Maternal Smoking:
An evaluation of the impact of additional funding from NHS England to address high rates of maternal smoking in Wakefield.

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Summary

This report evaluates the impact of interventions that have been delivered in Wakefield to address high rates of maternal smoking. The interventions were implemented as part of a grant received from NHS England in 2016/17. The grant was used to support the following projects:

- Carbon monoxide monitors and consumables
- Stop Smoking Champion Midwife
- Improving data recording and quality to ensure women can be identified and information shared appropriately
- Incentivised stop smoking programme - Personal Financial incentives

The report uses routinely recorded data and compares metrics against a baseline position to look at changes in the data since the interventions were implemented. This approach has been used in the absence of a control group. This means the report gives an indication of how successful the interventions have been, unfortunately it cannot tell us that any changes that have occurred are as a direct consequence of the interventions that have been introduced.

There have been a number of positive changes for women who are smoking in pregnancy and their babies:

- There has been a bigger than expected reduction in the percentage of women smoking at time of delivery
- There has been an increase in women from deprived areas consenting to a referral for support to help them stop smoking
- There has been a reduction in inequalities in smoking at time of delivery within Wakefield; the gap between the richest and poorest has narrowed
- There has been a reduction in hospital admissions caused by smoking for pregnant women and infants; this has resulted in a saving of at least £55,000 in a single year.

As a result of these positive changes the following recommendations have been made:

- Retain the Stop Smoking Champion Midwife
- Continue to improve data sharing and data quality
- Continue to have a smoking in pregnancy sub-group
Introduction

Background
This report evaluates the impact of interventions that have been delivered to address high rates of maternal smoking in Wakefield.

The interventions were implemented as part of a grant received from NHS England in 2016/17. NHS England used the CCG Improvement and Assessment Framework (CCG IAF) to highlight the challenges CCGs were facing in various aspects of services, particularly through the assessments against each of the clinical priority areas from the NHS Five Year Forward View, and made targeted offers of financial support to help CCGs improve. NHS Wakefield CCG was identified as having high rates of maternal smoking and was offered a grant of £75,000 in 2016/17 to implement or expand evidence based initiatives.

In Wakefield the grant has been used to support the following projects:

- **Carbon monoxide monitors and consumables**
  - In 2015/16 the Public Health team purchased and provided 55 Carbon Monoxide meters to Mid Yorkshire Maternity Service for use by Midwives in the community.
  - 10 meters and consumables were purchased for new members of the community midwifery service.

- **Stop Smoking Champion Midwife**
  - This role was introduced in November 2017 following delays to the recruitment process. The role is AFC Band 7 for 3 days a week and was introduced in order to
    - Reduce the smoking at time of delivery (SATOD) rate in Wakefield;
    - Reduce inequity in the rate of SATOD in communities;
    - Work with key stakeholders to implement the NICE smoking in pregnancy recommendations and National Centre for Smoking Cessation and Training–Smoking Cessation: a briefing for midwifery staff document
    - Evaluate the maternal smoking pathway and adherence to NICE smoking in pregnancy guidance.
    - Identify barriers within the midwifery service to successful delivery of advice and support to women smoking during pregnancy
    - Develop and implement strategies to overcome barriers to successful delivery of advice and support to women smoking during pregnancy in line with NICE 2010;
    - Identify training needs and implement a programme within midwifery service, including supporting and medical staff;
    - Work with local communities and key professionals, e.g. children’s first hubs, to increase awareness of the importance of smoking cessation during pregnancy, avoidance of tobacco smoke and inequity of impact across communities;
    - To plan, lead and deliver high quality smoking cessation advice and support for pregnant women within the Wakefield and district locality;
    - Work with other members of the multidisciplinary team in the implementation of specific aspects of national and Trust guidelines;

- **Improving data recording and quality to ensure women can be identified and information shared appropriately**
  - The Public Health Information team worked with partners to sign a data sharing agreement and were able to provide support and develop tools with partners and for use by partner organisations to improve data quality. In addition an integral part of the role of the Stop Smoking Champion was to work within their organisation to audit and cleanse data. This role was able to overcome barriers that had obstructed improvement.
Incentivised stop smoking programme - Personal Financial incentives

A Financial incentive scheme has been in operation in Wakefield for a number of years and has been shown to be successful when used in a targeted way. The scheme does not currently receive funding from the commissioner.

