Tobacco dependence treatment services: delivery model for maternity services

v1.0

July 2021

NHS England and NHS Improvement

Contents

Purpose of the delivery model

- This delivery model has been co-developed with a range of national, regional and system partners with an aim to support delivery of **NHS-funded tobacco dependence treatment services** in maternity settings in line with the NHS Long Term Plan commitments (LTP, 2019).
- It is designed to be a practical framework which lays out the **background, context and practical criteria** for delivering services alongside links to other available resources.
- It builds on the Saving Babies' Lives Care Bundle v2.0 and sets out our expectations for maternity providers and providers of tobacco dependence treatment services, including the following:
    - **Smoking status** is recorded for pregnant women admitted to hospital and pregnant women at booking and at 36 weeks (as a minimum, with additional testing throughout pregnancy as appropriate);
    - Pregnant women who smoke are immediately **opt-out** referred to a in-house specialist maternity stop smoking team to receive support from an appropriately trained tobacco dependence adviser;
    - Pregnant women who smoke have early access to appropriate **pharmacotherapy**; and
    - Pregnant women who smoke are able to agree a **personalised plan** to support them to quit smoking tobacco both whilst in contact with NHS services and beyond.
- This delivery model will be further developed over the course of 2021/22, informed by the early implementer sites' work, but we **welcome any additional feedback** on how it can be developed or any case studies that might be useful to share. Please send to the following address: england.prevention-pmo@nhs.net

Introduction

- The LTP set out clear commitments for NHS action to improve prevention by **tackling avoidable illness**, as the demand for NHS services continues to grow.
- Supporting those who are pregnant and smoking, their families and staff to overcome their tobacco dependence will not only provide improvements in theirs and their families' health, but also **reduce health inequalities** and **decrease demand on services** by reducing the number of smoking related admissions and readmissions.
- The NHS is investing in frontline services to tackle tobacco dependence for all **inpatients**, **pregnant women** and those in long term **metal health** and **learning disability** services by 2023/24. This is being facilitated with support from national and local teams, as well as other key stakeholders.
- These services will be delivered in in addition to, and where relevant, in conjunction with, **local authority (LA) Stop Smoking Services** (SSS). They will support delivery of the government's Tobacco Control Plan (TCP, 2017) and the ambition to go smoke-free in England by 2030 (AOH, 2019).
- The recommended models will see **in-house opt-out services** rolled out across the NHS. Patients and service users will be given the opportunity and support to beat their tobacco dependence and quit smoking at a time when they are likely to be motivated to quit.
- Funding is devolved to Integrated Care Systems (ICSs) to allow all providers to offer these services either individually or across local systems in conjunction with NHS and LA partners.
- This slide deck sets out the case for change, outlining both the clinical and business arguments. It includes expectations in terms of timescales and the recommended model of delivery, also offering ideas on how to improve local delivery and case studies from existing practice that has yielded good results.

Why tackle smoking in pregnancy – clinical and business case

- Smoking is the leading modifiable risk factors for **poor pregnancy outcomes**. These include low birth weight (250g lighter), miscarriage (up to 3 times as likely), preterm birth (up to 27% more likely) and stillbirth (twice the likelihood) (ASH, 2018). It also triples the risk of sudden infant death (ASH, 2018).
- 9.6% of pregnant women at the point of delivery in England still smoke tobacco (GBD, 2019; NHSD, 2021).
- Maintaining smokefree status postpartum has a beneficial impact on subsequent pregnancies, women's general health and the harmful impacts of exposure to second-hand smoke in infancy and childhood, which carries similar risks to smoking (ASH, 2018).
- Addressing smoking in other family/household members helps support women to quit themselves and reduces exposure of pregnant women and children to second-hand smoke.
- Maternal smoking during pregnancy costs the NHS in England approximately £21million each year in secondary care costs, arising from low birthweight, premature rupture of membranes, ectopic pregnancy, miscarriage and placenta previa (RCP, 2018).
- Exposure of children to passive smoking costs the NHS in England at least £5million, possibly as much as £12million, in hospital costs (RCP, 2018).
- Public Health England is currently testing a benefit versus cost analysis model that will be made available later in 2021.

Why tackle smoking - health inequalities

Use of tobacco products is intrinsically linked with increased health inequalities. Smoking is widely accepted as being linked to significant disparity across socio-economic and geographical communities.

Drivers

- Smoking is the single largest cause of preventable deaths in England.
- People from the **most deprived communities** are much more likely to smoke and less likely to quit, compared with more affluent groups. In addition, smokers from lower socioeconomic groups are more likely to be admitted and treated in hospital compared to smokers from higher socioeconomic groups.
- ONS (2020) data shows that 23.4% of those working in routine and manual occupations said they currently smoked in 2019 – significantly higher than those reported among managerial and professional occupations at 9.3%.
- Rates of **smoking in pregnancy** have a strong social and age gradient with poorer and younger women much more likely to smoke in pregnancy. Public Health England has reported that 10 times as many pregnant women who smoke are from the most deprive decile (based on maternal address) compared to the top decile (PHE, 2019).
- **Ethnic minority groups** in general have slightly lower rates of smoking; however, some communities are at higher risk of harm, for example from shisha use.

