Purpose

This report sets out a template for use in preparation of the work programme for each of the Health and Wellbeing Board's ten interventions. The template is designed to;

- Create clarity on the desired impact of each intervention and on the specific roles of partners in delivering the intervention.

- Make explicit the shifts in ways of working that will allow partners to deliver the intervention.

The planning template

1. Reality
What's the current reality?

• What is currently working well?	Currently the number of women smoking at time of delivery (SATOD) is very slowly reducing across Lancashire; there is a need to accelerate the downward trend in order to reduce the number of babies born with potential life threatening and chronic lifelong term conditions caused by tobacco use during pregnancy. The provision of the service should be equitable across Lancashire and include equal access to the Incentive scheme, providing incentivised support to pregnant women. Currently the Pan Lancashire Tobacco Control leads oversee the implementation of the Pan Lancashire Tobacco Control Strategy, an overarching strategy which includes reducing the number of women who smoke during pregnancy.
• What is getting in the way of partners achieving desired impacts?	The combination of the illicit tobacco industry and high levels of deprivation in the county are totally entwined with the challenge of reducing the number of people who use tobacco. Across Lancashire referral pathways are very different, access to nicotine replacement therapies are very varied and the social context is extremely diverse. The main issues which hinder partners achieving

desired outcomes are:

1.   The lack of belief and knowledge about tobacco use and the harm it causes among providers and pregnant women often renders providers unable to implement evidenced based practices that encourage and support pregnant women to quit. (E.g. NICE Guidance)

2   Service providers do not consider it a priority target compared with other competing targets. Therefore, they experience difficulty implementing and adhering to local and national polices/guidelines.

3   Need to gain a better understanding of the barriers using insights from midwives and other professionals across Lancashire.

4   Incorrect, inconsistent data collection, exasperated by a level of deception regarding pregnant women self-reporting their smoking behaviour results in unreliable results and great difficulty in agreeing investment priorities.

5   Many pregnant women believe they cannot use NRT products whilst pregnant. This belief has reportedly been reinforced by some NHS staff and significant workers around pregnant women. The use of NRT is significantly better for pregnant women rather than continuing to use tobacco.

6   Lack of resources for specific project management with capacity to co-ordinate and provide training, prepare papers and co-ordinate actions.

• Where are the gaps in service delivery that really matter?	Current gaps in service delivery are that pregnant women, who are smoking during their pregnancy, are either not being identified or not referred to specialist stop smoking services (LSSS) at the beginning of their pregnancy. Additionally current maternity staff are not equipped with the tools or training to generate a teachable moment which inspires motivation to accept support and quit

	using tobacco during their pregnancy. This is exacerbated by the lack of IT systems which would ensure referrals are made, information is correct and appointments are made promptly. Current systems and process are difficult to track, the pathway being dependant on someone going to the office etc.
• What are the issues and opportunities that must be addressed if we are to make a breakthrough? i.e. what really matters?	What really matters is that all babies are given the best chance possible at the beginning, this should not be compromised by staff struggling to address smoking in pregnancy as a serious risk; by referrals not being made - consequently pregnant woman are left ignorant of the risks smoking in pregnancy can cause: • Premature birth, full term babies are healthier and stronger • Low birth weight • Still birth • Decreased lung function of the developing baby • Premature rupture of the membranes • Increased heart rate and blood pressure of the mother • Heavy bleeding caused by early detachment of the placenta from the wall of the uterus • Miscarriage: the risk of suffering a miscarriage is increase by 25% for a mother who has significant levels of CO in the body • Under development • Sudden Unexpected Death in Infants (SUDI)

2. Results
What does success look like?

2.1 Longer-term impact

• What will be the 3 to 5 year impact of the intervention?	• Reduction in number of premature births • Less use of NNU cot days due to smoking • Reduction in low birth weight • Reduction in number of grommet operations • Reduction in acute asthma admissions in children • Reduction in hospital admissions in under 5s for acute upper and lower respiratory infections, acute bronchiolitis caused by second hand smoke • Reduction in the number of pregnancy and pre-term complications • Reduction in the number of SUDI associated with tobacco use
• What are the longer-term measures of success?	• Reduced rates of women smoking at time of delivery • Reduction in health inequalities • Reduce delivery, neo-natal and early childhood cost to the NHS

