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Evaluation of the South West Guidance for Delivering Smoke Free Homes

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Contributors:

Russ Moody

Health & Wellbeing Programme Lead, OHID SW

Jodie Demmery

Project Officer & Co-ordinator for SW ADPH Network, South Gloucestershire Council

Kate Grant

Treating Tobacco Dependency Programme Lead, NHSE SW

Rosanne Sodzi

Health & Wellbeing Programme Manager, OHID SW

Amy Claridge

Health Inequalities Manager, NHSE SW

Becky Townsley

Digital & Treating Tobacco Dependence Midwife, Gloucestershire Hospitals NHS FT

Jennifer Davies

Senior Public Health Specialist, Bristol City Council

Laura Janes

Senior Policy/Project Officer, Bristol City Council

Hayley Martin

Public Health Specialist, North Somerset Council

Anna Dedman

Public Health Specialist & Certified Stop Smoking Practitioner, North Somerset Council

Claire Tatton

Public Health Specialist, Torbay Council

Michelle Sterry

Lead Midwife Healthy Lifestyles and Public Health, Gloucestershire Hospitals NHS FT

Jan Bray

Professional Lead for HV, Cornwall Council

Sarah Duffy

Health Visitor, Gloucestershire Care Services NHS Trust

Helen Aston

Public Health Specialist, Wiltshire Council

Heidi Croucher

Treating Tobacco Dependency Programme Manager, Dorset ICS

Amanda Safier

0-19 Team Leader, Torbay and South Devon NHS FT

Evaluation of the South West Guidance for Delivering Smoke Free Homes: Full Report

Background

In early 2023, as part of the South West Directors of Public Health (DsPH) Sector-Led Improvement (SLI) programme, a region-wide [Guidance for Delivering Smoke Free Homes](#) was developed by a team of expert professionals and commissioners informed by an online bench marking survey completed by Health Visitors (HV). The purpose was to have a regional approach for HV to support families to establish and maintain smoke free homes, helping to reduce infant exposure to smoking-related harms.

The resulting guidance contained 6 recommendations for best practice in:

- *Improving the communication between Midwifery and HV teams*
- *Increasing the number of HV services carrying out Carbon Monoxide (CO) monitoring*
- *Enhanced smoke free training for HVs*
- *Improved awareness raising of the risks of second-hand smoke to children*
- *Increased referrals to local stop smoking services*
- *Improved data collection and monitoring.*

Introducing the above recommendations will also contribute towards:

- *Reducing the risk of relapse, where parent/caregiver has recently quit smoking*
- *Increasing the proportion of children living in parents/caregivers reported smoke free homes*

Key learnings and recommendations from this evaluation

Broaden awareness of the guidance and promote engagement, specifically with Health Visitors. Embed the guidance into the SW Tobacco Control and Smoking Cessation Strategic Delivery Framework and Action Plan (2025-2030) as well as advocate through the regional Tobacco Control Network, Health Visitors Network, and Smoking in Pregnancy forums. Provide information and take the opportunity to provide advice to midwives and health visitors about the benefits of the guidance and adoption of the Smoke free homes standards.

Use the guidance to develop local quality improvement action that supports development of the maternity care pathway. Specifically, communication of handover processes, enhanced CO monitoring access, and engagement to training.

The South West DsPH requested to evaluate and understand how well the guidance has been implemented across the region. In August 2024 a refreshed expert group was re-established and as part of the evaluation a survey was developed. Launched in early December 2024, Health Visitor Leads/Managers, Health Visitors, Commissioners, and anyone involved in implementing or using the guidance across the region were asked to complete a survey as part of the evaluation. 71 participants responded to the survey.

Survey Participants	Count of No.
Health Visitor	35
Lead Health Visitor/Team Lead/Manager	18
EY/Family/Community Practitioner/Worker/Assistant	11
Public Health Specialist	3
Commissioner	2
Other	2
Grand Total	71

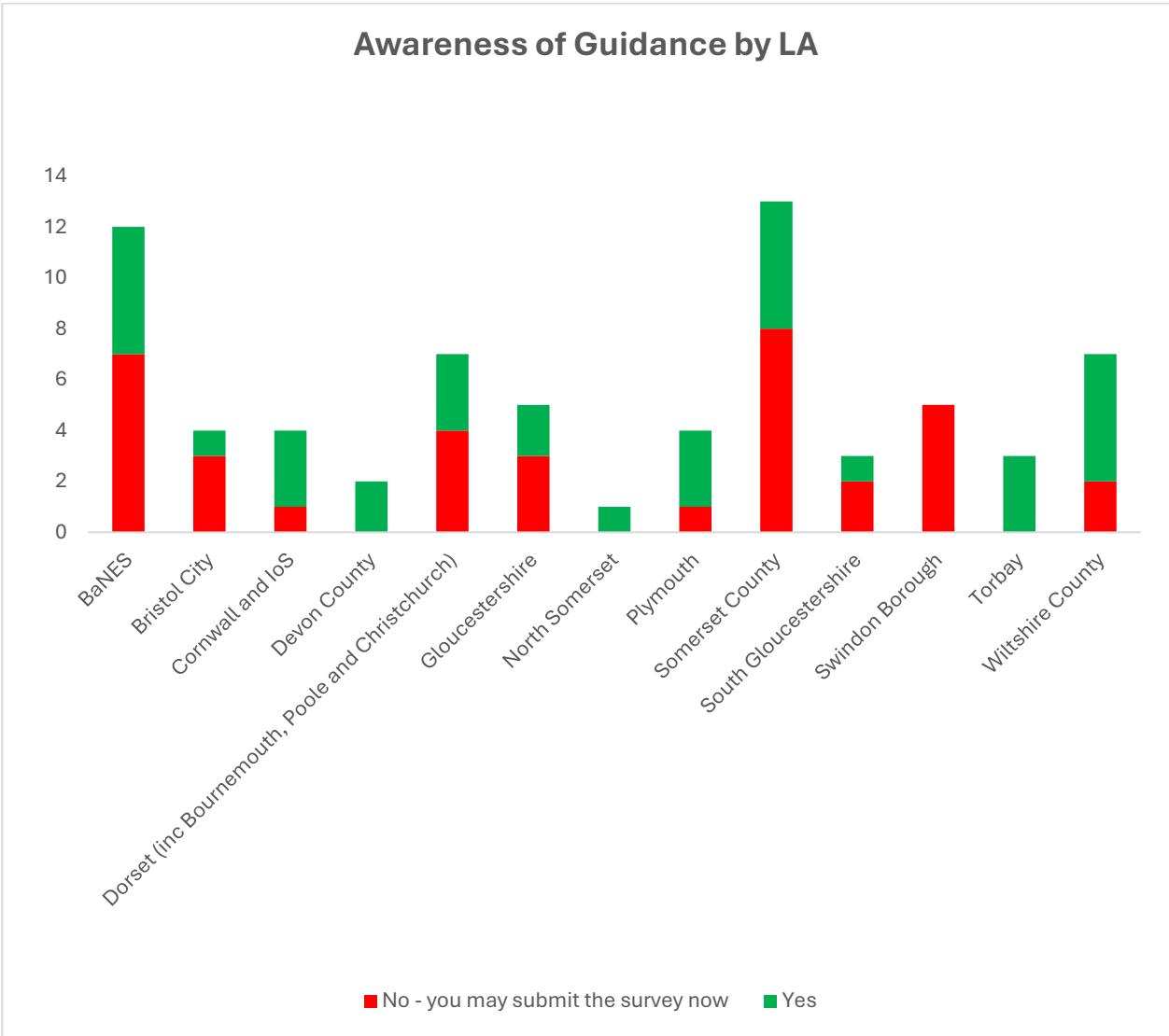
This survey was developed from the baseline, factfinding survey of the original expert group and guidance development from 2023 – as such some survey questions were repeated and comparable. Where we do have comparator responses and observation we have used them, and they are highlighted in blue.