When rolling out tobacco dependence treatment services, engagement and outcomes should be analysed locally by subgroups such as age, ethnicity and deprivation. Services need to ensure **equity of access**, particularly by ethnicity and deprivation quintile, with an aim to achieve high rates of uptake, especially in smokers from the more deprived communities.

Recommended model: maternity (1)

- The recommended model for **pregnant women** is more intensive than models for the non-pregnant population and should be delivered **within maternity services – in house**.
- It expands on recommendations in NICE guidance NG92 to drive engagement: despite good referral rates to LA SSS and outcomes when engaged, many women do not convert their referral to an appointment/quit. This is often not picked up until later in the pregnancy.
- The recommended model also builds on the Saving Babies' Lives Care Bundle version 2 (SBLCBV2), where all pregnant women should be assessed for carbon monoxide (CO) exposure at booking, the 36 week antenatal appointment and other appointments as appropriate. By focussing on the referral and treatment elements of SBLCBV2 and NG92, the model aims to increase engagement and improve outcomes.
- We anticipate Local Maternity (and Neonatal) Systems (LMSs) to play a key role in overseeing the delivery of these services across ICS footprints.
- At the antenatal booking visit, all women should be offered a CO test, and maternity staff need to record the outcome (as per SBLCB).
- If the reading is ≥4ppm or if the woman has stopped smoking since conception, staff should provide Very Brief Advice (VBA)[2], offer initial NRT[1] with an immediate **'opt-out'** referral made to a maternity specialist stop smoking service team, as per the local protocol, that will support them to beat their tobacco dependence through weekly face-to-face behavioural support and licensed pharmacotherapy – specifically combination NRT[1].

[1] Some Trusts stipulate prescribing, but NRT doesn't have to be prescribed or delivered via a Patient Group Directive as it's a General Sales List medicine.
[2] Very Brief Advice (VBA) is designed to be used by healthcare professionals to trigger a quit attempt among smokers. It is defined by a 3-step process: a) establishing and recording smoking status (ask); b) advising on the most effective way to stop (advise); and c) referring to specialist stop smoking support or prescribing stop smoking medicines (act).

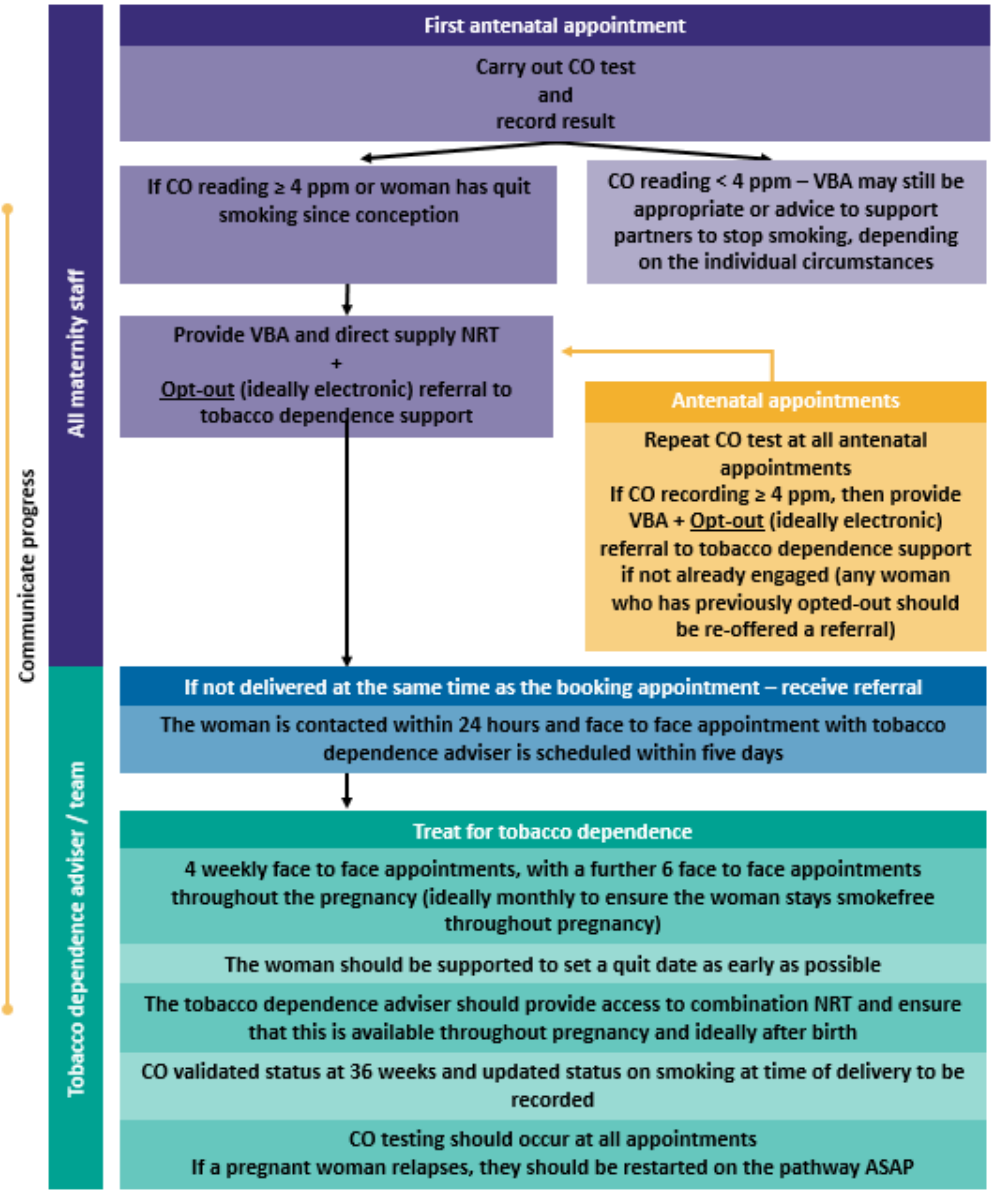
Recommended model: maternity (2)

