A close-up photograph of a pregnant woman's hands holding a lit cigarette. She is wearing a teal-colored top. The cigarette is held between her fingers, and the tip is lit with a small flame. The background is a plain, light color.

smoking in pregnancy
challenge group ●

Review of the Challenge

2018

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Foreword from Smoking in Pregnancy Challenge Group Chairs

When the first Smoking in Pregnancy Challenge Group report was published in 2013 around 8,500 more women were smoking throughout their pregnancy than they are today. In five short years great progress has been made and many services throughout the country should be rightly proud of the quality support they now offer pregnant women in their care to quit smoking.

And yet... the progress is not universal. The lack of ambition and action in some parts of England is holding back the rest. There is now a serious risk that the Government's much welcomed ambition of reducing rates of smoking in pregnancy to less than 6% by 2022 will be missed as rates of smoking in pregnancy have not fallen for the last 12 months.

If the Government's ambition is achieved our new analysis shows in 2022 this would mean that around 30,000 fewer women would be smoking in pregnancy. We estimate that this would mean from:

- » 45 – 73 fewer babies stillborn
- » 11 – 25 fewer neonatal deaths
- » 7 – 11 fewer sudden infant deaths
- » 482 – 796 fewer preterm babies and
- » 1455 – 2407 fewer babies born at a low birth weight.

Avoiding these tragic outcomes will only be possible if rates of smoking in pregnancy come down.

This report should be a wake-up call for national and local government and NHS organisations. NHS England and NHS Improvement nationally need to take responsibility for the differences in how local NHS organisations are implementing NICE guidance on smoking. Local authorities, CCGs and Trusts must work together to ensure pregnant women and their families have the support they need to ensure a smokefree pregnancy. Progress is not inevitable. If you take your foot off the pedal then rates of smoking in pregnancy can and will start to creep up.

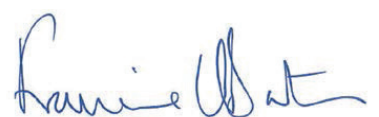
While more needs to be done to implement evidence-based models to reduce rates of smoking for communities with high rates of smoking, we must press forward and continue to find new ways to support women. The Challenge Group would like to see a national incentive scheme to support women in high prevalence communities to quit. The evidence shows that well implemented schemes can double a woman's chance of success.

However, we also need to do more to improve the environments that women are quitting in. Women need the support of their partners in making a quit attempt. Further, Dads who become smokefree during pregnancy are protecting their families from secondhand smoke as well as supporting their partners to successfully quit.

There is much more that needs to be done.



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This report is endorsed by



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- » Tommy's
- » Sands
- » Action on Smoking and Health
- » Tamba

1. Introduction

When a woman smokes during pregnancy or when she is exposed to secondhand smoke, oxygen to the baby is restricted making the babies heart work faster and exposing the baby to harmful toxins. As a result, exposure to smoke in pregnancy is responsible for an increased rate of stillbirths, miscarriages and birth defects. There is a major health inequality in this as women from more deprived backgrounds are more likely to be exposed to smoke during pregnancy.

The [Smoking in Pregnancy Challenge Group](#)¹ was established in 2012 in response to a challenge from the then Public Health Minister. The Minister asked us to deliver recommendations on how the smoking in pregnancy ambition contained in the Government's tobacco strategy could be realised.

The Challenge Group is a partnership between professional bodies, the voluntary sector and academia. It presented its original report and recommendations to the Public Health Minister in June 2013 and continues to meet annually to review progress and report back to the Minister. The Smoking in Pregnancy Challenge Group is jointly chaired by Francine Bates, Chief Executive of The Lullaby Trust, and Professor Linda Bauld of UKCTAS and the University of Stirling.

In light of the publication of the Government's Tobacco Control Plan in July 2017 and the new ambition to reduce smoking in pregnancy rates to less than 6% by 2022, this document reviews the progress towards reducing rates of smoking in pregnancy and sets out recommendations for further progress.