2.2 Impact in the year ahead

• What specific goals will the intervention achieve in the next year?	• All pregnant women in Lancashire are screened for carbon monoxide • Pregnant women who use tobacco are identified at time of booking • All pregnant women receive a brief intervention and are made aware of the risks CO • Automated referrals will be generated for women who are identified as smoking at time of booking. • Women who are referred to local SSS will receive evidence-based, enhanced and appropriate treatment and support. • Removal of any service weakness involving healthcare staff's personal relationship with

	tobacco which may be hindering identification, effective intervention or referral
	• A positive consent opt out model for pregnant women who smoke, ensuring that women who do opt out will be fully aware of the risks they are taking if they continue to smoke.
• What are the specific measures of success for the year ahead?	• All maternity staff trained and using CO monitors at booking appointment
	• All maternity PAS systems are able to generate automated referrals to the LSSS
	• All pregnant women receive a brief intervention about tobacco use during pregnancy
• How will the Health and Wellbeing Board know that the intervention has achieved its goals?	• All women are screened for CO at booking
	• Increase in referrals to local SSS of pregnant women
	• Improved performance towards the SATOD average for Lancashire or lower
	• Reducing the number of babies born early
	• Reduction in the number of low birth weight babies
	• Reduction in the number of babies requiring specialist NNU care

3.   Response
What needs to happen to ensure partners achieve better results?

3.1 Shifts in the way that partners deliver services

• How must partners work to ensure that the 'priority shifts' are applied and the intervention is effectively implemented?	• Adopt a performance management team within each area to oversee implementation, the group will be time served and is committed to meeting regularly
	• Scoping of the current maternity information

- and smoking cessation electronic systems
- Adaptations made to electronic systems making them fit to deliver the new pathway
- Deliver a CO screening training module for midwives and/or healthcare staff who book pregnant women
- Identifying local champions/leads for local implementation
- Design and implement on-going monitoring and evaluation providing opportunities to amend the pathway or system to meet the local need and make fit for purpose
- Increase resources within LSSS to meet the needs of pregnant women who use tobacco
- Establish and agree a performance monitoring process which monitors activity and applies scrutiny to relevant data
- Integrate the regional incentive scheme into mainstream working practice and continue to use as a tool for scrutinising the quality of local data

3.2 Programme of work

- Who needs to be involved to develop, commission and deliver the intervention?

	Role
Lead, Local Women and Children's Units NHS Acute/Foundation Trust maternity units	Ensure that SATOD improvement and NNU improvement is on the Trusts agenda. Attends performance management meetings.
Manager, Community midwifery service, Local NHS Acute/Foundation Trust	Ensure that all community staff are trained and smoke free policies are applied and enforced. Ensure that SATOD data collection is correct and support is given to informatics and Public Health Lead to scrutinise the data. Attends performance management meetings.
Midwifery Manager, Local	All staff working within the

NHS Acute/Foundation Trust	hospital are compliant with their smoke free policy. Attends performance management meetings.
Public Health Project Lead	Keeps the implementation of the scheme on track, facilitates meetings and co-ordinates actions. Provides training. Attends performance management meetings.
Manager, Local NHS Stop Smoking Services	Ensures that referrals are accepted and correct, shares anonymous data and accepts feedback about service. Attends performance management meetings.
Public Health Facilitator, Health Promoting Hospital, Local NHS Acute/Foundation Trust or LA	Ensure that all service development is in line with the hospital smoke free policy; any publications are developed within the PH strategy and are in the corporate theme of the hospital. Attends performance management meetings.
Local NHS Acute/Foundation Trust information analyst	Provides up to date data, informs of any issues which can affect the quality of the data. Attends performance management meetings.

- What are the 'milestones' for the Task Group in the year ahead?

Description
Establish a project group
Scoping data collection systems
Establish a SATOD improvement plan based on 5 objectives: 1) Increase access to information on the risks of smoking

during pregnancy: 2) Identify and refer all women who are smoking at the time of the booking appointment: 3) Increase compliance of smoke free hospital: 4) Increase to reliability of SATOD 5) Increase access to pharmacological support : To be signed off by CE or equivalent
Agree and develop any relevant contract variations
Agree standard pathway
Establish the specification for IT change request for automated referrals
Agree training and implementation programme calendar
Agree start date and train all staff
Support meeting schedule
Arrange evaluation and review meetings

- What are the specific activities to be carried out by each partner?

As indicated in 3.2

Priority shifts in the ways that partners deliver services

- Shift resources towards interventions that prevent ill health and reduce demand for acute and residential service

- Build the assets, skills and resources of our citizens and communities

- Promote and support greater individual self-care and responsibility for health; making better use of information technology and advice.

- Commit to delivering accessible services within communities; improving the experience of moving between primary, hospital and social care.

- Make joint working the default option; pooling budgets and resources to focus on priority outcomes, commissioning together on the basis of intelligence and evidence; sharing responsibilities for service delivery and combining services in the most effective way; sharing risk.

- Work to narrow the gap in health and wellbeing and its determinants