smoking Service. Commissioners should ensure that there are sufficient resources to enable specialist advisers to ring referred women twice, follow up with a letter and invite them to use the service.

*NICE public health guidance PH26* recommends that attempts to see those who cannot be contacted by telephone should be made. This could happen during a routine antenatal care visit (for example, when they attend for a scan).

When specifying a service for initial and ongoing support, commissioners should note that studies have shown that effective interventions in helping women who are pregnant to stop smoking are:

- cognitive behaviour therapy
- motivational interviewing
- structured self-help and support from NHS Stop Smoking Services.

Pregnant women who smoke should be provided with intensive and ongoing support (brief interventions alone are unlikely to be sufficient) throughout pregnancy and beyond.

Women with partners who smoke find it harder to stop smoking and are more likely to relapse if they do manage to stop smoking. Commissioners should also ensure that capacity is available within NHS Stop Smoking Services to enable the partners of pregnant women and others in the household who smoke to have access to support to stop smoking. Interventions that are effective with the general population will not necessarily work with the partners of women who are pregnant. Therefore commissioners should refer to the recommendation for partners and others in the household who smoke in *NICE public health guidance PH26*.

Commissioners should be aware that there is mixed evidence on the effectiveness of Nicotine Replacement Therapy (NRT) in helping women to stop smoking during pregnancy. Therefore commissioners need to ensure that specialist advisers are competent and practicing in line with the NICE recommendations that relate to NRT including the following:
Discuss the risks and benefits of NRT with pregnant women who smoke, particularly those who do not wish to accept other help from NHS Stop Smoking Services. Use only if smoking cessation without NRT fails. If they express a clear wish to receive NRT, use professional judgement when deciding whether to offer a prescription.

Only prescribe NRT for use once they have stopped smoking (they may set a particular date for this). Only prescribe 2 weeks of NRT for use from the day they agreed to stop. Only give subsequent prescriptions to women who have demonstrated on reassessment that they are still not smoking.

**NICE public health guidance PH26** recommends that neither varenicline nor bupropion should be offered to pregnant or breastfeeding women.

**Developing high-quality services for quitting smoking in pregnancy and following childbirth**

**NICE public health guidance PH26** on Quitting smoking in pregnancy and following childbirth recommends that NHS Stop Smoking Services provide services that meet the needs of disadvantaged pregnant women who smoke.

Commissioners should ensure that NHS Stop Smoking Services provide the following:

- Services should be delivered in an impartial, client–centred manner. They should be sensitive to the difficult circumstances that many women who smoke find themselves in.
- Services should take into account other socio-demographic factors such as age and ethnicity and ensure provision is culturally relevant. This includes making it clear how women who are non-English speakers can access and use interpreting services.
- Services should collaborate with the family nurse partnership pilot and other outreach schemes to identify additional opportunities for providing intensive and ongoing support. (Note: family nurses make frequent home visits).
- Services should work in partnership with agencies that support women who have complex social and emotional needs. These include substance misuse services, youth and teenage pregnancy support and mental health services.

**NICE public health guidance PH26** also recommends training to deliver interventions.

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Commissioners should therefore ensure that **training to deliver interventions** that help pregnant women stop smoking reflects the recommendations in *NICE public health guidance PH26*. They should also ensure the following:

- All midwives who deliver intensive stop-smoking interventions (one-to-one or group support) are **trained** to the same standard as NHS stop-smoking advisers. The minimum standard for these interventions is set by the **NHS centre for smoking cessation and training**. They should also be provided with additional, specialised training and offered ongoing support and training updates.

- Midwives who are **not** specialist stop-smoking advisers are trained to assess and record people’s smoking status and their readiness to stop smoking. They should also know about the health risks of smoking and the benefits of quitting – and understand why it can be difficult to stop. In addition, they should know about the treatments that can help people to stop and how to refer them to local services for treatment. (Acquisition of this knowledge and skill set is part of level 1 training in brief stop-smoking interventions.\(^2\) Commissioners should note that midwives are not advised to carry out brief interventions with pregnant women. However, they are advised to use these skills to initiate a referral to NHS Stop Smoking Services.)

- All healthcare and other professionals who work with pregnant women are trained in the same skills – and to the same standard – as those required of midwives who are not specialist smoking cessation advisers.

Commissioners may wish to note that *NICE public health guidance PH26* recommends brief stop-smoking interventions and intensive one-to-one and group support to stop smoking are incorporated into pre- and post-registration midwifery training and midwives’ continuing professional development, as appropriate.