All Responses

71 responses were received – of these, 37 (52%) had not heard of the Smoke Free Homes Guidance. Our survey was structured with conditional questions and as such those who had no knowledge of the guidance ended the survey at this point.

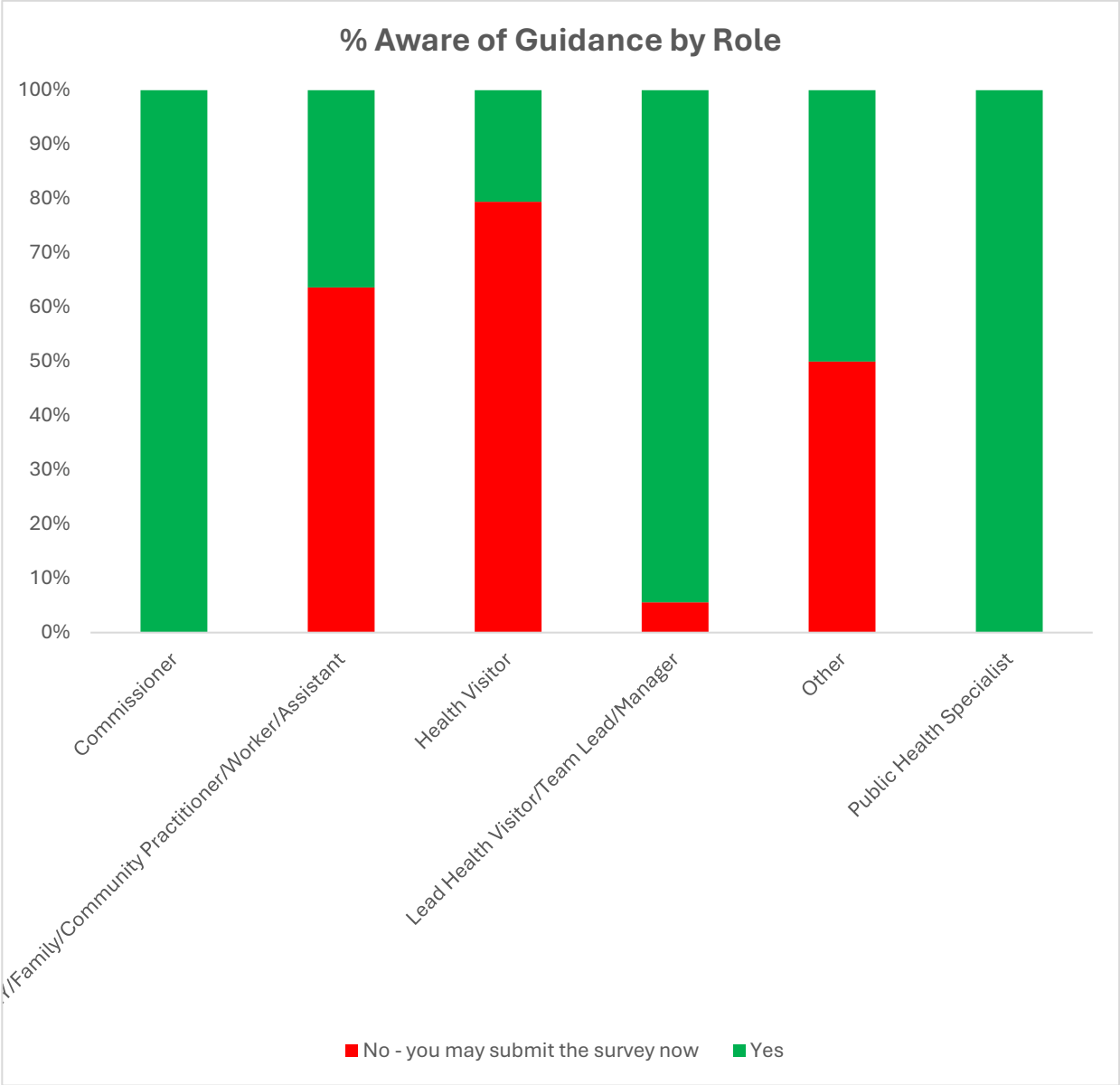
This is a key finding of the survey, particularly considering the recruitment bias this survey will encounter. It indicates that strategic awareness is high (e.g. among Commissioners and Public Health Specialists), but front-line awareness is low (e.g. Health Visitors). The remaining analysis represents the 34 respondents that were familiar with guidance.

Overall, Somerset had the most responses (13) with BaNES close behind (12). Both had more respondees who *were not* aware of the guidance than were aware. In fact, only Cornwall and Ios, Devon, North Somerset, Plymouth, Torbay and Wiltshire had more people respond to say they were aware of the guidance than not, although these LAs also had some of the lowest overall responses too. All five responses from Swindon said they had not heard of the guidance.