- A 1:1 meeting with a Tobacco Dependence Adviser (TDA) is arranged at the first antenatal booking appointment, with a one-stop approach being the ideal model. If this is not possible, women should be contacted within one working day to arrange this.
- The first 1:1 should last approximately 40 minutes, taking place within five days of booking. If not already done so, NRT should be offered at the appointment, with easy access if not supplied at the time.
- Weekly face-to-face appointments with the Tobacco Dependence Adviser take place for at least four weeks (appointments can be in clinic, community or home visit, depending on local protocol).
- Pregnant women should have their 28-day quit status recorded by the TDA (ideally face-to-face to undertake a carbon monoxide (CO) test).
- NRT should be supplied for up to 12 weeks beyond the quit date.
- A further six face-to-face appointments should take place throughout pregnancy to support the woman to remain smokefree. The schedule is to be agreed between the pregnant woman and the specialist. Telephone and other forms of support can be delivered in addition to face-to-face support.
- Smoking status should be CO verified by the Tobacco Dependence Adviser at each appointment and at the appropriate midwife antenatal appointments (as per SBLCB). Women who have relapsed should be offered another referral. CO validated smoking status at 36 weeks and updated smoking status at time of delivery should be recorded for all women.
- This model recommends face-to-face contact as the evidence available to date indicates that it is the most effective. We will continue to monitor emerging evidence about the effectiveness of virtual and telephone appointments.

Recommended model: maternity (3)

- If a pregnant woman is admitted as an inpatient, her smoking status should be identified immediately and she should be offered NRT if she is a smoker. If under the care of the maternity service TDA, the adviser should be notified. If not, VBA should be delivered and referral offered to the maternity stop smoking team or inpatient pathway depending on which is most appropriate.
- For detailed information on the recommended inpatient model, please refer to the overall specification accessible on the Prevention Programme's NHSFutures platform.
- On discharge from maternity services, the health visitor should be informed of the woman's smoking status to allow continuity of care and consistent messaging to support a smokefree home and safe sleeping.
- To improve a woman's chances of quitting, advisers can support partners who smoke, e.g. through referral to community stop smoking services, in line with local protocols or by delivering messages/resources to support smoke free homes.
- Services should consider how women can be supported postnatally – when relapse rates are often high. If the woman is admitted postnatally, her smoking status should be identified immediately and she should be offered NRT and services in line with the standard inpatient model if she is a smoker. If she is under the care of the maternity service TDA, the adviser should be notified.
- Tobacco Dependence Advisers are well placed to identify mental health needs early and, where appropriate, should escalate any concerns or suggest referral to IAPT/specialist perinatal MH teams as per local pathways.
- The recommended model is designed to be delivered as part of "business as usual", but the Prevention Programme's NHS Futures platform contains case studies and other resources to support adapting delivery for the COVID-19 pandemic.

Model pathway – maternity



A separate PDF version of this graphic is available on the Community of Practice

Essential measures for success (1)

It is essential to ensure that there is dedicated support and capacity within NHS trusts to help embed tobacco dependence treatment interventions. This will require a combination of strategic measures and operational processes. A list of the **strategic measures essential for successful implementation** is set out below.

- **Executive leadership** – visible, vocal commitment from ICS, commissioners and the Trust Board to deliver tobacco dependence treatment, reflected in system- and trust-wide smokefree policies. Established Maternity Safety Champion roles.
- **Clinical leadership** – visible and vocal commitment from Nursing Director, Heads of Midwifery, obstetric leads and clinicians, with a dedicated clinical lead identified to implement the service in each Trust.
- **Local authority engagement and cross-organisational pathways** – pathways to ensure that care for patients is seamless when they change organisations need to be agreed, e.g. transfer into community/social care services.
- **Multidisciplinary Project Steering Group** – senior representation and early engagement to help implement the model with all stakeholders, including senior leaders, pharmacy, communications, LAs, primary care, information governance, IT, patient facing staff, shop floor team.
- **Established protocols** to formalise and enforce policies, including a trust Smokefree policy (in line with recommendations in NICE PH48) and prescribing protocols.
- **Governance processes** that incorporate **patient experience** – in conjunction with external providers e.g. LAs where relevant.
- **Data systems** to capture and record smoking status at booking, 28 days after commencing treatment, 36 weeks and at time of delivery; for full details see Metrics section. IT departments should be consulted as early as possible.
- **New funding** – directed to frontline services to underpin activity rather than developing additional system infrastructure.