**Service models**

Commissioners may wish to consider commissioning services for quitting smoking in pregnancy in a number of different ways. **Mixed models** of provision may be appropriate in some localities. This may include non-NHS services that offer help to stop smoking (that operate to the same standard as NHS Stop Smoking Services), and maternity services with midwives who have been specially trained to help pregnant women to stop smoking.

General examples include:

\(^2\) For the national standard for level 1 see ‘**Standard for training in smoking cessation treatments**’ or future updates from the **NHS Centre for smoking cessation and training**. Note: ‘**Standard for training in smoking cessation treatments**’ is due to be superseded by the new **NCSCT training standard** from the end of March 2010.
• routine referrals of all pregnant women who smoke from maternity services to local NHS Stop Smoking Services
• specialist stop-smoking provision within maternity services or other settings where midwives are trained to deliver local specialist support
• Integrated smoking cessation as part of routine antenatal care.

(Please note – these examples are offered to share good practice and NICE makes no judgement on the compliance of these services with its guidance).

Commissioners should consider making resources available for stop-smoking interventions in the immediate postnatal period in line with passive smoking and children: a report by the tobacco advisory group of the Royal College of Physicians and the Healthy Child Programme: pregnancy and the first five years of life. They should also consider the needs of their whole population when commissioning stop-smoking services, including women who are planning a pregnancy and their partners and families.

Commissioners may wish to consider using the Commissioning for Quality and Innovation payment framework as a lever for influencing change where there are perceived barriers. Examples may include the number of referrals from maternity services to NHS Stop Smoking Services.

**Service specification**

Commissioners should collaborate with clinicians, local stakeholders, and service users when determining what is needed from services for quitting smoking in pregnancy in order to meet local needs and the needs of hard to reach groups including pregnant teenage young women who smoke. The service should be client-centred and integrated with other elements of care for women who are pregnant such as Sure start children’s centres and non-statutory organisations.

The service specification needs to consider:

• the scope of service in relation to local prevalence of smoking during pregnancy
• the rationale for the service
• the required competencies of – and training for – staff responsible for providing the service (see training standards at www.ncsct.co.uk)
• the expected number of referrals of pregnant women, partners and others in the household who smoke (this should take into account how quickly any changes in service provision are likely to take place)
• ease of access, service location, times and type of delivery (for example, home visits or other venues if it is difficult for women to
attend specialist services) ensuring that services can be tailored to meet individual needs and are flexible and coordinated; commissioners should engage with service users and other relevant individuals and organisations locally

- care and referral pathways to ensure that all opportunities are maximised to refer to NHS Stop Smoking Services, and to encourage pregnant women who smoke to stop
- providing structured self-help materials or support via a telephone helpline for women who are reluctant to attend the clinic
- links with other services such as contraceptive services, fertility clinics and antenatal and postnatal mental health services so that everyone working in those organisations knows about local NHS Stop Smoking Services and is promoting maternal smoking cessation
- measuring outcomes and performance indicators including percentage of women with their smoking status recorded at booking and delivery, and the percentage of women referred to local NHS Stop Smoking Services
- information and audit requirements, including establishing and maintaining data collection systems, IT support and infrastructure
- planned service development setting out any productivity improvements including redesign, quality and equitable access
- address any safeguarding concerns and promote the welfare of children and vulnerable adults
- service monitoring criteria.

Useful sources of information may include:

- ‘Brief interventions and referral for smoking cessation in primary care and other settings’ (NICE public health guidance PH1), ‘Workplace interventions to promote smoking cessation’ (NICE PH5) and ‘Smoking cessation services’ (NICE public health guidance PH10).
- ‘Behaviour change’ (NICE public health guidance PH6) and ‘Identifying and supporting people most at risk of dying prematurely’ (NICE public health guidance PH15).
- The NICE shared learning database offers examples of how organisations have implemented NICE guidance locally and implementation advice on stopping smoking in pregnancy (NICE public health guidance PH26).
- NHS stop smoking services: service and monitoring guidance 2010/11.
• **Department of health tobacco control national support team (TCNST)** and **Excellence in tobacco control: 10 high impact changes to achieve tobacco control. An evidence-based resource for local alliances.**

• **Action on smoking and health (ASH).**

• **The NHS smokefree pregnancy campaign** and **The NHS Smoking helpline.**

• **Tackling health inequalities: targeting routine and manual smokers in support of the public service agreement smoking prevalence and health inequality targets.**

• **The standard NHS contracts for acute hospital, mental health, community and ambulance services and supporting guidance**

• **NHS networks: learning from practice** database offers examples of innovative commissioning across the NHS and its partners.