1 For more information on the Smoking and Pregnancy Challenge Group visit: www.smokefreeaction.org.uk/smokefree-nhs/smoking-in-pregnancy-challenge-group/

2. Progress towards the Challenge

2.1 Progress against 2015 Challenge Group recommendations

In 2010 the Government set an ambition of reducing rates of smoking in pregnancy to less than 11% by 2015 as measured by Smoking At Time of Delivery (SATOD). This goal was achieved, and in 2015 the Challenge Group published a report setting out the next priorities for action, including a renewed target to encourage action to bring rates down further (see table below).

Progress against the priority recommendations is assessed below.

2015 Recommendation	Rating	Progress
<i>Priority recommendations</i>		
1. A new national ambition to reduce smoking in pregnancy to less than 6% by 2020.	Green	The Government has published a new Tobacco Control Plan with an ambition to reduce rates of smoking to 6% in 2022. In light of the changes in how SATOD is calculated, this seems sufficiently ambitious.
2. National leadership to provide clarity about the roles local authorities and local NHS organisations should play in tackling smoking in pregnancy.	Amber	There have been a number of national initiatives to improve local practice since 2015 including: <ul style="list-style-type: none"> • The roll out of the Stillbirth Care Bundle • Activity through the Maternity Transformation Programme • Commitments in the Tobacco Control Plan
	Green	However, there remain gaps in practice on the ground and unwarranted variation between CCGs.
3. A robust and consistent national data collection system implemented across the country	Amber	The definition of SATOD has changed and is now calculated excluding those whose status is not known. There is evidence of an improving trend in data collection of SATOD nationally. There is improved completion of the Maternity Services Data Set and indications that this will be a valuable source of data in the future. Data captured includes smoking status at Booking and will allow for better understanding of demographic characteristics. There is a commitment in the Tobacco Control Plan to include CO screening in the Maternity Services Data Set. If this is implemented and mandated the quality of national data collection should be improved.
4. Training of professionals to tackle smoking in pregnancy must be nationally mandated.	Amber	The ASH/Challenge Group review of the training environment for midwives and obstetricians identified the lack of mechanisms through which training can be nationally mandated. The Challenge Group remains concerned about the inconsistency this leads to locally and are working with PHE and NHSE to maximise the level of training in Trusts. Although there is welcome activity via the Maternity Safety Strategy to support training at a local level and the planned development of resources to support Mandatory Midwifery Training. There are free options available for training front line staff via National Centre for Smoking Cessation and Training (NCSCT) and the Royal College of Midwives with modules planned to be added to the e-Learning for Healthcare platform.

<p>5. Opt-out referral² of all pregnant women who smoke to specialist services must become standard practice across the country.</p>	<p>Amber</p>	<p>There are examples of good practice particularly in the North East where research has shown the extent to which full implementation of NICE guidance alongside opt-out referral can improve outcomes.</p> <p>This is a core part of the Still Birth Care Bundle, part of the PHE menu of preventative interventions and recommended in the CLear Tobacco deep dive on pregnancy. However, this is still not being consistently implemented around the country.</p>
<p>6. Public Health England and NHS England should publish a shared national communications strategy on tackling smoking among pregnant women and their families</p>	<p>Amber</p>	<p>The quarterly communications meeting of the Smoking in Pregnancy Challenge Group provides a forum for shared approaches around communications for all stakeholders.</p> <p>There is a commitment in the Tobacco Control Plan to produce a shared action plan around smoking in pregnancy for PHE and NHSE.</p>
<p>7. Research funders should continue to support high quality studies to help inform policy and practice on the best ways to help women to stop smoking in pregnancy.</p>	<p>Green</p>	<p>Useful research continues to be funded by charities, government and research councils and there are a number of new studies currently underway.</p> <p>More detail is provided in section 5 of this report</p>

Overall, there has been steady progress towards embedding the changes needed to support all women to be smokefree throughout pregnancy. The detailed recommendations for the 2015 report are reviewed in Appendix A – there is progress against a number of these recommendations and the Challenge Group is committed to driving forward those where more still needs to be done.

2.2 Challenge Group activity

Since 2015 the Challenge Group has continued to work to support organisational change and provide front line staff with tools and advice to support their practice.