Interestingly, out of all of the responders, Health Visitors were most likely to **not be aware** of the guidance – only 20.6% of them had heard of it, followed by 36.4% of Early Years/Family/Community Practitioners. 94.4% of Lead Health Visitors, and 100% of Commissioners and PH Specialists were aware of the guidance.

This appears to highlight that the guidance is known on a strategic level but has not necessarily been shared widely or embedded with front-line workers.



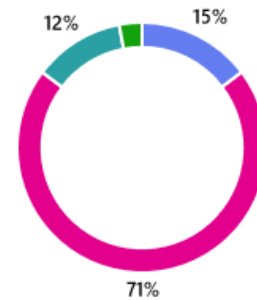
Responses

(Note that only the respondents that had awareness of the guidance went on into the survey to provide further responses)

Almost three quarters (71%) thought it was partially embedded in their area. A further 15% thought the guidance was Fully embedded (15%), which is positive. However, 12% were aware of the guidance and thought it was Not embedded at all.

6. In your area, would you consider the guidance recommendations to be...?

Fully embedded	5
Partially embedded	24
Not embedded at all	4
N/A	0
I don't know	1



There were 22 comments around what had hindered the embedding of the guidance, which are themed below. The full comments are available in Appendix 1. Some comments included references to more than one theme:

Theme	No. of Comments
Funding	3
Recording	3
CO Monitoring	7
Handover & Communication	4
Capacity	12
Other	6

There were also six comments about what had helped, which mainly focused on strong local working relationships.

What helped embed the guidance?

The additional stop smoking grant received this year means we are exploring funding a full time smokefree homes role within the Public Health Nursing service who will focus on implementing the Smokefree Homes Recommendations in this report. However we are hopeful this position will improve, particularly if we get a dedicated role into the service itself. That said the guidance is helpful, as it clearly communicated to the service what we are seeking to achieve, and provides a benchmark to work towards.

It helps that we have a strong network around tobacco control in B&NES

Help: smokefree grant funding. This is being used to fund training and to purchase CO monitors for all members of the health visiting team. willingness to work collaboratively between local services - midwifery TTD team, health visiting, public health and Healthy Cornwall (in-house health improvement service) have set up a working group to look at the guidance. locally all pregnant women are offered CO monitoring at every antenatal appointment. locally there are midwives working in the health visiting team and they have be able to share their experience of the benefits of offering routine CO testing.

Somerset has had a very effective smoke free families team for many years where a number of innovations have been championed such as training with health visiting teams, attendance of smoke free families at health visiting groups and promotion of the smoke free families offer within health visiting. However, we are now in a position to think about how we implement this pathway locally and have started these discussions. Work has taken place outside of smoking, looking at addressing broader inequalities in the transition from maternity to health visiting with the advent of the Forest programme and joint training and interventions from 16 weeks antenatally. We have also have a template for midwifery communication where there is a risk factor such as smoking in pregnancy.

Recording if fathers smoke or if home is smoke free (as other adults might also live there)

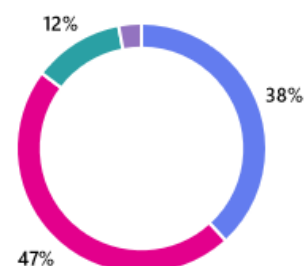
More visibility

Helpfulness of the Guidance

85% of respondents said the guidance was Very or Somewhat helpful. 15% said the guidance was Neither helpful nor unhelpful or Somewhat unhelpful. These answers could perhaps be investigated more to understand why this was the case.

8. How helpful have you found the Guidance in your role?

Very helpful	13
Somewhat helpful	16
Neither helpful nor unhelpful	4
Somewhat unhelpful	1
Very unhelpful	0



73.5% of respondents said that either having an agreed pathway or Helping support families were the most helpful things about the guidance. Only 17.4% said the guidance had supported joint working or improved handover. Three people gave other answers about what had helped.

What was helpful?	No.
Having an agreed pathway and best practice standards to strive for	13
Helping support families to establish smoke free homes	12
Supporting joint working between maternity and HV	5
Improving handover and communication	1
Other: driver to implement routine CO monitoring	1
Other: motivation from partners which we have found helpful to work with	1
Other: helps support discussion about what we could do if capacity	1
Total	34

17 respondents left comments about what could be improved. These included suggestions about improving clarity, adding flow diagrams, increasing communication, additional training for staff and linking the guidance with funding or national priorities.

What could be improved?
Clarity re follow up when high score and non smoker and support for agreed national reporting
Making it more accessible.
Specific flow chart - condensed info for ease of access
better communication between midwifery and HV re interventions during pregnancy
Nothing it is very clear, perhaps more direction about the handover between maternity and HV services.
I could probably do with an update on what is offered re advice around vaping etc.
Aimed at all parents.
I'm not sure whether it should be changed, but often the recommendations seem quite out of reach which may be off putting for the service.
Flow charts could be clearer about pathway if person has never smoked and reason for completion and supportive conversation around this
Guidance itself is fairly reasonable, its the context it has landed in which impacts ability to enact the guidance. Funding should have been associated, to pay for time or to solve some of the issues like transfer of information between partners.
Input from all maternity and health visiting systems. Understanding and flexibility in what constitutes success for areas where full implementation is not possible or delayed.
We would have welcomed a community of practice forum to discuss and share implementation of the guidance. We felt unclear about the expectations for delivery and would have welcomed some clarity on this. Not specific to the guidance, but we also would like national resources on smokefree homes that could be shared with families, akin to the resources Better Health have developed for other aspects of early years e.g. healthy eating toolkit
How we embed this across different IT systems - the transfer of notes. Making SF homes conversations a part of every conversation and trying to offer continuity of care and so that patient's don't feel like they are repeating themselves at every appointment.
I think this needs to have a policy and resource link that could influence the public health grant which then could influence resource within the Devon County Council area. This is a national issue based on public health grant funding decisions from 2010.
increase notification of support being offered.
direct referral to Smoking advice support when identified and consented
Reduce the number of questions on the passport - Change 'Advised to reduce smoking' to advised to stop smoking' as reducing smoking does not reduce harm. HVs do not need to know what the individual's quit date is or last cigarette.

The following sections deal in turn with the different elements relating to the minimum standards and best practice within the guidance: communication and handover; training and champions, referrals; CO monitors; and resources.

Communication and Handover

This section looks at the questions relating to the Communication and Handover section of the guidance. The minimum standards and best practice are summarised below:

Minimum Standard

Sharing of a minimum data set includes:

- *Demographics*
- *Resident parent/caregiver smoking status*
- *Whether resident parent/caregiver has reported child lives in smoke free home*

Best Practice

Full completion of Maternity Stop Smoking Passport, and for this to be shared via an agreed pathway with HV.