• **Local Government Improvement and Development** supports improvement and innovation in local government.

• **Total Place: better for less** looks at how a ‘whole area’ approach to public services can lead to better services at less cost.

• **Every child matters** is a Green paper that aims to strengthen preventative services by focusing on supporting families and carers.

• **Teenage parents next steps: guidance for local authorities and primary care trusts** and **Teenage parents: who cares? A guide to commissioning and delivering maternity services for young parents.**

• **National guidelines for maternity services liaison committees (MSLCs):** MSLCs are for maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local women, parents and families. See also **website of the maternity service liaison committees.**
Determining local service levels for quitting smoking in pregnancy and following childbirth

**Benchmarks for a standard population**

Available data suggest that the indicative benchmark rate for the number of pregnant women who smoke at first maternity booking and are referred to an NHS Stop Smoking Service is **0.27%** or approximately 270 per 100,000 population **per year**.

For the purpose of this commissioning guide, the population has been defined as women aged 15–44 years old.

For a standard **population of 100,000** the number of women aged 15–44 is approximately 20.5% of the population or 20,500. Of these, around 6%, or 1250, will become pregnant each year. Approximately 21.5%, or around 270 pregnant women per year will be smoking at first maternity booking and referred to an NHS Stop Smoking Service.

For an average **GP practice** with a list size of 10,000 the number of women aged 15–44 is approximately 20.5% of the population or 2,050. Of these, around 6%, or 125, will become pregnant each year. Approximately 21.5% or around 27 pregnant women per year will be smoking at first maternity booking and referred to an NHS Stop Smoking Service.

Examine the **assumptions used in estimating these figures**.

This service is likely to fall under the **programme budgeting** category 221X (healthy individuals).

Use the quitting smoking in pregnancy and following childbirth **commissioning and benchmarking tool** to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

**Further information**

Sources of further information to help you in assessing local health needs and reducing health inequalities include:

- **Stop smoking services-needs analysis: a toolkit for commissioners** developed by the **NHS centre for smoking cessation and training** (NCSCT) to help commissioners identify, assess and prioritise where effective action should be taken when commissioning Stop Smoking Services.
- Annex A of the **Commissioning framework for health and well-being** outlines the process and data needed to undertake a joint strategic needs assessment.
• Department of Health Delivering quality and value – focus on benchmarking.

• NICE Health equity audit – learning from practice briefing.

• NHS Comparators provides comparator data for NHS commissioning and provider organisations to enable users to investigate aspects of local activity, costs and outcomes.

• Health profiles produced by the Association of Public Health Observatories (APHO) provide set of key health indicators at primary care trust level that show how the area compares to the national and regional average.

• Measuring smoking prevalence in local populations produced by the Association of Public Health Observatories (APHO) provides useful sources of local-level smoking data, option appraisals for local-level surveillance of smoking.

• PRIMIS+ provides support to general practices on information management, recording for, and analysis of, data quality plus a comparative analysis service focused on key clinical topics.
Assumptions used in estimating a population benchmark

The assumptions used in estimating a population benchmark for smoking in pregnancy of 0.27%, or 270, per 100,000 population per year is based on the following source(s) of information:

- epidemiological data on the prevalence/incidence of smoking in pregnancy from published research and literature
- activity data to establish smoking in pregnancy from audit and other sources
- current data collection where there is existing national smoking in pregnancy data collection
- additional factors which may influence smoking in pregnancy
- expert clinical opinion of the topic-specific advisory group, based on experience in clinical practice and literature review.

For the purpose of this commissioning guide the population has been defined as women aged 15–44 years old. Approximately 20.5% of the population in England are women aged 15–44 years old.¹

Epidemiological data

The diagram below illustrates four of the stages in pregnancy and the rate of smoking for each stage. For this commissioning guide, the first maternity booking stage has been used as the benchmark rate for the number of women who smoke in pregnancy. This is the expected stage that pregnant women are most likely to be in contact with maternity services. Commissioners should note that higher rates of women who smoke in pregnancy have been reported for the time period before women become pregnant, and in the time period following childbirth.