The Challenge Group has taken particular leadership around e-cigarettes where there is a gap in national advice and information in relation to pregnant women. The Challenge Group have produced a guide for Midwives, an infographic for pregnant women and delivered an online webinar to support health professionals to engage with the evidence.

In 2017 the Challenge Group published a [review](#) undertaken by ASH of the training needs of midwives and obstetricians. Launched in Parliament with the Public Health Minister this report has gone on to influence activity within the Maternity Safety Strategy, development of curricula and guidelines. Resources to support training of front line staff have been produced in collaboration with PHE and the Challenge Group will continue to work to implement its recommendations.

The first set of resources the Challenge Group produced were handouts for midwives to provide to women carrying out CO Screening and a guide for midwives about CO Screening. These resources are very popular, with hundreds of thousands being distributed via maternity units. These have been updated and, with the help of councils in London, translated into nine different languages.

In December 2017 the Challenge Group held a national conference to review progress in reducing rates of smoking. Insights from that event have informed the recommendations in this report. Details of the conference are available on the Challenge Group web page.

For more information about the work of the Challenge Group and the resources available to support local practice see: www.smokefreeaction.org.uk/smokefree-nhs/smoking-in-pregnancy-challenge-group/

² Opt-out referrals mean patients are automatically referred onwards unless they say no

2.3 Government action to address smoking in pregnancy

The most significant development since 2015 has been the publication of the Tobacco Control Plan in July 2017 with renewed ambitions and a focus on reducing rates of smoking in pregnancy. The Challenge Group was pleased to see smoking in pregnancy featured prominently in the Plan and a new ambition to reduce rates to 6% or less by 2022. The Plan further commits Government to a number of specific actions including commitments to embed CO Screening in Maternity Services Data Set and to take further action via the Maternity Transformation Programme.

The Prevention strand of the Maternity Transformation Programme has since become a hub for national action on smoking in pregnancy. It brings together NHS England, NHS Digital, NHS Improvement, Public Health England and other parts of Government in a shared approach to tackling smoking in pregnancy. There have been a number of developments through this programme of work and through the national Maternity Safety Strategy which has seen particular emphasis on the training needs of the workforce in line with 2017 ASH/Challenge Group report.