This dataset can be embedded digitally within relevant software, completed electronically, and emailed, posted, attached to maternity notes, or by any other secure and mutually agreed pathway.

Robust and secure data sharing protocols are in place and adhered to, aligning with respective information governance requirements.

Sharing agreements will need to be in place to manage data.

Smoking Status - During Pregnancy

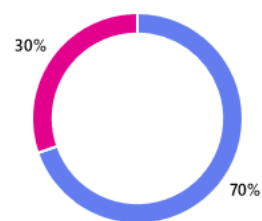
70% said they received the smoking status of the mother-to-be, but this dropped to 42.4% for the status of the partner and 18.2% for others in the household.

In the previous survey 88% of respondents stated that they received the smoking status of the mother to be.

le, the response in the most recent survey is 18 percentage points lower than the previous survey.

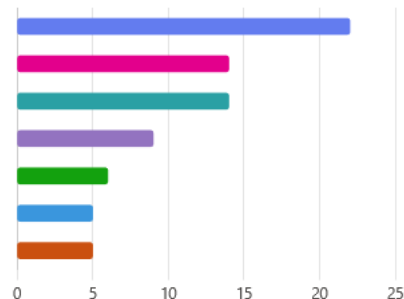
11. **During pregnancy** does your Health Visiting Team receive any information from Midwives about the smoking status of the mother to be?

Yes	23
No	10



12. If yes, does your Health Visiting Team receive information about the following during pregnancy? (Tick all that apply)

Mother	22
Partner smoker	14
Current smoker	14
Ex-smoker	9
Others smoking in the household	6
Support provided	5
Vaping	5



Smoking Status – Postnatal

In the postnatal period, the smoking status of the mother being passed on from Midwives to HVs reduced to 55%, 24.2% for partners and only 15.1% for others in the household, showing that smoking status in the postnatal period is communicated less often from Midwives to HV than during pregnancy.

33% of respondents received information on the smoking status of the mother in the previous survey, suggesting that this area of practice has improved.

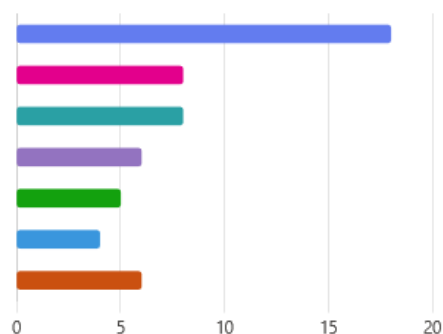
13. In the **postnatal period** does your Health Visiting Team receive any information from the Midwives about mothers smoking status?

● Yes	18
● No	15



14. If yes, does your Health Visiting Team receive information about the following in the postnatal period? (Tick all that apply)

● Mother	18
● Partner smoker	8
● Current smoker	8
● Ex-smoker	6
● Others smoking in the household	5
● Support provided	4
● Vaping	6



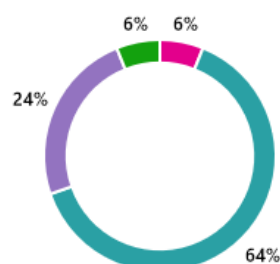
Stop Smoking Passport

Only 6% of people said that fully completed passports were received by HVs from Maternity Services at handover. 64% said they were not received and almost a quarter said they didn't know.

The two people who said passports were received said these were attached to maternity notes or given verbally.

15. Does your Health Visiting Team receive a fully completed Maternity Stop Smoking Passport at handover from the Maternity Service?

● Yes - always	0
● Yes - sometimes	2
● No	21
● I don't know	8
● Other	2



Communication between Maternity and HV

One of the key aims of the guidance was to improve communication between Maternity Services and HV Teams.

The table below shows the results from this and the previous survey. A higher percentage thought communication was Very Poor this time and no-one thought it was Excellent, however more people thought it was Fair and/or Good, presenting a rather mixed picture.

Rating	Previous Survey	This Survey	Change
Very Poor	5%	10%	Declined
Poor	30%	23%	Improved
Fair	37.5%	45%	Improved
Good	20%	23%	Improved
Excellent	7.5%	0%	Declined

The table below shows the responses to 'What information does your Health Visiting Team receive about supporting someone in the household's attempt to quit smoking?'. This was a free text question and it is unclear whether everyone answered the question in the same way. Most people said they either received minimal information on handover or in notes or did not know.

[This mirrors responses in the previous survey.](#)

Type of Information	No.
Minimal	11
Unknown	10
Training	4
Referral info	4
Signposts	2
Mother smoking status	2
Household smoking status	1
Total	34

Overall, although some aspects of recording smoking status have improved, communication and handover still appear to be an area for concern.

Training and Champions

This section looks at the questions relating to the Training section of the guidance. The survey asks respondents about the type of training they have done and when it was completed.

Summary of Training ‘Gold Standard’

- 90% of the HV workforce have completed the NCSCT online antenatal training.
- Core HV champions have been identified.
- 1 HV champion per locality.
- Core HV champions have completed specialised training.
- Core HV champions attend Local Tobacco Control Network.
- All HVs are issued with CO monitors.
- All HVs can recommend NRT/vapes.

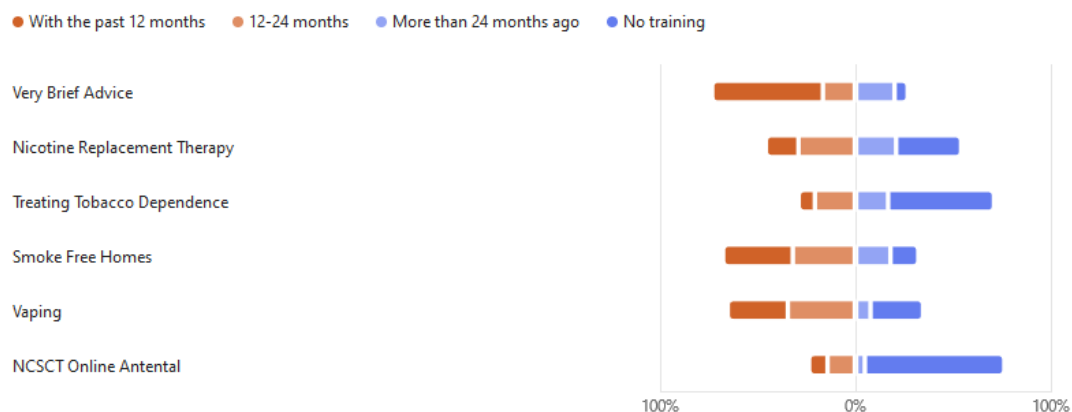
Types of Training

95% of respondents have attained the NCSCT VBA Training with 60% reporting completion within the past 12 months.