Essential measures for success (2)

The minimum national requirements also include a number of essential **operational processes**:

- **Mandatory training programme for tobacco dependence advisers** – combination of online and face-to-face training for **all** staff who deliver in-depth advice. Staff need to be competent in having meaningful conversations and be familiar with the options for additional support outside the hospital.
- **Generic training programme for all frontline staff** – focussing on their role within tobacco dependence treatment, including online VBA training for all clinical staff (depending on local decision, this could be made mandatory).
- **Capacity of specialists to spend an appropriate amount of time with each patient**, including regular follow-up. **Check-backs** should happen with those women who have not engaged or relapsed.
- Ensure the **availability of NRT** on hospital formulary for pregnant women.
- Capacity of and encouragement to all staff to provide **VBA and support** as part of everyday care to patients who are trying to quit or remain abstinent.
- **Support women with perinatal mental health conditions**, as there are links to anxiety and depression, as well as impacts on child health (RCP, 2013; JBS, 2010).
- **Discharge package** for pregnant women who have an inpatient episode – they should be discharged with a minimum of one week's supply of take home medications and linked into the maternity tobacco dependence treatment service for ongoing support and access to pharmacotherapy (or community services if postnatal).
- NHS commissioners and LAs should work with provider organisations to ensure a smooth **referral pathway** on for any ongoing support postnatally (including where women lapse back to smoking after delivery) and ideally quick access to LA SSS for partners and family members.
- **Communications** plan to inform staff of the new tobacco treatment programme prior to launch.
- Appropriate **data sharing agreements** and processes between NHS and external providers e.g. LA organisations where relevant.

Staff training

- Patient-facing staff will need to be given **training that is appropriate to their role** in the maternity and tobacco dependence treatment pathways.
- Different modes of training should be made available, e.g. face-to-face, online, observed practice and mentoring. It should remind staff that **tobacco dependence is a medical condition**, not a lifestyle choice[1].
- This requirement includes VBA training for **all frontline healthcare professionals in all grades and roles,** including midwives, MSWs, medical staff and sonographers.
- Below is a broad summary of the required competencies across the different models and staff groups. A new competency framework and eLearning packages are currently in development and will be made available through the Community of Practice.

	Staff group	Training need	External training resources
Maternity	All	All staff should be receiving VBA training as part of the SBLCB delivery. VBA, including CO testing Reintroduction of CO testing	NCSCT VBA (pregnancy) E-learning for healthcare (elf) eLFH
	Tobacco dependence advisers	Patient-facing staff should undertake 2 day specialist training to become a TDA. VBA; use of CO monitors; evidence-based behavioural support; regulated and consumer nicotine products; local pathways and protocols; leadership	NCSCT training standards NCSCT (practitioner + specialty pregnancy programme), eLFH

[1] Current NCSCT guidance focuses on community settings and not the opt-out model of treatment. However, the fundamental skills and knowledge that the training sets out are transferable.

Tailoring your service for success (1)

To optimise pathways and achieve success, there are a number of additional actions that systems and providers may wish to consider:

- Undertaking a CLeaR deep dive self-assessment for maternity settings to help benchmark current activity. For areas where use of smokeless tobacco is more prevalent (e.g. higher numbers of South Asian populations (ASH, 2019)), the CLeaR Niche tobacco deep dive self-assessment will support the establishment of appropriate local pathways.
- Providing programme management – dedicated resource to plan and lead implementation.
- If not in already in post, a key driver for success will be the appointment of a specialist stop smoking midwife within your trust to assist midwife support workers where necessary and provide clinical leadership e.g. a Stop Smoking midwife or a PH Consultant Midwife.
- Reviewing how services could work with SSS to support / improve delivery and better support system integration.
- Providing interventions for staff as part of a comprehensive Occupational Health offer, ideally supporting staff to access support within working hours, to help abstain when on-site and quit.
- Making information readily available to support visitors and contractors to stop smoking including links to local SSS (where applicable).
- Engaging with the LA and third sector to access wider community support, including support from social prescribers, promoting participation in peer support groups (Ford, 2013) and using volunteers and community support to help patients after they leave hospital.

Tailoring your service for success (2)

- Ensuring there is clear signposting for longer-term support in the community, e.g. as about 50% of women who quit in pregnancy relapse within six months.
- Driving joined up and effective communication between teams caring for the individual across the pathway of care e.g. tobacco dependence advisers, the antenatal team and mental health practitioners for women with perinatal mental health conditions.
- Consider engagement with wider programmes, for example:
    - Maternal and neonatal health safety collaborative drivers, e.g. increasing the proportion of smokefree pregnancies.
- Utilisation of Maternity Voices Partnerships to understand how pathways can be improved, especially in relation to closing inequalities.
- Amendments to patient letters, informing of the new tobacco treatment policy prior to admission.
- Raise awareness of **free dental care** until 12 months postnatally.
- Use positive messaging and communications to encourage quitting and adherence to a smokefree environment (e.g. “This is a smokefree hospital” not “smoking prohibited”).
- The national Maternity and Neonatal Safety Improvement Programme has published a QI tool (driver diagram) on their website.