Evidence shows that financial incentives in the form of shopping vouchers can have an impact on maternal smoking rates when accompanied by support to give up smoking. Significantly more smokers offered Personalised Financial Incentives (PFI) stopped (22.5%) than a control group (8.6%) offered usual care. An acceptable level of payment of between £20 and £80 per month has been established and full cost analysis demonstrates that this falls well within the NHS threshold for cost effectiveness.

This scheme implemented evidence based selection using the following criteria:

- Pregnant smokers, regardless of age or stage of pregnancy living in a challenging environment:
- Living in an area of high smoking prevalence or deprivation
- Smoked during a previous pregnancy
- Living with a smoker
- Teenage pregnancy

In addition local practitioners are given the discretion to exercise their professional judgement to determine if individual women are living in a ‘challenging’ environment.

A £20 PFI was provided at initial face to face consultation to encourage women to engage with the service. This would allow the service to assess the woman’s readiness to take action and provide initial contact to demonstrate the services non-judgemental and supportive approach, removing a substantial barrier around negative perceptions of the service.

PFI is provided on a monthly basis until 2 months post-partum to support maintenance of the behaviour change. All payments are made following face to face consultation and CO monitoring to provide an objective measure of abstinence. Vouchers are used to make payments. Based on previous activity it was predicted that total payments would not exceed £200 in all but rare occasions when women present very early in pregnancy. The targets set with the stop smoking service were to enrol 100 women, meeting the recruitment criteria.

Scope

We would like all pregnant women who are smokers to have the same access to interventions to support them to become smoke free. Because of the way services are structured and paid for this may not always be possible. The interventions are available to pregnant women who smoke that:

- Live in Wakefield or are registered with a Wakefield GP
- And book their pregnancy with MYHT or accesses support from Smoke free Wakefield

The following groups are out of scope:

- Women who live in Wakefield or are registered with a Wakefield GP but chose to book their pregnancy with a different maternity provider
- Women who book their pregnancy at MYHT or access support from Smoke free Wakefield who don’t live in Wakefield and aren’t registered with a Wakefield GP
Evaluation Outline

Evaluation Questions
As part of the grant application process it was agreed that the following evaluation questions would be considered:

1. Has there been a reduction in smoking at time of delivery?
2. Has there been an uptake of referrals in deprived areas?
3. Has there been a reduction in the variation of smoking at time of delivery within Wakefield?
4. Has there been a reduction in the number of babies born with low birth weight (delivered at 37 weeks)?
5. Has there been a reduction in the number of pre-term babies born to mothers who smoke?

The project group agreed to also consider the following:

6. Does the incentivised programme increase engagement and lead to an increase in quits?
7. Has there been a reduction in pregnancy smoking attributable admissions to hospital?

Methodology
Ideally this evaluation would compare the outcomes of women receiving the interventions (intervention group) with the outcomes of similar women who haven’t received the interventions (matched control group). However, this is not possible as the interventions have been implemented for all women. The evaluation will use routinely recorded data and compare metrics against a baseline position to look at changes in that data since the interventions were implemented.

Many of the interventions could not be implemented in 2016/17; it took longer than anticipated to initiate the different work streams and things didn’t really start until March 2017. The financial year 2016/17 is used as the baseline to compare against.