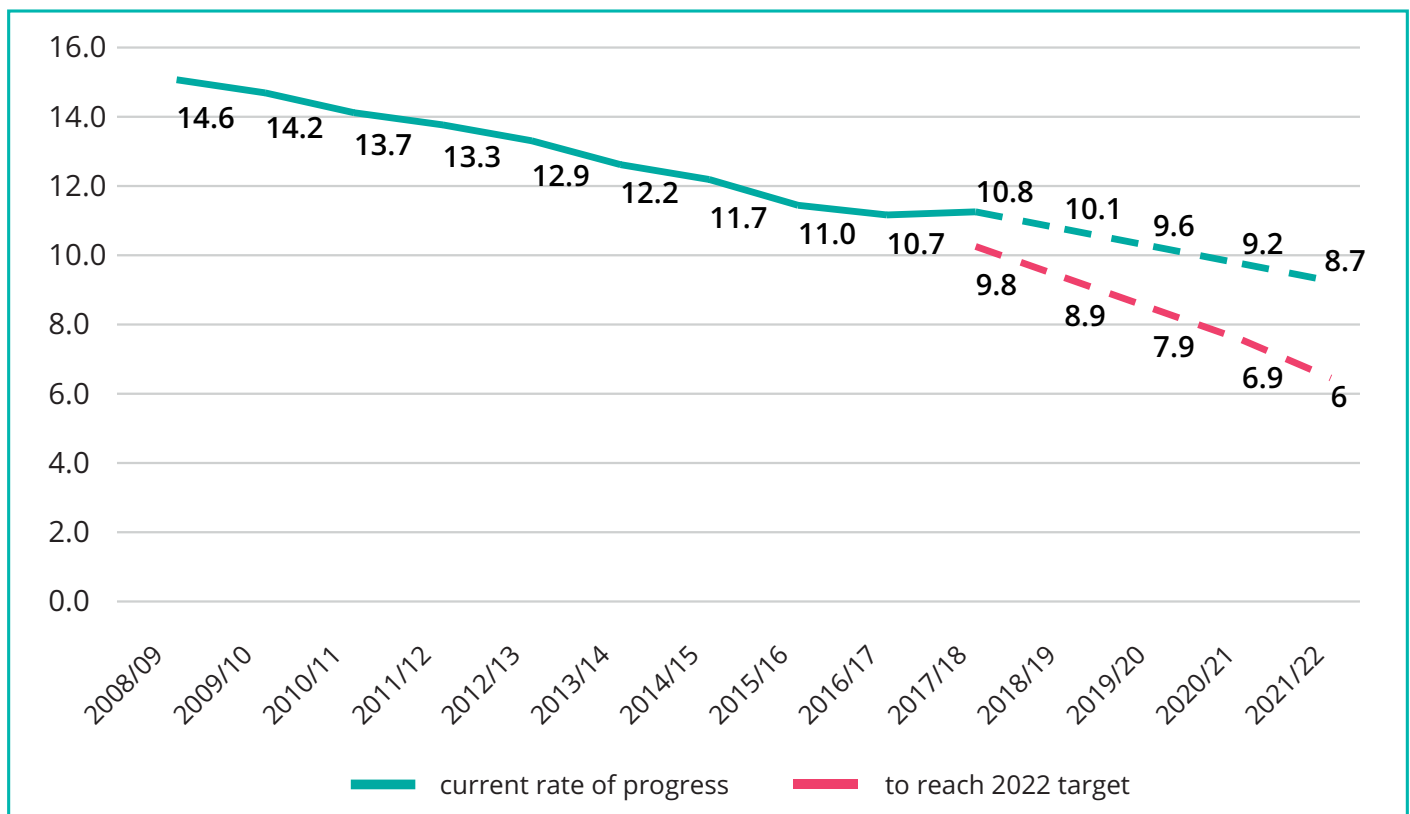
3. Meeting the Challenge

3.1 The new ambition

While the Challenge Group has welcomed the Government's continued commitment to reducing smoking in pregnancy there are concerns that the national action is not managing to sufficiently impact on local practice and secure the consistency needed to meet the Government's ambition. Progress in reducing the rate of smoking in pregnancy has stalled with the current rate being just under 11%. This rate has been recorded for the last four quarters (Q4 2016/17, Q1, Q2, Q3 2017/18).

On the current trajectory, the Government's ambition will not be achieved. The average rate of decline in smoking rates among pregnant women in recent years has been approximately 0.5 percentage points each year. To reach 6% by 2022 this progress will need to nearly double to 0.9 percentage points (Figure 1).

Figure 1: Progress needed to achieve 2022 ambition



3.2 Benefits of achieving the ambition

Achieving the ambition will have a major impact on wider Government objectives beyond the Tobacco Control Plan. By 2022 it will result in around 30,000 fewer women smoking during pregnancy. More importantly it will lead to a drop in the numbers of families who experience harmful impacts of smoking in pregnancy. Table 1 shows the number of adverse birth outcomes our analysis predicts will be avoided annually if the Government ambition is achieved.

Table 1: Estimated impact of reducing rates of smoking to 6% by 2022³

Poor birth outcome	Estimated numbers reduced
Stillbirth	45 – 73
Neonatal deaths	11 – 25
Preterm births	482- 766
Low birth weight	1455 – 2407
Sudden Infant Death	7 – 11

These ranges are estimates of the impact of achieving the Government ambition based on the best available data. They do not include the impact on reducing the number of women who smoke in their pregnancy but quit before birth nor do they account for any decline in women’s exposure to secondhand smoke.

This is also only a snapshot of the potential gains for pregnant women and their families. Achieving the ambition will also mean reductions in miscarriages, birth defects and improvements in the longer-term health of children who would otherwise be born to smokers.

The analysis also looks beyond the life of the Tobacco Control Plan to what the impact might be of this potential rate of decline after 2022. If the Government were to achieve the stated ambition of 6% by 2022 and maintained this progress then rates of smoking in pregnancy would be below 4% by 2025 with around 23,000 women smoking throughout their pregnancy compared with over 68,600 today. The analysis estimates that in 2025 between 73 and 114 stillbirths will be avoided and between 18 and 39 neonatal deaths. This would contribute to the Government’s goal to halve the rate of stillbirth and neonatal deaths by 2025.