Stages of smoking in pregnancy

2 English estimate calculated from Scottish Morbidity Record (SMR02) and prevalence of smoking in England/Scotland. Adjusted for under reporting.
3 Department of Health, NHS IC Omnibus, 2008/09
In the financial year 2008/09 there were around 638,000 women who gave birth and had their smoking in pregnancy status recorded. It has been calculated that 21.5% of these, or around 131,000 women, would be smoking at first maternity booking. (This is examined further in the ‘current practice’ section).

**Activity data**

A standard population of 100,000 has around 1,250 pregnancies per year. Of these, 21.5%, or 270 pregnant women, would be smoking at first maternity booking. Currently around 38 pregnant women (14% of the 270) set a quit date with an NHS Stop Smoking Service.

Information gathered from ten local audits on Stop Smoking Services that adopted a routine referral system showed a range of outcomes. The common results include a large increase in the number of referrals to Stop Smoking Services, with an increase in quit dates set and the number of women who successfully quit.

One service adopting such a system estimated that in a 15-month period, almost half of mothers that smoked at first maternity booking set a quit date with the service. In addition, the quit rate for pregnant women accessing Stop Smoking Services increased by 12% during this period.

Another example of a Stop Smoking Service showed that the number of referrals trebled 12 months after a routine referral approach was adopted. There was also around a 50% increase in the number of women setting a quit date.

An increase in the number of referrals of pregnant women who smoke to NHS Stop Smoking Services is likely to have an impact on the number of women that successfully quit. However, commissioners may find that the increase in the number of women who successfully quit is not proportional to the increased number of referrals. This is examined further in the commissioning and benchmarking tool.

It is also likely that there will be additional people taking up the offer of a referral to NHS Stop Smoking Services from partners and others in the households of pregnant women who smoke.

**Current data collection**

In 2008, the percentage of women who smoked aged 16–44 in Scotland was 29.3% compared to 26.3% of women in England aged 16–49. In 2008, the number of women who were smoking in Scotland at first maternity booking was 19.2%. The smoking at first maternity booking figure is not currently available for England. However, when taking into account the prevalence of smoking in the two countries, it has been calculated that 17.2% of pregnant women will be smoking at first maternity booking in England.
Current data collection is based on self-reported smoking status. The use of a carbon monoxide (CO) test at first maternity booking to identify pregnant women who smoke is likely to increase the number of pregnant women identified as smoking. Research has shown that self-reported smoking status underestimates the true level of smoking prevalence by 25%. When this figure is applied to the number of pregnant women currently identified as smoking at first maternity booking, it increases the number of pregnant women who smoke in England from 17.2% to 21.5%.

Additional factors

For a local population, factors such as deprivation, smoking prevalence and demographics have a significant impact on the number of pregnant women who smoke in pregnancy. The commissioning and benchmarking tool can be used to adjust the national figures to reflect local circumstances.

In 2008/09, the percentage of mothers smoking at time of delivery was 14.4% in England. Data shows that there is wide variation among pregnant women who smoke at the time of delivery across primary care trusts (PCTs), ranging from 4.4% to 31.4%. The large regional variation reinforces the importance of each PCT gathering local level data in order to accurately calculate the costs that would be incurred and benefits that could be achieved by implementing the guidance.

In 2005, almost four in ten mothers in England (38%) lived in a household where at least one person smoked during their pregnancy. In most cases the person who smoked was the mother’s partner. Mothers aged 20 or under are five times more likely than those aged 35 and over to have smoked throughout pregnancy (45% and 9% respectively). Mothers in routine and manual occupations are more than four times as likely to smoke throughout pregnancy, compared to those in managerial and professional occupations (29% and 7% respectively).

Expert clinical opinion

In 2008/09, around 19,000 pregnant women who smoked set a quit date with NHS Stop Smoking Services in England. Of those who set a quit date, 24% were carbon monoxide test validated (CO) at the four-week follow up. The consensus opinion of the topic-specific advisory group was that implementing a routine referral service would have an impact on the number of women who set a quit date, and the number of women who successfully quit. In part, the NICE Quitting smoking in pregnancy and following childbirth self assessment tool can be used for data collection to determine the impact of 100% referrals into NHS Stop Smoking Services on the number of pregnant women who set a quit date and who successfully quit.

Conclusions

Based on the epidemiological data and other information sources outlined above, it is concluded that the population benchmark for smoking in
pregnancy and referral to an NHS Stop Smoking Service is 0.27% or 270 per 100,000 population per year.