Data Quality and Limitations
A form of financial incentive scheme has been available in Wakefield since April 2009. This means it isn’t possible to look at the impact of the incentivised programme on engagement and quit outcomes; there isn’t a control group to compare against in Wakefield. The possibility of using another area to compare against was explored but a suitable control was not identified. Areas that had similar characteristics to Wakefield, like smoking rates and deprivation also had financial incentive schemes, and areas that didn’t have financial incentive schemes didn’t have similar characteristics.

Without a control group (smoking pregnant women trying to stop smoking without an incentivised programme) it is impossible to establish if the incentivised programme in Wakefield increases engagement and leads to an increase in quits.

All other aspects of the evaluation are based on data that is routinely available; comparing data from the baseline to data after the interventions were introduced. It is not possible to know if any changes that have occurred in the data are a direct result of the interventions that have been introduced.
Findings

**Evaluation question 1: Has there been a reduction in smoking at time of delivery?**

There are two different sources of information to consider when answering this question; national data and local data.

**National data:**

Information on the percentage of women smoking at time of delivery is published every three months by NHS Digital. This data is available by area, it collates information for all women regardless of where they give birth. This means the figure presented for Wakefield will include women who are out of scope for this evaluation; some women will have given birth at a different maternity provider where the interventions were not implemented.

Despite this limitation it’s important to consider this data to give context to any changes that have happened in Wakefield. If rates are reducing in Wakefield, but they are also reducing on the same scale in other areas, this would indicate a general pattern rather than the reduction being caused by anything that’s happened specifically in Wakefield.

National data sets show the percentage of women smoking at time of delivery in Wakefield has reduced; there has been a 9.2% reduction from the baseline. Other areas have also seen a reduction, but this is much smaller than in Wakefield, nationally the rate fell by less than 1%.

**Table 1: Percent of women smoking at time of delivery in Wakefield, 2017/18 compared to the 2016/17 baseline.**

<table>
<thead>
<tr>
<th></th>
<th>2016/17 Baseline</th>
<th>2017/18</th>
<th>% change from baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wakefield</td>
<td>19.5</td>
<td>17.7</td>
<td>-9.2%</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>14.4</td>
<td>14.2</td>
<td>-1.4%</td>
</tr>
<tr>
<td>England</td>
<td>10.7</td>
<td>10.8</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Source: Fingertips

Data suggests the size of the reduction in Wakefield in 2017/18 is greater than expected. Using historical data it is possible to predict future rates; the predicted rate for 2017/18 was 17.9%, this would have given an 8.2% reduction on the baseline.

There has been a reduction in smoking at time of delivery in Wakefield. Data indicates the reduction is greater than expected and that the interventions introduced may have contributed to this reduction.

**Local data:**

Locally sourced data on the percentage of women smoking at time of delivery applies only to the women who are in scope for this evaluation; this means these rates will not match data that it published nationally, but they will give a clearer indication about the impact of the interventions.
Like the national data set, local data shows that the percentage of women smoking at time of delivery has reduced. The data also shows the reduction from the baseline is greater than in the national data, suggesting that there has been a bigger change locally. Locally there was a 9.5% reduction from the baseline, compared to the 9.2% reduction when including women out of scope of the evaluation.

Table 2: Percent of women smoking at time of delivery in Wakefield, 2017/18 compared to the 2016/17 baseline.

<table>
<thead>
<tr>
<th></th>
<th>2016/17 Baseline</th>
<th>2017/18</th>
<th>% change from baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wakefield</td>
<td>20.0</td>
<td>18.1</td>
<td>-9.5%</td>
</tr>
</tbody>
</table>

Source: MYHT maternity data

A possible cause of the reduction in women smoking at time of delivery could be that there are fewer women smoking at the time they book their pregnancy; if this is the case then the reduction in smoking in pregnancy rates can’t be attributed to the interventions that have been introduced. Data shows this is not the case. Figure 1 shows smoking at delivery data from 2016/17, it also shows the smoking at booking rates for those women; it is clear that the reduction in women smoking at delivery is not because of fewer women smoking at booking.