However, if the current stagnation in rates of smoking persists then these tragic outcomes will not be avoided, to the detriment of thousands of families.



Melanie’s story

Melanie Snowdon, 40, from South Shields, welcomed her fifth child, Faith, to the world in March. When she found out she was expecting she sought support from her local stop smoking service to quit tobacco for the good of her unborn child. She’s continued to be smoke free following the birth and is confident that she’ll remain that way in the future.

She said: “I was about 17 when I started smoking. In those days everybody smoked, we knew it was bad but you don’t think about that when you’re a teenager. On average I smoked about 20 - 30 a day and it wasn’t until I was pregnant with my fifth child that I stopped.

“I smoked through my first four pregnancies and there were no issues, I had four healthy babies. There was a big gap in between my first four and my youngest.

“Not long after I married my husband, we fell pregnant again. I decided that I needed to quit smoking as my husband doesn’t smoke and doesn’t like it.

“The thing that really hit home for me was when the midwife at hospital showed me how much carbon monoxide was in my breath and explained how smoking starves the baby of oxygen.

“I was referred to my local stop smoking service and, at first, I was very sceptical. I used patches, sprays and an ecig for a little bit too and I managed to come off the cigarettes completely after seven weeks.

“I couldn’t quite believe the difference in weight, my daughter was 9lbs 12oz whereas all my other children were much lighter. I never believed that smokers had smaller babies.

³ These estimates are based on an analysis undertaken by The Lullaby Trust on behalf of the Smoking in Pregnancy Challenge Group for the full methodology see www.smokefreeaction.org.uk/smokefree-nhs/smoking-in-pregnancy-challenge-group/

"I wasn't sure how I would do after my daughter was born but I'm still off the cigarettes and I can't see myself going back. I still carry a spray in my bag just in case but the thought and the smell of smoking really puts me off.

"My husband has said he is really proud of me because he thought once the baby was born I would have started again.

"I would encourage other mums to give it a try - it doesn't cost anything. I smoked for so many years and would never have thought I would be able to stop but I did."

CASE
STUDY

Martin and Heather's story

Martin started smoking at 14. He'd grown up in a smoking home with a Mum who smoked, so starting smoking in his early teens seemed normal.

When he met Heather she had quit smoking but it wasn't long before she started again tempted back by always being in the company of a smoker.

But at the beginning of 2018 everything changed. Martin and Heather found out they were going to have a baby. As a smoker Heather was referred to the local stop smoking service by her midwife. The service arranged to visit Heather at her home.

It was at this home visit that Martin too became involved with the stop smoking service.

"I always intended to quit to support Heather but it wasn't until I met the advisor that I realised there was a service out there that could help me."

Martin agreed to face to face meetings with the advisor and was prescribed a nicotine inhalator to help with cravings.

Martin was strongly motivated to quit to protect his new baby: "I wanted to make sure that my child had a safe and healthy environment to grow up in where they wouldn't be around smoke or the risk of a fire. Plus it meant we could save money to spend on the baby"

But he also wanted to be there for Heather: "I knew if I quit it would help Heather too."

Heather agrees: "I needed his support to stop more than anything. His strength gave me strength."

Martin has advice for other Dad's in his position: "You have to support the mother of your child, it's just as hard for them but they have to think of the baby. It's your job to protect them both."

Their baby is due in September.