Suggested delivery infrastructure

	NHS Prevention Programme	Regional Board (with responsibility for tobacco)	System Steering Group	Provider MDT Delivery Group
Core roles & responsibilities	National leadership National stakeholder management Provision of support package e.g. delivery model Identify national data collection processes & metrics Maintain Community of Practice Driving changes to culture at a national level	Oversight and assurance of delivery Reporting regional position to national team (incl. exception reporting) Engagement of regional partners e.g. clinical networks Driving changes to culture at a regional level	Ensuring cross-organisation engagement and planning Reviewing and agreeing whole system pathways Systems funding oversight Driving changes in culture at a system level Resilience planning Reporting at a systems level and provision of oversight, support and assurance to providers	Agreement on systems and processes to deliver the intervention with associated communications Ensuring recruitment and training of frontline staff Driving culture change Communications Collecting and reporting data Patient engagement in development & evaluation Quality improvement strategy
Suggested key membership	Central NHS Prevention Team Senior cross system membership of Prevention Board e.g. PHE, DHSC Tobacco dependence stakeholder group	RDsPH (SRO) RMD Prevention Programme Manager PHE Tobacco Control Programme Managers – LTP Delivery PHE Centre representation	ICS lead LMS SRO (for Maternity Models) Local Authority NHS Commissioner NHS Provider(s): primary & secondary care Clinical Lead Project Manager PHE Region representation	Trust SRO (Executive) Clinical Lead Nursing/Midwifery Lead Project Manager Lead tobacco dependence adviser User with lived experience Pharmacy Communications lead Analytics Maternity Safety Champions
Potential Delivery partners	PHE National / DHSC	PHE Regional Hubs Clinical Networks AHSNs	Local Authorities NHS Right Care / GIRFT AHSNs Clinical Networks 3rd Sector	

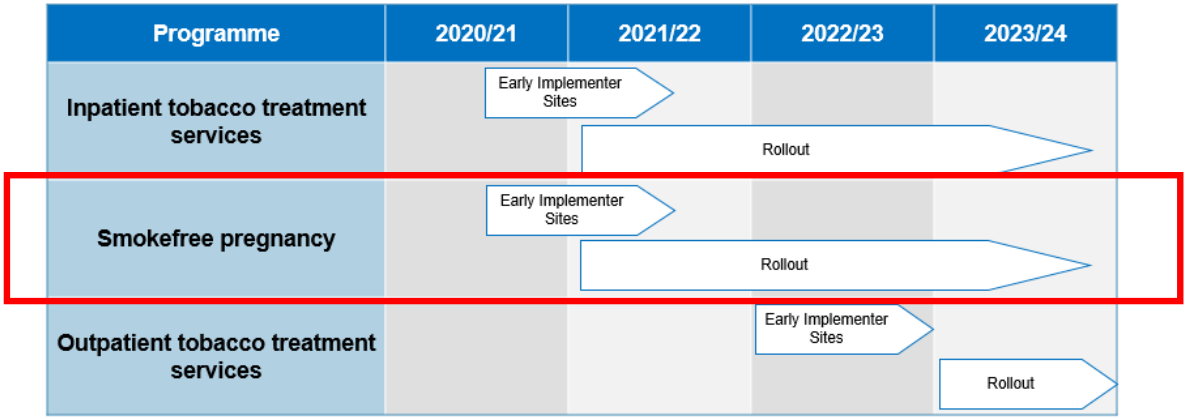
Planned implementation timeline

The impact to date and continuing uncertainty on how COVID-19 will affect delivery of NHS services means that there is a need for continuing flexibility in how tobacco treatment services are rolled out.

From October 2020, EIS started the development of services, and are starting to post learning and resources on the Community of Practice.

Assuming minimal impact of COVID-19, the **proposed delivery timeline** will see:

- EIS start service delivery in Q1/Q2 of 2021/22 with learning and resources being shared
- ICS Prevention plans prioritising rollout agreed in Q1/Q2
- Phased additional rollout starting during Q3/Q4 of 2021/22



The intention is still to deliver an offer of NHS-funded tobacco treatment to 100% of inpatients, pregnant women and higher risk outpatient service users by the end of 2023/24.

Metrics

Metrics are being tested with EISs and are likely to be refined depending on site feedback. Templates supporting semi-aggregate and patient-level data collection, including technical guidance, are accessible on the NHS Futures Prevention Programme Page. Below is a list of the headline metrics summarising what they consider:

Metric *	Description
Tobacco dependence treatment services provided (coverage)	% of maternity services per system for which a tobacco dependence treatment service is provided
Identification of smoking in maternity services	% of all pregnant women that have a recorded smoking status at booking (CO test verified)
Percentage of pregnant women who are smokers	Total number of pregnant women booked identified as current smokers
Number of maternal smokers referred and seen by in-house tobacco dependence treatment service	% of maternal smokers referred to the in-house tobacco dependence treatment service and % of those actually seen
Tobacco dependence interventions provided for current smokers identified at booking	% of all current smokers provided with an intervention (incl. the recommended intervention from this model)
Type of pharmacotherapy prescribed	% of different pharmacotherapies out of all current smokers in receipt of tobacco dependence pharmacotherapy
Smoking cessation 28-day quit rates – all smokers provided with support and those taking up the recommended intervention	% of maternity smokers who receive support/undertake an intervention with the Tobacco Dependence Adviser and report a 28-day quit and those who undertake the recommended intervention
Change in smoking status – maternal booking against delivery and 36 weeks	Change in smoking status as a % of total number of women identified as smoking at antenatal booking compared to at delivery and at 36 week antenatal appointment

* To note, these are the headline metrics, but more detail specific to each care setting as well as the accompanying guidance is available on the FutureNHS page.