Figure 1: Percent of women smoking at time of delivery in Wakefield, 2017/18 compared to the 2016/17 baseline and 2018/19 year to date – compared to smoking at booking.

Source: MYHT maternity data

Figure 2 shows there has been an increase in the number of women who are quitting smoking after they book their pregnancy. In 2016/17 less than 20% of women who were smoking at the time they booked their pregnancy were smoke free by the time they delivered, in 2018/19 (year to date) almost 30% of women quit; a 43% increase in the quit rate from the baseline.
The reduction in smoking at time of delivery is bigger when looking only at the women who were affected by the interventions that have been implemented. Data suggests this reduction is due to an increase in quit rates for women who are smoking when they book their pregnancy; it is not because fewer women are smoking.

**Evaluation question 2: Has there been an uptake of referrals in deprived areas?**

There is a general consensus that quit rates among pregnant women could be increased if more women from deprived areas accepted support.

Work locally indicated fewer women than expected were getting referred to Smokefree Wakefield, the number of referrals into the service was much lower than the number of women smoking at booking. Anecdotally this was thought to be because a large number of women were not consenting to a referral, however there wasn’t any data available to understand this fully. Changes were made to the clinical system used by MYHT to enable midwives to record a woman’s consent status, this change was implemented in October 2017.

Data shows that since the IT changes were made in October 2017 there has been a steady increase in the percentage of women consenting to a referral; this increase also coincides with the Stop Smoking Champion Midwife commencing in post in November 2017. The percentage of women booking for support has also increased over this period, from 48% in October 2017 to 79% in September 2018.
Figure 3: Consent rates for women smoking at booking and the percentage of women who booked with Smokefree Wakefield

The percentage of women consenting to a referral and the percentage of women booking for support to help them stop smoking has increased since the Stop Smoking Champion Midwife came into post and changes were made to the clinical system. Unfortunately, data isn’t currently available to see if there has been an increase in women from deprived areas booking for support to stop smoking. Work is currently underway to address this gap in data. We can however look at the percentage of women living in the most deprived areas that consented to a referral, this data shows there has been an overall increase since October 2017, as shown in figure 4.

Figure 4: Consent rates for women living in the most deprived areas in Wakefield
Table 3 shows there has been a 14.4% increase in the percentage of women living in the most deprived areas who consented to a referral.

Table 3: Percent of women in the most deprived areas in Wakefield consenting to a referral to support them quitting, 2017/18 compared to the 2018/19.

<table>
<thead>
<tr>
<th>% women in the most deprived areas consenting to referral</th>
<th>2017/18 (October onwards)</th>
<th>2018/19 (up to September)</th>
<th>% change</th>
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<tr>
<td></td>
<td>54.8</td>
<td>62.7</td>
<td>14.4%</td>
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Source: MYHT maternity data

Evaluation question 3: Has there been a reduction in the variation of smoking at time of delivery within Wakefield?

Data shows there has been a reduction in the variation of smoking at time of delivery in Wakefield (figure 5). In 2016/17 the gap between the most and least deprived areas was 25.4%; 32.4% of women in the most deprived areas were smoking at time of delivery, compared to 7% in the least deprived areas. In 2017/18 this gap reduced, to 19%. The percentage of women smoking at time of delivery in the most deprived areas has fallen sharply, with a 17.3% decrease from the baseline (32.4% 2016/17 dropped to 26.8% in 2017/18).

Figure 5: Inequalities in smoking at time of delivery: a comparison of the gap between the most and least deprived

Evaluation question 4: Has there been a reduction in the number of babies born with low birth weight (delivered at 37 weeks)?