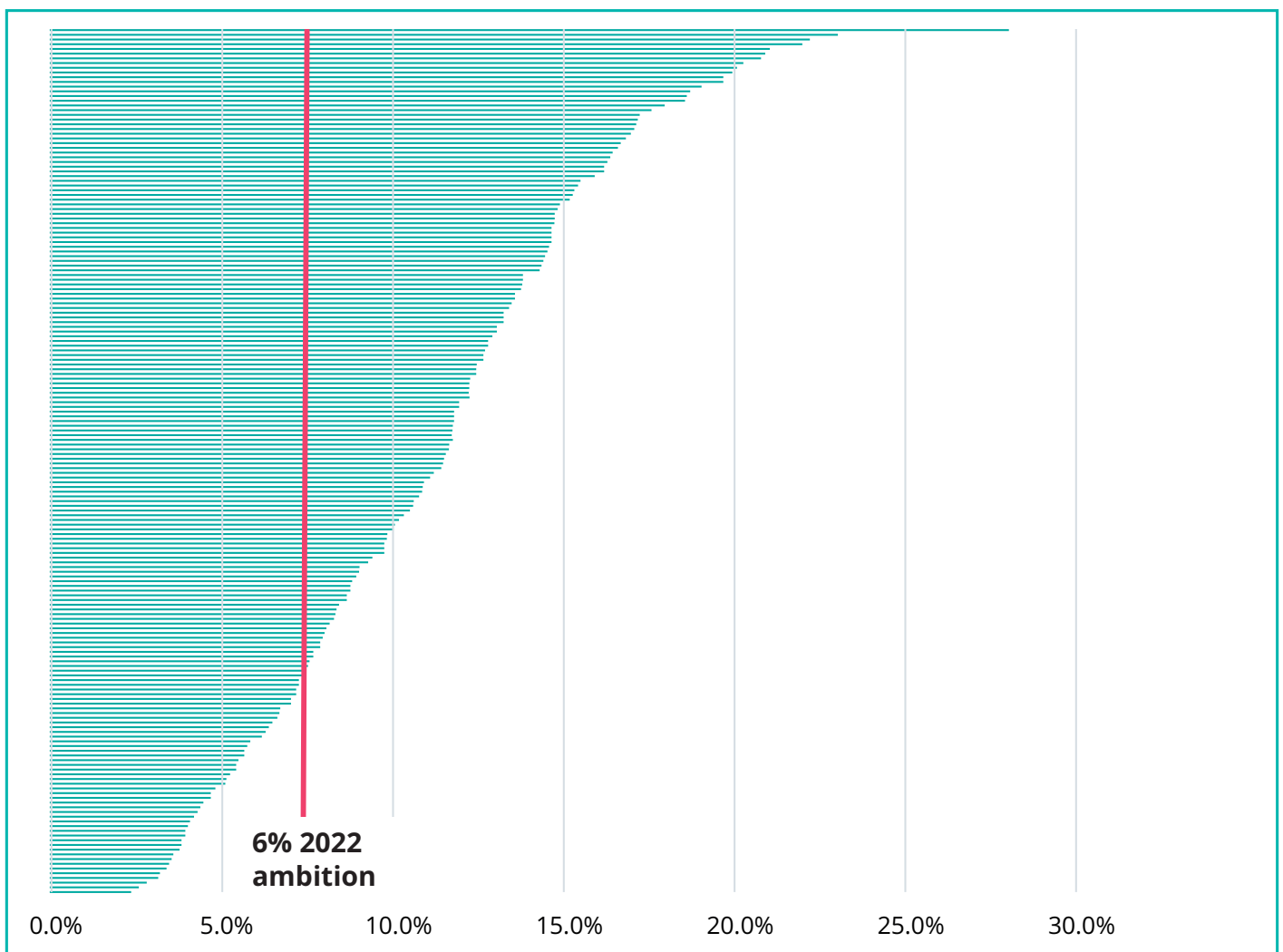
4. Rising to the Challenge

4.1 Local variation in progress

Ensuring consistency in the support women receive across the country and intensifying that response for women experiencing high levels of disadvantage and multiple barriers to quitting remain key challenges.

There is significant variation in the rates of smoking in pregnancy in different parts of England (see Figure 2). This variation is linked to levels of deprivation and variation in overall rates of smoking. Areas with high levels of disadvantage and high rates of smoking have correspondingly high rates of smoking in pregnancy.

Figure 2: Variation in 2016/17 rate of SATOD by CCG



However, high rates of smoking in pregnancy in a locality are not necessarily an indication of poor local performance. Some areas where rates of smoking in pregnancy continue to be high compared to the average have achieved reductions. But progress in reducing local rates is variable. Between 2014/15 and 2016/17 rates declined by 0.9% or more in 73 CCGs. However, in 45 CCGs the rate of SATOD either did not decline or increased over the same period. Continued variation in progress between areas will undermine the likelihood of achieving less than 6% by 2022.