This is based on the following assumptions:

- in 2008/09 there were 637,764 women who gave birth and had their smoking in pregnancy status recorded
- approximately 21.5% of pregnant women will be smoking at first maternity booking
- 100% of pregnant women who smoke will be referred to NHS Stop Smoking Services.

Therefore the population benchmark for smoking in pregnancy and referral to NHS Stop Smoking Services is estimated to be 0.27% per year.

Use the quitting smoking in pregnancy and following childbirth commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

References

1. The Information Centre for health and social care (2010) GP List Populations of Primary Care Organisations


7. ISD Scotland (2010) SMR02 Births and babies, smoking and pregnancy


The commissioning and benchmarking tool

Download the quitting smoking in pregnancy commissioning and benchmarking tool.

Use the quitting smoking in pregnancy commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service, as described below.

Identify indicative local service requirements

The indicative benchmark based on the national average for the number of pregnant women who smoke at first maternity booking and are referred to an NHS Stop Smoking Service is 0.27% or approximately 270 per 100,000 population per year.

Currently, 14% of pregnant women set a quit date and receive stop smoking support with an NHS Stop Smoking Service. An increase in the number of referrals of pregnant women who smoke to NHS Stop Smoking Services is likely to have an impact on the number of women that successfully quit. However, commissioners may find that the increase in the number of women who successfully quit is not proportional to the increased number of referrals. You can amend the percentage of pregnant women you expect to set a quit date and receive stop smoking support in the commissioning and benchmarking tool.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmark as a starting point. With knowledge of your local population and its demographics, you can amend the benchmark to better reflect your local circumstances. For example, if your population is significantly younger or older than the average population, or has an ethnic composition different from the national average, or has a significantly higher or lower rate of smoking in pregnancy, you may need to provide services for relatively fewer or more people.

Review current commissioned activity

You may already commission services for quitting smoking in pregnancy for your population. The tool provides tables that you can populate to help you calculate your current commissioned activity and costs.

Identify future change in capacity required

Using the indicative benchmark provided, or your own local benchmark, you can use the commissioning and benchmarking tool to compare the activity that you might need to commission against your current commissioned activity. This will help you to identify the future change in capacity required. Depending on your assessment, your future provision may need to be increased or decreased.
Model future commissioning intentions and associated costs

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark level, and to model the required changes over a period of 4 years.

Use the tool to calculate the level and cost of activity you intend to commission and to consider the settings in which the services for quitting smoking in pregnancy may be provided, comparing the costs of commissioning the service across the various settings. The tool is pre-populated with data on the potential recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

Commissioning decisions should consider both the clinical and economic viability of the service, and take into account the views of local people. Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.
Ensuring corporate and quality assurance

Commissioners should ensure that the services they commission represent value for money and offer the best possible outcomes for pregnant women who smoke. Commissioners need to set clear specifications for monitoring and assuring quality and productivity in the service contract.

Commissioners should ensure that they consider both the clinical and cost effectiveness of the service, and any related services, and take into account clinicians’, and service users’ views and those of other stakeholders when making commissioning decisions.

Services for quitting smoking in pregnancy and following childbirth need to:

- be effective and efficient
- be responsive to the needs of pregnant women who smoke and their partners and families
- provide treatment and support based on best practice, as defined in NICE public health guidance PH26
- deliver the required capacity and outcomes ensuring that all pregnant women who smoke are identified, referred and have access to ongoing and intensive support throughout pregnancy and beyond from specialist stop-smoking advisers
- be integrated with maternity services and other public, community and voluntary services offering elements of care for pregnant women and for women following childbirth
- ensure a coordinated approach is taken to promoting the quality of care and support across all pathways spanning more than one provider (for example maternity services, other services and NHS Stop Smoking Services)
- define agreed criteria for referral, local protocols and the care pathway for pregnant women who smoke to ensure that opportunities are maximised for pregnant women who smoke to be identified and referred for specialist support
- be client-centred and provide equitable access, ensuring that women and their partners are treated with dignity and respect, are fully informed about their care and support, and are able to make decisions in partnership with healthcare professionals
- consider and respond to recommendations arising from any audit, serious untoward or patient safety incidents
- demonstrate how they meet requirements under equalities legislation, are providing responsive and targeted services to meet the needs of the locality, and are reaching and supporting women from black and minority ethnic groups and routine and manual occupations
• demonstrate value for money
• consider where the barriers are for implementation before considering Commissioning for Quality and Innovation payment framework (CQUIN) as a lever for change.