There has not been any significant change in the percentage of babies born to women who smoke that have a low birth weight. The percentage women who smoke that have a low birth weight baby (at full term) has fluctuated since 2016/17, figure 6 shows there is no meaningful difference between the different time points.
**Evaluation question 5: Has there been a reduction in the number pre-term babies born to mothers who smoke?**

Women who smoke at the time of delivery are more likely to have their baby early, before 37 weeks gestation compared to women who don’t smoke. Around 11% of babies born to smoking women are born prematurely, significantly higher than the 7% of premature babies born to women who don’t smoke. Table 4 shows there has been a 2.7% increase from the baseline in the proportion of premature births to mothers who smoke, in contrast there was a 8.4% decrease in non-smoking mothers.

**Table 4: Percent of babies born prematurely, 2017/18 compared to the 2016/17 baseline.**

<table>
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<tr>
<th></th>
<th>2016/17 Baseline</th>
<th>2017/18</th>
<th>Change Vs baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>All births</td>
<td>8.1%</td>
<td>7.6%</td>
<td>-6.4%</td>
</tr>
<tr>
<td>Non-smoking mother</td>
<td>7.4%</td>
<td>6.8%</td>
<td>-8.4%</td>
</tr>
<tr>
<td>Smoking mother</td>
<td>11.1%</td>
<td>11.4%</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

Source: MYHT maternity data

There is a considerable amount of uncertainty in comparing the percentage of premature births between groups and time periods. This is because the number of premature births is relatively small, and analysis of small numbers always has a high level of uncertainty. Confidence intervals have been used to estimate the amount of uncertainty there is, these are shown in figure 7. If confidence intervals overlap, then we cannot be sure there is a true difference. Figure 7 shows the confidence intervals don’t overlap when comparing the percentage of premature babies born to women who smoke and women who are non-smokers. This means we can be 95% sure there is a real difference between the two groups; women who smoke have more premature babies. The chart in figure 7 also shows that when comparing the baseline with 2017/18 the confidence intervals overlap; we cannot be sure there has been a true change between the two time points.
Figure 7: Percent of babies born prematurely, 2017/18 compared to the 2016/17 baseline.

Source: MYHT maternity data

The proportion of premature births born to women who smoke has increased since the baseline period; however there is a large degree of uncertainty around this data and we cannot be sure that there is a meaningful difference between the two time points.

Evaluation question 6: Does the incentivised programme increase engagement and lead to an increase in quits?

Due to the issues described in the data quality and limitations section it is not possible to answer this evaluation question.

To increase uptake of the scheme the amount of financial incentive given was increased during 2017/18. Not enough time has elapsed to assess the impact of this increase.

Evaluation question 7: Has there been a reduction in pregnancy smoking attributable admissions to hospital?

Research completed by the University of York\(^1\) identifies conditions affecting pregnant women and infants aged under one that are caused by smoking. Smoking isn’t the only cause of these conditions so the research estimates the number of cases caused only by smoking, this is called the population attributable risk. Using the population attributable risks and hospital activity data we can estimate the number of admissions to hospital caused by smoking for women and infants aged under one.

Data shows there has been a reduction in pregnancy and infant hospital admissions caused by smoking; there has been a 9.5% decrease in admissions for both pregnant women and infants aged under one year (table 5).

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\(^1\) Estimating the Costs to the NHS of smoking in Pregnancy for Pregnant Women and Infants
http://phrc.lshtm.ac.uk/papers/PHRC_A3-06_Final_Report.pdf
Table 5: Hospital admissions caused by smoking, 2017/18 compared to the 2016/17 baseline, rate per 1,000 maternities.

<table>
<thead>
<tr>
<th></th>
<th>2016/17 Baseline</th>
<th>2017/18</th>
<th>Change Vs baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant admissions caused by smoking (aged under 1 year)</td>
<td>58.7</td>
<td>53.2</td>
<td>-9.4%</td>
</tr>
<tr>
<td>Pregnancy admissions caused by smoking</td>
<td>40.2</td>
<td>36.4</td>
<td>-9.6%</td>
</tr>
<tr>
<td>Infant and pregnancy admissions caused by smoking</td>
<td>49.5</td>
<td>44.8</td>
<td>-9.5%</td>
</tr>
</tbody>
</table>

Source: MYHT maternity data

We cannot be sure this reduction is a meaningful change between the two time points, figure 8 shows the degree of uncertainty and that the confidence intervals overlap. The rate of admissions has decreased but this is not statistically significant.