There are likely to be many contributory factors to the range in progress across local areas, including demographic changes. Local and national government and NHS organisations need to take note of:

- » The continued variation in how NICE guidance is implemented locally,
- » The extent to which local NHS organisations are embedding support for pregnant women who smoke and,
- » The availability of local authority funded stop smoking support.

NICE guidance on smoking in pregnancy has been in place since 2010. While a number of national initiatives have supported implementation of NICE guidance, in particular the roll out of Saving Babies Lives Care Bundle, there remains inconsistency. The Tobacco Control Plan calls for: *“All CCGs, Trusts and local councils fully implementing NICE Guidance including Smoking: stopping in pregnancy and after childbirth (PH26) which recommends that all pregnant women are CO screened and those with elevated levels referred via an opt-out system for specialist support.”* It further commits Government to work nationally through the Maternity Transformation Programme to sustainably achieve smokefree pregnancies. This work must continue locally and nationally.

Compounding the problems in implementing NICE guidance consistently is the increasing postcode lottery in the availability of local stop smoking services. ASH research shows that just under 40% of local authorities no longer have specialist stop smoking services available to all smokers to help them quit. According to the data published by NHS Digital 40% fewer pregnant women set a quit date with specialist stop smoking services in 2016/17 compared to 2011/12. In 2011/12 specialist stop smoking services supported over 11,500 to quit. By contrast last year they supported just under 7,000 to quit.

A number of areas that have closed their specialist stop smoking services to most smokers have maintained provision for women who are pregnant. While it is important that women have access to support during pregnancy both women and members of their household would benefit from support before and after pregnancy to enable families to be smokefree and further protect children. Those local authorities that are facing tough financial decisions should consider how they can best support families to be smokefree not only pregnant women.

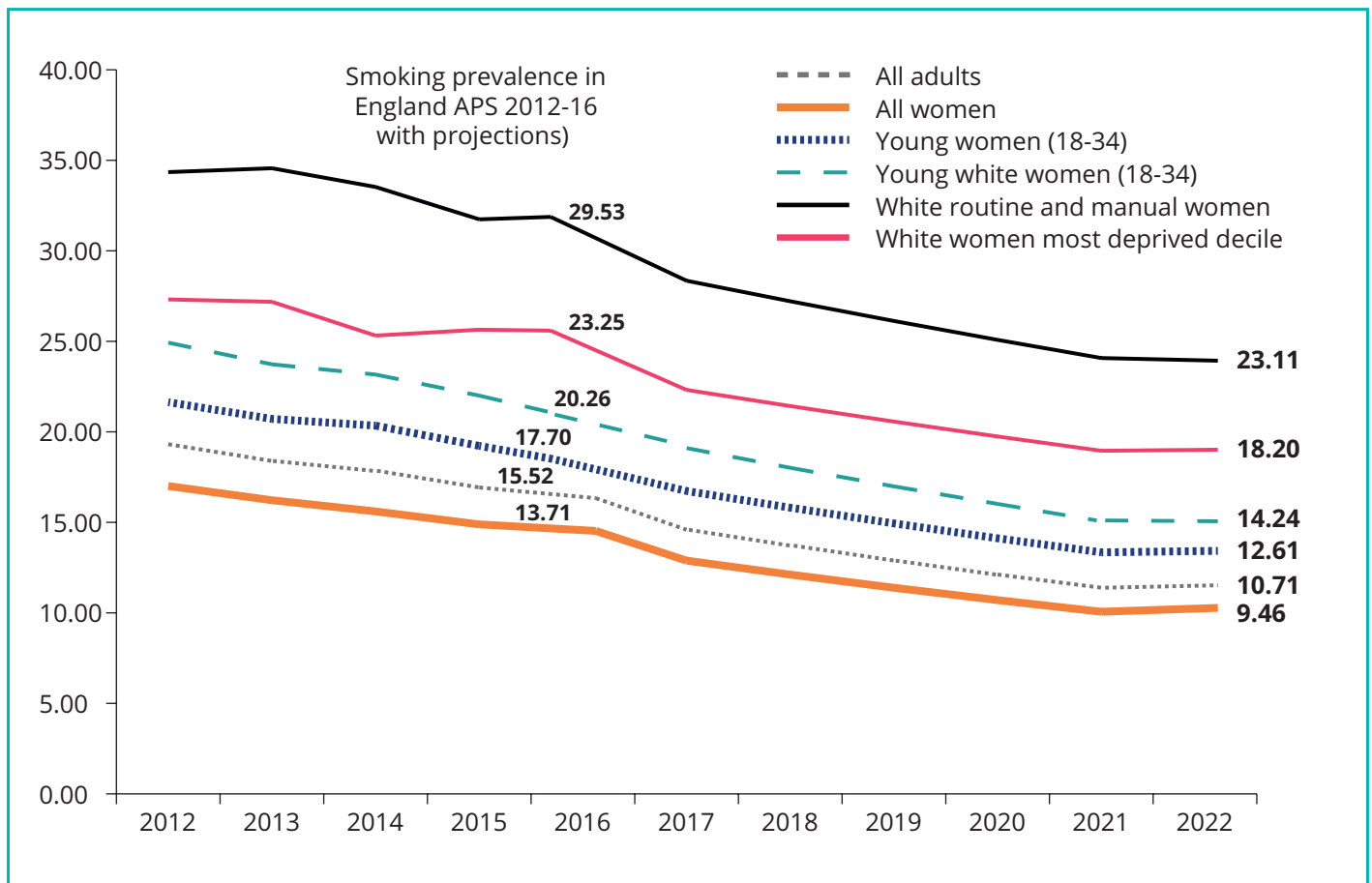
Recommendations: Address variation in local implementation of NICE guidance