Regional assurance process

The 2021/22 Operational Planning Guidance included a specific Long Term Plan objective in the Maternity Transformation Programme (MTP): make new NHS smoke free pregnancy pathways available for up to 40% of maternal smokers by March 2022.

The following deliverables are incorporated into the Regional Assurance Plan, which sets out the key lines of enquiry for which LMSs will have to assure delivery, on a quarterly basis, at Regional Maternity Boards:

	Deliverable	Delivery Date	
4a	A trajectory and delivery plan is in place for up to 40% of maternal smokers across providers to be offered Smoke free pregnancy pathways by March 2022, and 100% of maternal smokers by March 2024.	31/09/2021	G – in place for all providers A – in place for some providers R – not in place
4b	In each quarter, all providers are on track against agreed milestones within their delivery plan to make smoke free pregnancy pathways available for up to 40% of maternal smokers by March 2022.	31-Mar-22	G- on track A – at risk R – no plan in place R – not on track (support required)

Additional lines of enquiry to provide assurance

The following key lines of enquiry are proposed to support the assurance process in conversations between Regions and LMSs throughout 2021/22:

	Key lines of enquiry		Proposed RAG scoring
1	A trajectory in place (or will it be by Q2 21/22) for delivery of 100% of maternity services across LMS by 2023/24 (21/22 allocations will allow coverage 40%* of pregnant women.		R = Trajectories not agreed for any sites A = Trajectories only agreed for 2021/22 but not other sites / trajectories are all backloaded into later years and need refinement G = All sites have a planned trajectory for delivery
2	Gap analyses of current service delivery against the national delivery model have been undertaken across all maternity services in the ICS – by the end of October 2021 for sites prioritised for delivery in 2021/22 and the end of Q3 for all other sites.		R = Gap analysis not complete and no plan for or anticipated delivery >2 months after target timescale A = Evidence of gap analysis in progress but anticipated within 1 month of target timescale G = Gap analysis complete in agreed timescales
3	In areas prioritised for delivery in 2021/22:	a. A local service model and action plan, with key process milestones, should be agreed by end of quarter 3 to deliver services by year end.	R = Action not started and no anticipated delivery date/delivery date >2 months of target timeline A = Action completed, but evidence **not** shared with LMS and region / Action in progress (evidenced) and due for delivery within 1 month of target timescale G = Action completed and evidence shared with LMS and region
		b. Multiagency steering group established, with representation including the named executive and clinical lead	
		c. Track delivery of agreed key process milestones to ensure service model is in place by the end of the 2020/21	
4	For sites that are not prioritised for delivery in 2021/22, gearing up activities are still required to ensure delivery as early as possible once funding is agreed. Local timescales should be agreed between the provider and LMS.	a. Clinical leadership roles established and membership of the MDT delivery group determined	For 4a, 4e and 4f: R = Action not started and no agreed / outside timescale for delivery A = Action underway but not in line with timescales agreed with LMS G = Action complete / underway an on track for delivery in line with timescales agreed with LMS For 4b, 4c and 4d RED = Data not available and no plan for delivery / deterioration in performance for 2 months or more AM = Data not available but delivery plan agreed with LMS for delivery / 1 month deterioration in performance GREEN = Data available and improvement on previous month
		b. Reduction in the numbers of women with unknown/not stated smoking status	
		c. Determine, together with relevant stop smoking services where used, the percentage of women referred who a) attend their stop smoking service appointment and b) set a quit date	
		d. Improvement in capture and reporting of 36-week smoking status	
		e. Assessment of IT capability to collect and report data against the national dataset – associated action plans generated as required.	
		f. Ensure the availability of NRT on the hospital formulary and relevant PGDs are in place	

*It is anticipated that 40% coverage (i.e. services available to 40% of maternal smokers) will be delivered by the end of the financial year. For practical purposes, it is anticipated that full services will be delivered within providers (available to 100% of maternal smokers within that provider). An appropriate number of providers would therefore deliver services, to reach 40% coverage within the LMS as a whole, rather than achieving 40% coverage across all providers within the LMS. However, this is for local agreement based on circumstances.

Frequently Asked Questions (1)

Q. What is an in-house service?

A. Services are considered as in-house when the bespoke offer of behavioural support and pharmacotherapy is delivered without an external referral to a third party, with patient administration and responsibility for delivering the tobacco dependence intervention staying in the NHS.

An example of an in-reach service is where an LA SSS is subcontracted by the NHS to deliver a service on its behalf, which would count as a in-house service as long as there is no transfer of care.

Q. What staff should deliver the interventions?

A. The model has been developed based on learning from sites that are already delivering services with good outcomes, with the bulk of activity delivered by Band 3 maternity support workers. However, it is expected that there will need to be leadership roles incorporated into these services.