Figure 8: Hospital admissions caused by smoking, 2017/18 compared to the 2016/17 baseline, rate per 1,000 maternities.

Source: MYHT maternity data

As well as looking at the number of admissions for women and infants caused by smoking we have also looked at the cost of these admissions. This has been done using the population attributable fractions and financial data detailing how much Wakefield CCG paid for the treatment of the conditions attributed to smoking. Table 6 shows Wakefield CCG saved over £55,000 in 2017/18 compared to the baseline year. This saving is based on those being admitted to hospital requiring average treatment, if more people needed emergency treatment, had complications or needed to stay in hospital longer the cost of treatment would be greater, this could mean the saving made in 2017/18 could be more than £55,000.

Table 6: Cost of hospital admissions caused by smoking, 2017/18 compared to the 2016/17 baseline.

<table>
<thead>
<tr>
<th></th>
<th>2016/17 Baseline</th>
<th>2017/18</th>
<th>Change Vs baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of infant and pregnancy admissions caused by smoking</td>
<td>£ 575,419.78</td>
<td>£ 520,116.80</td>
<td>-£ 55,302.98</td>
</tr>
</tbody>
</table>

Source: MYHT maternity data, Wakefield CCG SUS data, HES (Hospital Episode Statistics)
Conclusion and Recommendations

Conclusions
The purpose of this report is to evaluate the impact of interventions that have been delivered to address high rates of maternal smoking in Wakefield. To be able to evaluate this properly we would have needed to compare the outcomes of women receiving the interventions with outcomes of very similar women who hadn’t received the interventions. Unfortunately this was not feasible as the interventions were implemented for all women, this report focuses on comparing metrics against a baseline position. This baseline position is from a period before the interventions were introduced. Data from the baseline has been compared to data after the interventions were introduced. Unfortunately this method does not tell us if any changes that have occurred are as a direct result of the interventions, it can only be used as an indication of how successful the interventions have been.

To conclude this report, it makes sense to consider the evaluation questions:

Evaluation question 1: Has there been a reduction in smoking at time of delivery?
There has been a reduction in the percentage of women smoking at time of delivery in Wakefield. This reduction is greater than expected when considering historical trend data and is also much greater than the reduction seen in other areas. We know this reduction isn’t as a consequence of fewer women smoking at booking, as the percentage of women smoking at booking continues to remain high. Analysis indicates this reduction is a result of increased quit rates in women who are smoking when they book their pregnancy; more women are quitting and are smokefree by the time they have their baby. Quit rates in pregnant women have increased significantly since the interventions have been implemented.

Evaluation question 2: Has there been an uptake of referrals in deprived areas?
The percentage of women consenting to a referral and the percentage of women booking for support to help them stop smoking has increased since the interventions have been implemented. Data isn’t available to see if there has been an increase in women from deprived areas taking up the referral and booking for support to stop smoking. We can however look to see if there has been an increase in women consenting to a referral for support. There has been an increase in the percentage of women living in the most deprived areas giving their consent to a referral to support them to quit.

Evaluation question 3: Has there been a reduction in the variation of smoking at time of delivery within Wakefield?
Inequalities in smoking at time of delivery have reduced since the interventions have been implemented; the gap in smoking at time of delivery rates between the most deprived and least deprived communities was 25.4% in 2016/17, this was reduced to 19.0% in 2017/18.

