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# Examples of good practice within the pregnancy smoking cessation services

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## Background

- 1998 Government White Paper:

  Reduction in prevalence of smoking during pregnancy from 23% to 18% by 2005

- NHS smoking cessation services received funding to target pregnant smokers in 2000 & 2001

# Rationale

- HDA survey (Taylor & Hajek 2001):
  - 30/99 Health Authorities had a service in place running for at least 3 months
  - All interviewed
  - Found much variability;
    - Length of intervention time & venue
    - Referral procedure
    - Use of CO monitors
    - Treatment model used and medication offered
    - Calculating success rates & defining 4 week quitters

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# Rationale cont.

- HDA study (2005)
  - Large differences in outcome reported to DoH
  - Time to identify examples of best practice
- Aim to develop guidance based on examples of best practice
- Aim to share methods that appear to work with all services in this difficult area

# Method

- 6 services to be identified and interviewed

3 highest ‘returners’ as identified by DOH figures

**&**

3 services known in the field to provide exceptional service

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# Some preliminary findings

# Training

- Focused on referring to service
- Aims to increase confidence in raising topic & making appropriate referrals

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# Training cont.

- Recruiting midwives for training can be made easier by:
  - Ensuring the training is compulsory
  - Trainees are released from shift
  - Time is paid
  - Sessions are brief & relevant

## In terms of: Recruitment

- Referrals mainly come from midwives
  - Midwives raise the topic @ Booking Interview. BI contains questions about smoking status
  - Smokers are informed about the service & referral form completed for those who want help quitting. Forms are sent to clinician or details are left on clinician's phone (1)

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## Contacting clients

- Variation with contacting clients

Day of referral → 2 weeks

- Proactive phone call in most cases
- Those that cannot be contacted/have specified no phone contact are sent letter inviting them to make an appt

## Venue

- Home visits appear to be most attractive/common venue
- Partners/family can also be treated at home alongside client
- Much effort involved & problem of wasted journeys if clients not at home(2)

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## Venue cont.

- Alternative method is to offer appts at a designated time slot, one morning a week for one to one support.
- Can see up to 8 clients per morning

# Treatment

- Multi session, intensive, one to one support, NRT offered
- Structure of:
  1. Info session
  2. Setting quit date
  3. Telephone on quit day
  4. Weekly contact for 8-12 wks [3]

Withdrawal oriented & emphasis on support

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# NRT

- ~80% uptake of NRT
- Common use of P16
- Some use of P24 used as a P16
- Clinician prescribes/makes recommendation to GPs to prescribe
- Some use consent forms

## Miscellaneous

- CO monitoring continuously, well received
- No 6 month rule
- Post delivery support offered

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## When asked
## ‘What doesn’t work?’

## Comments:

- ‘Sitting in antenatal clinics when trying to recruit clients’
- ‘Relying on consultant referrals as rarely appropriate referrals’
- ‘Not offering NRT’

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## When asked about ‘recommendations to new services’

## Comments:

- 'Establish good links with midwifery'
- 'Make service as easy to access as possible & have good referral system'
- 'Be assertive with GPs if relying on them to prescribe NRT'
- 'Be as flexible as possible with clients e.g. evening visits, home visits'
- 'Midwives & clinicians should be non judgemental when raising the topic'

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## Watch this space

- Data analysis in process
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