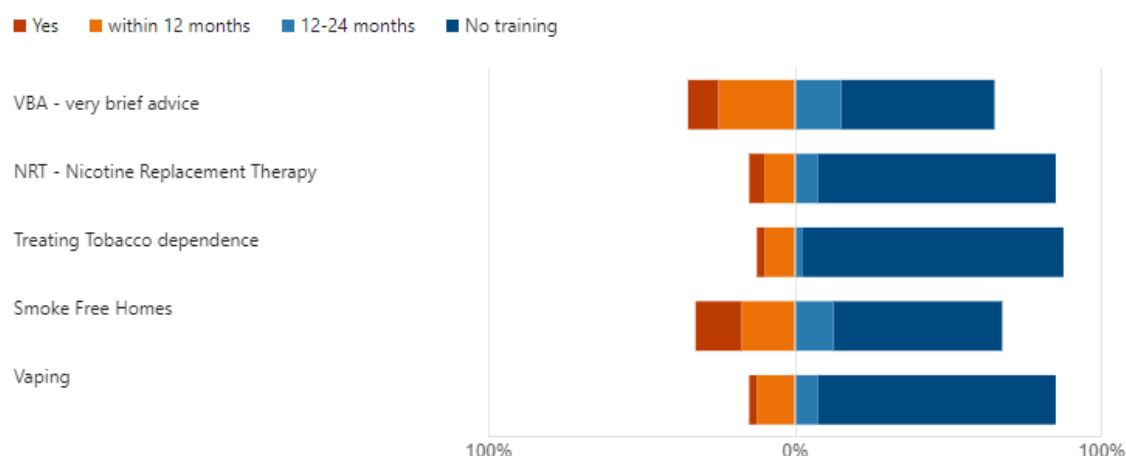
Just under 70% have done NRT training at any time, and just under half have ever done TTD training. Just over 85% and 65% have completed Smoke Free Home and Vaping training, respectively – the majority within the last two years.

Unfortunately, the lowest take-up of training is directly connected to the target of 90% highlighted in the guidance – the NCSCT Online Antenatal training. Currently, only 28.5% of respondents said they have completed this training at all, and less than 10% within the past year.

19. Has your Health Visiting Team received any training on the following and if so how recently was this?



Despite there being some room for improvement still to go, the situation has improved from the previous survey, particularly around NRT, Smoke Free Home and Vaping training, where most people had not completed any training. The chart below shows the responses we had from the previous survey.



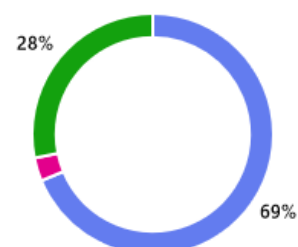
Smoke Free Homes

85.7% of respondents have completed Some Free Homes training. The survey then asked how frequently smoke free homes were discussed with families when they identified that someone smokes in the household.

Almost 70% said this was at every visit to the family, with the remainder mainly saying Other, which includes people who were unsure, and those who said it depended on the family circumstances, or that it would be mentioned when appropriate.

21. If your Health Visiting Team identify a family that smokes, how frequently are smoke free homes discussed with them?

At every visit	22
At the first visit only	1
At the last visit only	0
Never	0
Other	9



The question in the previous survey had slightly different wording in that it asked about 'every visit or mandated contacts', so it is difficult to compare. Then the results were that smoke free homes were discussed at either every visit or at the mandated contacts - combined 95%. It appears that this measure may have declined in the second survey, which is disappointing. There appear to be more answers suggesting it is discussed when appropriate.

Nicotine Replacement Therapy (NRT)

The guidance states that all HVs should be able to recommend NRT. Despite 66.7% of people receiving training in NRT, almost 60% said their HV Team did not provide NRT, information or advice. Just over a quarter (28%) could provide advice only and only 13% could give information only. No respondents could prescribe or directly supply NRT.

22. Does your Health Visiting Team provide Nicotine Replacement Therapy (NRT), information or advice?



In the previous survey, less than 20% could provide advice only and about 30% could provide information only, so the data suggests that more people have moved from giving information to being able to give advice in the new survey, although the majority can still do neither.

Vaping

As with NRT, the guidance says that HVs should be able to recommend vapes in a person's attempt to quit. Despite 65.5% of respondents receiving training on vaping within the past two years, only 47% of them are Confident or Fairly Confident in providing advice on vaping or e-cigarettes. Almost half (47%) said they were Not Very Confident.

24. How confident do you feel your Health Visiting Team are in advising someone on vaping or e-cigarettes?



However, it should be noted that this is an improvement on the previous survey when only 37% said they were Confident or Fairly Confident in providing advice on vaping or e-cigarettes.

This would indicate that the increase is recent training around vaping has increased people's confidence in advising on this, but there is still some progress to be made before the majority felt confident on this issue.

Agreed Pathways

The next question focussed on agreed pathways for supporting a quit attempt. 66% of respondents said their HV team did have this, which compares favourably to the 25%

who said yes in the previous survey. This indicates there has been positive progress on developing and embedding agreed care pathways for supporting quit attempt of people within the household.

18. Within your Health Visiting Team do you have an established and agreed care pathway for supporting someone in the household's attempt to quit smoking?



Champions

A key part of sharing, implementing and embedding the guidance, as well as giving a strong platform to general stop smoking work is the existence of smoke free champions within the HV service in each area.

Unfortunately, only 16% said they did have champions (in Torbay, Bristol and BaNES) and a further 22% were unsure (in Cornwall, Somerset, Wiltshire and Dorset). The remaining responses – almost two thirds – said they did not have champions in their area, suggesting that this is an area for improvement.

25. Do you have any Health Visitor smokefree champions within your Health Visiting Team?



However, this is an improvement on the previous survey when only 5% said they had a champion.

The guidance also mentions additional training that champions should access and suggests they join their Local Tobacco Control Network. These aspects will be followed up in the focus groups.