Local quality assurance

Any mechanisms for quality assurance at a local level are likely to refer to the following:

• **Service and performance targets**, including estimated activity levels, and waiting times (ensuring that pregnant women who smoke and their partners do not experience unnecessary delays), complaints procedures.
• **Clinical governance arrangements**, including incident reporting.
• **Clinical quality criteria**: appropriateness of referral, clinical protocols.
• **Audit arrangements**: refer to NHS stop smoking services: service and monitoring guidance 2010/11 for specific information. Arrangements should include monitoring of outcomes and complications (see audit support for NICE public health guidance PH26 on Quitting smoking in pregnancy and following childbirth for further information).
• **Health, safety and security**: infection prevention, waste management, confidentiality procedures, legislative requirements.
• **Equipment**: testing and calibration according to local and manufacturer protocol. Capacity and capability to comply with CO monitoring requirements (under core contracts and Service Level Agreements [SLAs]).
• **Accreditation requirements**: for some or all elements of the service, the premises and/or staff.
• **Patient and service user experience**: using the national patient survey and patient-reported outcome measures (PROMS); taking into account perspectives and perception of service provision to help shape services, engagement to inform commissioning decisions, complaints. See also client satisfaction survey tool developed by the smoking cessation service research network. Commissioners should note that all CQUIN schemes should include a patient experience element and providers should meet agreed patient satisfaction goals on a service-by-service basis.
• **Outcomes**: numbers of pregnant women who smoke have been identified, referred to and followed up by NHS Stop Smoking
Services, and have received specialist support to stop smoking. Numbers of pregnant women who have successfully stopped smoking during pregnancy and are not smoking at time of delivery.

- **Staff competencies**: individual and team baseline requirements, monitoring and performance.

- **Information requirements**: including both patient-specific information (NHS number, referring GP or other professional, provision of high-quality information to women and their families) and service-specific information (see also NHS stop smoking services: service and monitoring guidance 2010/11 for further information).

- **The process for reviewing the service with stakeholders**: including decisions on changes necessary to improve or to decommission the service.

- **Achieving targets associated with equalities legislation.**

**Further information**

**General information** on quality and corporate assurance can be obtained from the following sources:

- [NHS Alliance online resources](#). NHS Alliance is the representational organisation of primary care and primary care trusts, and provides them with an opportunity to network and exchange best practice. The alliance supports its members with an open-access helpline, in-house and joint publications and briefings, internal newsletters and a website.

- The [Department of Health commissioning framework](#) provides guidance on the commissioning process in the context of the NHS reform agenda.

- NHS Institute for Innovation and Improvement support for commissioners, includes [Commissioning for Health Improvement](#) products to accelerate the achievement of world class commissioning; [The Productive Leader](#) programme to enable leadership teams to reduce waste and variation in personal work processes, and [Better care, better value indicators](#) to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care, and to generate ideas on how to achieve these savings.

- [10 Steps to your SES: a guide to developing a single equality scheme](#). This guidance has been developed to assist NHS organisations that have a duty, as public authorities, to comply with the race, disability and gender public sector duties, and in anticipation of new duties in relation to age, religion and belief, and sexual orientation.
Specific information on quality and corporate assurance for quitting smoking in pregnancy and following childbirth services can be obtained from the following sources:

- **NHS stop smoking services: service and monitoring guidance 2010/11** provides best practice guidance relevant to the provision of all NHS stop-smoking interventions and sets out fundamental quality principles for the delivery of services, which can be used to inform the development of local commissioning arrangements.

- **The NHS Centre for Smoking Cessation and Training (NCSCT)** national training standards are the official benchmark of quality training for stop-smoking personnel in England. Standards have now been mapped to the knowledge and skills framework. The core training provided by the NCSCT will be free of charge until April 2012. See also Learning outcomes for training stop smoking specialists.

- The **Quality and outcomes framework (QOF)** is a voluntary quality incentive scheme that rewards general practices for implementing systematic improvements in the quality of patient care.

- **Skills for health** works with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of healthcare services. See details of Maternity and care of the newborn, Public health, Psychological therapies.

- **Midwifery 2020, The future of the profession** is a project commissioned by the Chief Nurses of England, Northern Ireland, Scotland and Wales to set the direction for midwifery and identify the changes needed to the way midwives work, and to their roles, responsibilities and training and development requirements. The Midwifery 2020 project will end in 2010 with a report setting out the vision for 2020.
Topic-specific Advisory Group: quitting smoking in pregnancy

A topic-specific advisory group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email.

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