Q. What is the age range of maternal smokers who should be offered the service and/or included in data submissions?

A. Any individual aged 16 years or older accessing an adult service. The programme is primarily focussed on adult services. Age-appropriate tobacco dependence treatment services should be offered to all under 18s – even if this falls in a paediatric service that isn't submitting data.

Q. What populations should be prioritised by March 2022?

A. Every system should establish a prioritisation process, targeting the first phase of implementation to areas of greatest need based on local data.

Q. What do systems need to do?

A. Systems should establish a joined-up approach with LA partners where relevant and develop an overarching strategy and clear delivery plans for rollout, reflecting prioritisation and trajectories.

Frequently Asked Questions (2)

Q. What funding is available to support delivery?

A. From FY 2021/22 funding is being devolved to system transformation allocations. Every system will receive funding, but it will not support rollout across all inpatient and maternity services in year and will need to be prioritised for phased rollout up until the end of 2023/24 – as more funding is released.

Q. What does the funding cover?

A. The long term plan funding has been calculated for the whole pathway of care including both staff time to deliver interventions, plus nicotine replacement therapy. Overheads have also been incorporated to fund leadership roles.

Funding is not anticipated to be used for additional elements outside of the core model, such as incentives. There is evidence for the effectiveness of these interventions, but local funding would be needed to add them into the care pathway.

Q. Will LMSs need to collect additional local data to monitor delivery?

A. Sites are encouraged to collect additional intelligence locally, depending on what is relevant for local populations, particularly on health inequalities.

Q. How will we collect and submit data?

A. Current Early Implementer Sites are testing the metrics listed in the delivery model, and the national programme team are in the process of establishing a new NHS-wide data collection through the Data Alliance Partnership. Once established this will involve submitting data to NHS Digital. This will be different to the NHS Digital Stop Smoking Services data collection.

PHE support for regional and local health systems

Public Health England (PHE) has programme managers in each NHS region who are dedicated to supporting roll out of the NHS LTP tobacco dependence treatment programme. The programme managers are:

- Expert in evidence-based models and pathways to treat tobacco dependence and can provide advice to health systems about how models can be adapted to meet local contexts.
- Connected to implementation partners across the healthcare system and can convene discussions, support with formalising steering groups and support systems to establish meaningful governance structures.
- Familiar with tobacco control and health inequalities datasets and can assist with using these to support programme planning, implementation and monitoring.
- Knowledgeable of the resources that are available to support programme implementation and can ensure partners have access to these tools and understand how to use them.
- Part of national NHSEI and PHE teams, and can feedback regional and local learning to inform direction of the national programme and support peer-to-peer learning.
- CLeaR tobacco control assessment and deep-dive facilitators, and can support local systems to use these tools.

Contact england.prevention-pmo@nhs.net to connect with your regional PHE lead.

To find out more about what we've learned through providing support at regional and local footprints, please visit the Prevention Programme's NHSFutures platform.

Case study: Greater Manchester Smokefree Pregnancy Programme

The Programme

Challenge

The vision is to reduce smoking in pregnancy across Greater Manchester through a standardised smokefree pregnancy pathway to achieve no more than 6% pregnant people smoking at time of delivery in any locality by 2021 and ultimately for no person to smoke during their pregnancy.

Approach

System-wide support for smoking cessation in pregnancy delivered via the evidence-based babyClear model which includes a unique risk perception intervention for parents who continue to smoke at their booking scan.

A smokefree pregnancy incentive scheme targets a defined group of vulnerable pregnant people.

The Intervention

Our Smokefree Pregnancy Programme includes:

- Funding for band 3 maternity support workers (MSWs) to train as specialist stop smoking advisers across local maternity systems
- Pan-GM Smoking in Pregnancy Guidance including a Standardised Pathway
- Encouragement for maternity services to CO test at each antenatal appointment for those who have quit since conception or are smokers – optimising making every contact count
- Standardised training for midwives/MSWs/medical staff
- Introduction of CO testing at 36 weeks as well as at booking for all
- Stop smoking pathway – weekly support by advisers at the place defined by the pregnant smoker (home, hospital clinics, children's centre and stop smoking services)
- Weekly appointments for the first 4 weeks then monthly until birth – CO validating quits and provision of Love2shop vouchers
- The programme ensures those pregnant smokers who relapse are offered a second attempt at benefiting from the incentive scheme

Benefits and Outcomes

- 250 additional smokefree babies born in the first year of programme implementation
- Increased CO testing at booking from 20% to over 90%
- Increased referrals to SSS by 170% in some localities
- Increased number of CO validated 4-week quits from c.25% to 57%
- Increased numbers of pregnancy smokers achieving 4-week quits – with maximum quit rate of 84% in one geography with specialist midwife and MSW support
- Increased capacity to offer maternity-led support
- Increases in significant others making quit attempts >50%
- Increases in smokefree homes
- Over 1200 women signed up to the incentive scheme to date