Referrals

This section looks at the questions in the guidance relating to Referrals. The minimum standards and best practice are listed below:

Minimum Standard

All HVs are able to refer people who would like help to stop smoking, into local smoking cessation services or equivalent support.

Robust smoking cessation pathway established between HV services and local smoking cessation services (where applicable).

Best Practice

Access to an electronic system i.e. Quit Manager for HV teams to refer electronically and instantly to smoking cessation services, where applicable (plus associated training).

Outcomes reporting from smoking cessation services to HV agreed locally with feedback to HV following TTD referral.

Improving referrals is a key part of the guidance. 84% of people said they could refer directing to local Stop Smoking Services, which is positive. 16% said they were unsure – these respondents were from four different areas, which indicates that reiterating the referral process across all areas may be of benefit. Of those who said they could referral directly, 62.1% said they could do this using an electronic system – almost a quarter were unsure and just under 14% said they could not. This is again something which could be clarified for those who were unsure, and something which could be promoted in the areas which currently do not use an electronic system.

Almost 40% said they had received training on using the electronic system, but 25% hadn't and almost 30% were unsure. This is something which could be focussed on and improved.

Only 17.9% said they receive feedback following a referral, whilst a quarter said they did not receive any feedback, and the majority (57.1%) said they were unsure. Again, this is something which could be improved upon.

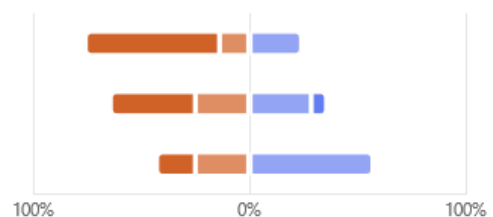
28. If yes...

● Yes ● No ● Unsure ● N/A

Can HVs refer using an electronic system?

Have HVs received training on how to do this?

Do HVs receive feedback following a referral?



In the previous survey, 60% said they could refer directly, so this has improved in the past 18-24 months, which is positive.

Carbon Monoxide Monitors

This section looks at the questions relating to the guidance and Carbon Monoxide Monitors. The minimum standards and best practice are listed below:

Minimum Standard

CO testing at pre-birth HV visit and primary birth visit • Access to CO equipment • Capturing of results in patient notes • CO screening training • Establish a local CO screening pathway.

Best Practice

CO testing at all HV visits • All HVs issued with own CO equipment • Home CO monitoring kits provided to women • Standardised CO pathway.

Overall, 75% said that their HV team does not provide CO monitoring – only 22% (7 respondents) said their team did and 3% were unsure. All those saying yes were from Dorset and Wiltshire.

The following questions were only answered by those saying yes to the above question, and all answers were mainly positive in terms of testing at pre- and primary birth visits, recording the results in the patient notes, HVs receiving training and being issued with a CO monitor and there being a pathway.

The only question which has different results was 'Are home monitoring CO kits provided to the patient?', which is in the best practice section of the guidance, where 6 respondents said 'no' and 1 was 'unsure'. Where CO monitoring is being done, the results are positive, but many responses declared their team does not do CO monitoring. There is potential room for sharing learning from Dorset and Wiltshire to areas where this is not currently in place.

30. If yes...

● Yes ● No ● Unsure

Are HVs doing CO testing at the pre-birth visit?

Are HVs doing CO testing at the primary birth visit?

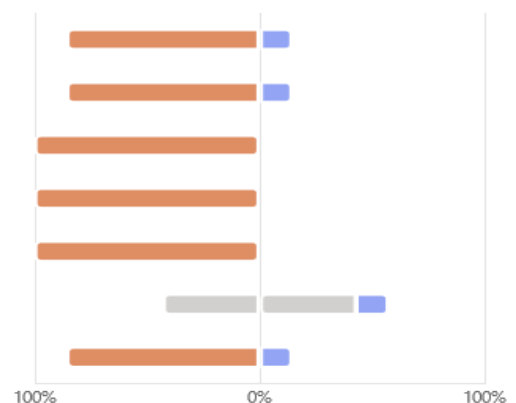
Are the results recorded in the patient notes?

Have HVs received CO screen training?

Have HVs been issued with their own CO monitor?

Are home monitoring CO kits provided to the patient?

Has the service established a CO screening pathway?



In the previous survey, only Dorset were doing CO monitoring, so it is positive this has been expanded into Wiltshire, but there is a significant way to go before this covers the whole of the South West region.

Resources

This section looks at the questions in the guidance relating to Resources. The minimum standards and best practice are listed below:

Minimum Standard

Smoke free home leaflet • Second-hand smoke leaflet • Vaping information • Risks to baby information • Smoking Cessation Services info for partners and others in home • Smoking and pet's info • Social smoking info • CO testing information.

Best Practice

Locally designed smoke free home leaflet • Locally designed smoke free home information pack.

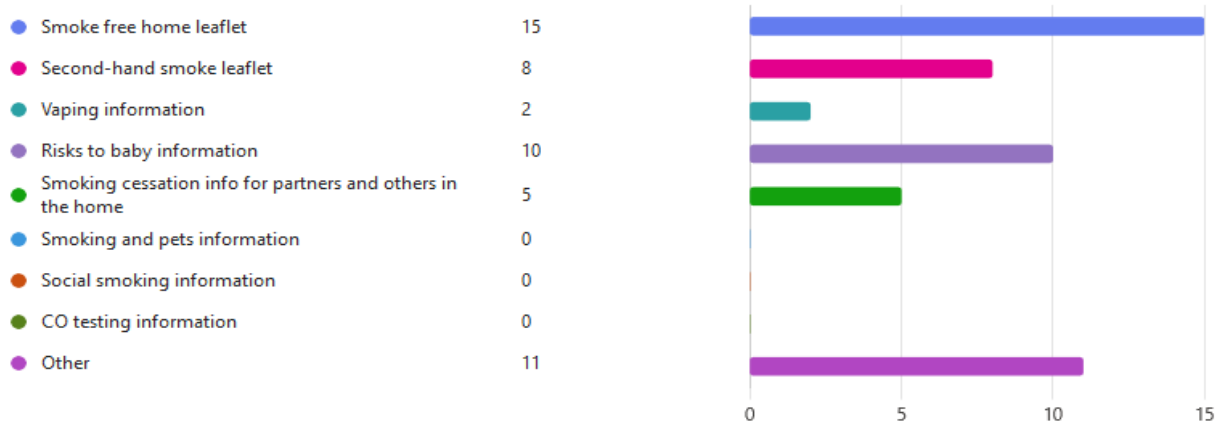
Leaflets in the Minimum Standards

The Minimum Standard sets out a number of leaflets which should be handed out. 14.7% (5 respondents) said they do not hand out any of these leaflets, although two of these said they do signpost to information online. A further 14.7% of responses were blank.