Evaluation question 4: Has there been a reduction in the number of babies born with low birth weight (delivered at 37 weeks)?
There has not been any significant change in the percentage of babies born with a low birth weight. There is a large amount of uncertainty surrounding these figures as they are based on small numbers. 95% confidence intervals have been used to measure the degree of uncertainty and to establish if there have been any meaningful changes, this shows there has been a fluctuation in the percentage of low birth weight babies but none of these changes are statistically significant.
Evaluation question 5: Has there been a reduction in the number pre-term babies born to mothers who smoke?
The proportion of premature babies born to women who smoke has increased since the baseline period; however there is a large degree of uncertainty around this data and we cannot be sure that that the increase is meaningful.

Evaluation question 6: Does the incentivised programme increase engagement and lead to an increase in quits?
Due to the issues described in the data quality and limitations section it is not possible to answer this evaluation question.

Evaluation question 7: Has there been a reduction in pregnancy smoking attributable admissions to hospital?
Since the interventions have been implemented there has been a reduction in pregnancy and infant (aged under one year) hospital admissions caused by smoking. There were fewer admissions in 2017/18 than in the baseline year. Data indicates that a saving of at least £55,000 has been made because of this reduction in admissions. This saving only considers costs associated with hospital treatment requiring admission, it does not take into account other associated costs or longer term costs. In reality the saving is likely to be much greater.

Recommendations
It is not possible to know if the positive changes that have occurred in Wakefield are as a direct result of the different interventions that have been implemented. However, it is clear that since the interventions have been implemented that smoking at the time of delivery has reduced in Wakefield. The level of reduction seen is greater than anticipated and indicates the interventions have been successful. Based on this, the following recommendations are made:

Recommendation 1: Retain the Stop Smoking Champion Midwife
The role of the Stop Smoking Champion Midwife has been key to providing the relationship with frontline clinicians and management within the local provider Trust. The role unlocked many of the barriers to transformational change in pathways and process with the greater understanding and hands on experience of this senior Midwife. The role provided peer to peer discussion that, despite excellent relationships between the provider Trust and Stop Smoking Service, had not previously been possible and resulted in a number of significant changes in practice. The role has continued to provide insights that will allow continued innovation in service provision, a key role in supporting education and practice of midwives and more recently patient support and awareness raising. This role has been pivotal in delivery of these improvements.

Recommendation 2: Continue to improve data sharing and data quality
Appropriate access to accurate and timely data enables all partners to understand what is happening for pregnant women who smoke in Wakefield. Without this information the sub-group would not have identified an issue with women consenting to a referral and they would not have been able to work together to address this issue. It is important that partners continue to improve data quality and share information appropriately, to ensure that progress on improving outcomes continues and can be monitored to identify areas for improvement.

Recommendation 3: Continue to have a smoking in pregnancy sub-group
The Smoking in Pregnancy sub group, led by Wakefield Public Health Team, has provided a forum that brings together key stakeholders across the district who have a role to play in the reduction of smoking in pregnancy and maintaining stop smoking after the birth of the baby. Membership
includes, Stop Smoking Champion Midwife, Stop Smoking Specialist Services, Public Health Intelligence and Analyst, Public Health 0-19 service (Health Visitors and Family Nurse Partnership), CCG representation, Children’s team, Community Workers and neighbouring Local Authority Public Health Team.

The group has supported the reduction in SATOD Targets across the health economy and facilitated work across organisations that has been much wider than the NHS England funded project. This group should remain in place to ensure the momentum, awareness and priority placed on the Smoking in Pregnancy work currently in place is not lost and allow us to continue with shared priorities, mutually supported activities and reduced duplication.

**Recommendation 4: Continue the Incentivised stop smoking programme**

Although it hasn’t been possible to evaluate if the incentivised programme in Wakefield has resulted in an increase in the number of quits, there is evidence that shows this is the case elsewhere. Based on this evidence the incentivised programme in Wakefield should continue.

**Recommendation 5: Assess the impact of changing the amount of the financial incentive**

When enough time has elapsed it is recommended that the change in the amount of financial incentive should be assessed, to establish if increasing the amount has resulted in more women taking part and completing the programme. This assessment should then be used to inform the amount of financial incentive given in the future.