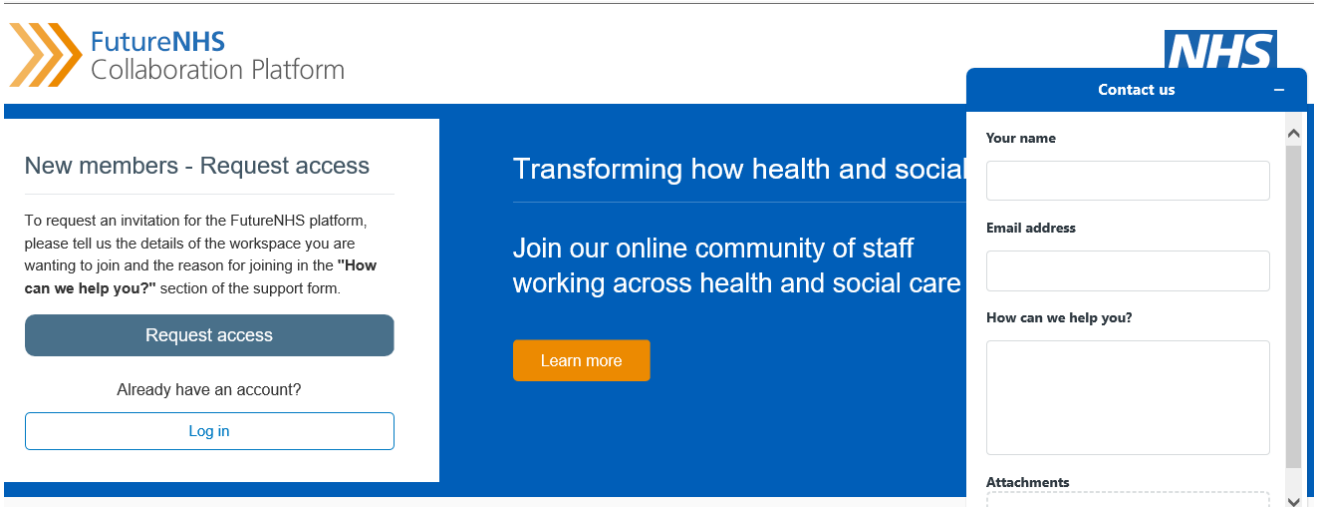
Useful resources (1)

There are a number of external resources that can be used to support implementation and treatment of tobacco dependence:

- The NHS LTP website, providing background to our work on prevention (incl. tobacco dependence) https://www.longtermplan.nhs.uk/areas-of-work/prevention/treating-and-preventing-ill-health/
- Further resources from the National Centre for Smoking Cessation and Training https://www.ncsct.co.uk/ which also includes treatment programmes.
- Use of Local Tobacco Control Profiles can assist regional and ICS teams to have a clear map of local smoking behaviours and smoking related morbidity and mortality to inform implementation priorities.
- Resources developed by Action on Smoking and Health Smoking in Pregnancy Challenge Group http://smokefreeaction.org.uk/smokefree-nhs/smoking-in-pregnancy-challenge-group/
- PHE guidance on Screening and brief advice for alcohol and tobacco use https://www.gov.uk/government/publications/preventing-ill-health-commissioning-for-quality-and-innovation
- e-Learning for Healthcare, Alcohol and Tobacco Brief Interventions programme https://www.e-lfh.org.uk/programmes/alcohol-and-tobacco-brief-interventions/
- e-Learning for Healthcare, Supporting a SmokeFree Pregnancy https://portal.e-lfh.org.uk/Catalogue/Index?HierarchyId=0_41043&programmeId=41043
- E-Learning for Healthcare, Making Every Contact Count https://www.e-lfh.org.uk/programmes/making-every-contact-count/
- PHE, All our Health: https://portal.e-lfh.org.uk/Component/Details/596376
- British Thoracic Society –Smoking Cessation Quality Improvement toolkit https://www.brit-thoracic.org.uk/quality-improvement/clinical-resources/smoking-cessation/smoking-cessation-qi-tool/
- Maternity and Neonatal Safety Improvement Programme: https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/

Useful resources (2)

- The NHS Prevention Programme FutureNHS Collaboration Platform is also available for staff to access various resources for tobacco dependence treatment services.
- The platform has been created to be a hub of information for sites and to encourage communication and knowledge sharing between sites and the national team.
- As shown in the folder structure, the platform includes various materials that are useful for sites to initiate tobacco dependence services such as delivery models, cover template job descriptions, example governance documentation, data templates, communications materials and case studies.
- To join our Community of Practice, please access the NHS Prevention Programme FutureNHS Collaboration Platform, click "Request to Join" and send a brief message as to why you would like to join the platform. A platform manager will review your request and give you the appropriate access.



Tobacco Dependence Treatment - Early Implementer Site Information

- 01 Background
- 02 Delivery model
- 03 Early implementer sites
- 04 Data and metrics
- 05 Workforce and training
- 06 Governance and service guidelines
- 07 Communications
- 08 Case studies
- 09 COVID-19
- 10 FAQs
- 11 Pharmacotherapy
- 12 Discussion forum
- 13 The National Team
- National Team Communications
- Tobacco: Events & Meetings

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Contacts

To join our Community of Practice please sign up to the FutureNHS Collaboration Platform and search for the NHS Prevention Programme

For further queries, please contact the NHS England & NHS Improvement national prevention team at:

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