Of those who responded to the leaflets listed (below), 44.1% gave out the smoke free homes leaflet; 29.4% gave out the risk to baby info; and 23.5% handed out the second-hand smoke leaflet.

32.3% said they gave out other leaflets or information, which might be in their local HV information.

33. What leaflets/information does your Health Visiting Team hand out?



It is clear from this information that the Minimum Standards are not being consistently met across the region and many families are not getting written information about smoke free homes. This is an area for improvement.

Locally Designed Information

Best practice says that each should have a locally designed leaflet or information pack.

Currently, only 15% of respondents said they had a leaflet or information pack (responses from BaNES, Torbay and Somerset), whereas over a quarter said they were unsure if one existed locally. 56% are not meeting the best practice guidelines.

34. Does your Health Visiting Team have a locally designed smoke free information leaflet or information pack?



Where there is locally designed information, only one person said this was handed out to every family (Somerset), whilst all three responses from BaNES said that it was not.

Influencing Homes to be Smoke Free

The survey asked how HV teams could better influence homes to be smoke free and 23 people gave free text replies. The responses are below and cover, CO monitoring, training, time and resources, and improved pathways.

Key themes that emerge from responses focus on capacity, training and confidence, time and resources, CO monitoring, better referral pathways, stronger partnership with midwifery services, consistent messaging, and family-tailored, direct approaches.

How do you feel your Health Visiting Team could better influence homes to be smoke free?

Improved data from midwifery and a smoking cessation pathway from the local smoking cessation service.

Have access to equipment that works for longer! Be able to have a PGD to prescribe.

I feel the training they have had, in terms of making every contact count when discussing smoking cessation has been very useful. They would not currently have any capacity to complete carbon monoxide monitoring.

Feel each contact counts and discussing options at each visit

Planning a pilot for carbon monoxide monitoring. This will provide focus on info sharing on smoke free homes. Possibly the development of a leaflet jointly with mat service

The new commissioning arrangements mean that we will be routinely offering CO monitoring.

i feel i could do with an update and ideally spend more time around this with families

Able to deliver stop smoking services directly without a referral to another agency.

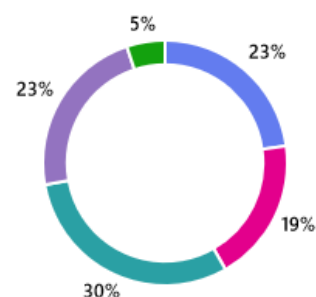
CHOOSE RIGHT TIME TO INFLUENCE

Easier referral process/support. Training
Many ways as outlined in guidance - be trained and deliver VBA and referral, give out information, carry out CO monitoring
For practitioners to be more confident on advice around stopping smoking and also on completing the CO monitoring if mother is actually a non-smoker
This is discussed at every mandated contact and ad hoc.
We are investing resource in a SF HV Champion to train/upskill and encourage the team to have conversations around smoking and vaping, making referrals as needed. This will help HV and associated colleagues take action in supporting families to become smoke free.
We are looking at CO testing as part of the pathway
Consistent messaging and time to have the conversation. Perhaps VBA+
More time to talk about smoking
If we had the capacity then CO monitoring at all five of the mandated contacts would be positive.
I feel that they already give valuable information and have an enormous amount of other information to incorporate in each contact.
We are planning to introduce CO monitoring for mandated contacts
continue to ask at every contact and sign post support
Health Visiting need to be more direct in stating the facts and harms that smoking in the home can cause and not be afraid to raise the issue of smoking.
by making smoking cessation support tailored to the individual needs / at home if needed

This question was followed up by asking HVs what resources they would need to better influence homes to be smoke free. 30% said training would make a difference, closely followed by 23% who said more staffing and more information. 9% said CO monitors would enable them to better influence households.

32. What resources do you feel your Health Visiting Team would need for this?

● Staffing	18
● CO monitors	15
● Training	24
● Information resources	18
● Other	4



These were the themes which came out in the previous survey and were then built into the guidance. These themes continue to be mentioned now, so there may be further work required on additional training and resources, in particular.

Supporting TTD, Maternal Smoking and Smoke Free Homes

21 responses gave free text answers to the question 'Where do you feel your Health Visiting Team can best support Treating Tobacco Dependency, maternal smoking and smoke free homes?' which are shown below.

Again, certain themes come up, including training and using every opportunity/contact to pass on information.

Where do you feel your Health Visiting Team can best support Treating Tobacco Dependency, maternal smoking and smoke free homes?
We are rolling out our smoke free homes offer in April 2025 and undertook a small pilot in 2023. We will focus on antenatal contacts, the new birth visit and 6-8 week contact initially offering co monitoring and referral. Thereafter, we will involve the one and two and a half year checks. We will be involved in the local authority co production of evidence based resources for Torbay families.
Unsure-training would be needed.
By providing information and support
At each contact - home - clinic settings and review appointments
At every contact
information in the PCHR to remind parents of risks and where to seek help. To be discussed at all mandated visits
routine mandated contacts
antenatal contact and new birth, all contacts really
We need a lot more training. I didn't realise how little i knew until doing this survey.
Not always appropriate in our safeguarding team
Giving advice/signposting/referral to stop smoking service
CO testing and continued collaboration with the Smoke free families team
Good quality brief interventions and robust referral to Health Coaches or Smokefree App. Perhaps VBA+
At every opportunity / every appointment
At present through initial discussion and onward referral
They already offer advise re this and there needs to be a designated team rather than add to the role of the HV with regards to this.
Mandated reviews and any opportunistic contacts
during every contact through conversations
signposting to support
By asking all families at every visit and making referrals more.
during monthly team meeting / during HV training

Limitations

This is a small survey taken as a snapshot targeted towards relevant stakeholders. The distribution of the survey was via public health and professional networks. Specific respondents were not targeted or incentivised and there was no sampling strategy employed, as such there will be significant recruitment bias (e.g. commissioners and those close to the development of the guidance). In addition, we have not accounted for non-response bias and those at the front line (typically HVs) who are widely recognised as a set of professionals experiencing challenges with limited capacity. Accessibility of the survey will therefore be a factor.

Benefits

Even though the sample is small the strength of this approach is that responses reflect SW stakeholders views close to the agenda with-in professional practice and highlights key themes that can be improved.

Conclusion and next steps

The evaluation of the South West Guidance for Delivering Smoke Free Homes reveals mixed results in its implementation across the region. While strategic awareness among commissioners and public health specialists is high, front-line awareness among health visitors is notably low.

A key aim of the original guidance was to improve communication between Maternity Services and HV Teams. It is not clear if introduction of the guidance has seen improvement in this area, more needs to be done on supported joint working and improved handover. Other key challenges include insufficient HV capacity, lack of CO monitoring equipment and training, and inadequate funding.

Despite these challenges, the guidance has been somewhat helpful, with strong local networks, clear communication, and existing smoke-free teams aiding its partial embedding. However, improvements are needed in clarity, communication, training, national alignment, and resource availability. The guidance seems to have been particularly useful for strategic/commissioning purposes.

Suggestions for improvement focus on broadening awareness through campaigns, enhancing CO monitoring access, simplifying the guidance, boosting training and champion engagement, improving communication and handover processes, strengthening referral and feedback mechanisms, ensuring consistent resource distribution, and addressing capacity issues.

Next Steps

We will present a discussion paper for the SW ADPH to examine the core issues surrounding HV capacity as well as add support/resources to address practice improvement.

We will embed the guidance into the SW **Tobacco Control and Smoking Cessation Strategic Delivery Framework and Action Plan (2025-2030)** as well as advocate through the regional Tobacco Control Network, Health Visitors Network, and Smoking in Pregnancy forums. We need to broaden awareness of the guidance and promote engagement, specifically with Health Visitors, by providing information and advice about the benefits of the guidance and adoption of the Smoke free homes standards.

Local public health leaders will be encouraged to use the guidance to develop local quality improvement action that supports development of the maternity care pathway. Specifically, communication of handover processes, enhanced CO monitoring access, and engagement to training.

(Consider the nomination of a regional 'HV champion' to lead a workshop/simplify the guidance/source a standard HV NRT protocol).

Appendix 1

What hindered the embedding of the guidance?
Lack of funding
One of the key challenges implementing is not operational delivery or training - it is the ability to set up system reporting - there are currently no snomed codes for father/partner does not smoke and none for CO monitoring other than for 6 week quitters this needs to be set up centrally. We are having to request a local SystmOne Read Code to manage currently. We cannot get any update from any area about how or of they report results and record accurately.
The constant need to have CO monitors calibrated or when they become faulty makes it very difficult to carry out a true assessment.
Continuity between health professionals - handover between different organisation.
Gloucestershire were not in the original implementation of the guidance. The communication between maternity service and HV service is difficult. Capacity is an issue for the HV service
We started a small pilot however staff moved on and it wasn't prioritised.
I tend to just ask if people if they smoke and point them in the direction of self referral to smoke free services
It is heavily aimed at maternity services and health visiting services sometimes feel missed off. It's primarily aimed at pregnant people not other parents. e.g. fathers.
we enter families homes therefore we can only advise
Less home visits .
No opportunity to review outcomes , not received Carbon monoxide monitoring training
Originally lack of capacity in the system meant this was not a priority. However, capacity in the Public Health Nursing service are very stretched, with vacancies across the service hard to fill. They have had to focus on improving delivery of their core service. Some aspects of the recommendations, including the CO monitoring to be delivered at checks, seem to be very unlikely to be initiated. It is a low priority for the PHN service.
Professionals completing CO monitoring when the client has never smoked, professionals find this harder to explain and complete. Also HVs not completing the 10 month check, this is normally completed by a Nursery Nurse
Capacity within local authorities tobacco control teams, capacity from providers, the standards have not come with any resource to help them be implemented, provider contract specifies what HV are required to deliver and we cannot make them do significantly more than this without a contract variation with funding, practicalities around some of the standards i.e. our HV dont like the training, and carbon monoxide monitoring is not considered practical.
There has not been capacity across the system to adopt this approach previously and
Capacity of health visiting and maternity teams
Methods of communication and digital system limitations
Timescale of communication
different IT systems between midwifery and health visiting has resulted in very little progress made with implementing the passport. Existing systems need development time to include a passport template. This has also been hindered by limited staff capacity to complete a detailed passport.
Team capacity
changes to commissioning contracts
The midwifery side is better embedded than the health visiting elements. Staffing capacity within HV service is the barrier to achieving this. Within Devon PHN we receive a lower level of public health grant than many of our neighbours. We also have a lower trajectory of health visiting skill mix per child. This means that as a service we are not achieving all of our universal basic contacts and do not have the capacity in those

contacts we are doing to add additional information in - as all information is focused in one visit.

We do not currently have CO monitoring in B&NES but this is going to be introduced in new contract

We have all recently received very brief smoking cessation advice training and healthy homes training via Well being team

Limited human resources and cessation resources

Health Visiting Leads refuse to consider the introduction of CO monitoring, reasons stating is that HVs don't have time, CO readings doesn't help forge good relationship with mother/family, too much to carry around. This contradicts what the majority of HVs have said when we delivered smokefree homes training to the health visiting team in September 2023 and March 2024.

Health visitors have stated they only ask smoking status at two out of their five visits and do not provide any leaflets to the families - again stating it is too much to carry.

Communication with the Health Visiting team is challenging and does take time to get information fed down to community HV - I believe this to be staffing and time issues which as a local authority we can help.

I am not aware that maternity pass any smoking related information to the health visiting team, if they do then it is not in the form of the passport in the guidance.

Referrals to stop smoking service is low compared with the number of visits HV are undertaking especially in areas known to have high smoking prevalence. HV have stated that when asked many families report to be vaping however local HV data does not support this.

Referrals increased after delivering smokefree homes training to HV team in '23 and '24, we gained positive feedback from those HVs who made the most referrals on how they found the referral process. Positive feedback was gained from issuing a 'top referrer 23/24' certificate to a local HV for their efforts.

The increase in referrals has not been sustained for 24/25 and unfortunately in October '24 the referral pathway changed (due to a change in the record management system used by the Smokefree team) which probably hasn't helped the situation, although an easier referral pathway will be available in Jan '25, and training is planned to refresh the HV team on this.

Smokefree service are unable to find out how many HV have undertaken the NCSCCT training - we have asked but have received nothing back.

Capacity for staff and the high volume of public health messages to share at each contact