- » Public Health England and NHS England should review the implementation of NICE guidance across the country and assess the barriers and enablers to full implementation.
- » NHS Improvement and NHS England should work to reduce the variation in performance between CCGs and ensure there is a joined up national plan in line with recommendations in the Government’s Tobacco Control Plan.
- » Public Health England should work with local authorities to ensure that local strategies reduce rates of smoking among the most disadvantaged and that families who need to can access stop smoking support before, during and after pregnancy.
- » Public Health England and NHS England should support local leadership to tackle smoking in pregnancy through Local Maternity Systems and the promotion of Smokefree Pregnancy Champions in every local area.
- » Local authorities, CCGs and Trusts should explore ways to work collaboratively across LMS footprint to realise economies of scales in implementing NICE guidance on smoking in pregnancy.

4.2 Tackling smoking in high prevalence communities

Rates of smoking in pregnancy have a strong social and age gradient with poorer and younger women much more likely to smoke in pregnancy. This is reflected in the rates of women smoking in these groups overall.

Figure 3: Smoking prevalence in England among women



Source: Data and analysis provided courtesy of Public Health England

Rates of smoking in white women in routine and manual occupations are currently more than double that of women on average. This inequality for all women is reflected in pregnant women. If overall tobacco control strategies are not successful in reducing rates of smoking among women of child bearing age, particularly in low income groups, then maternity and stop smoking services will face an uphill battle in supporting pregnant women. Overall efforts to reduce smoking for the whole population are therefore highly relevant to achieving the goals of reducing smoking in pregnancy rates.

However, there is more that could be done to support women and their families to address smoking before, during and after pregnancy. The focus of most work to reduce rates of smoking in pregnancy has been only on the women who smoke, not on the environments in which they live. For many women struggling to quit throughout pregnancy the home environment and the communities they live in will play a crucial role in whether they are smoking at conception, if they are able to successfully quit, whether they relapse to smoking once the baby is born and if they and the baby are exposed to secondhand smoke.

Women who live with a smoker are 6 times more likely to smoke throughout pregnancy and those who live with a smoker and manage to quit are more likely to relapse to smoking once the baby is born. An estimated 20% women are also exposed to secondhand smoke in the home throughout their pregnancy, leading to many of the same adverse birth outcomes experienced by women who smoke.

Table 2: Impact of smoking and exposure to secondhand smoke in pregnancy

	Maternal smoking	Secondhand smoke exposure
Low birth weight	Average 250g lighter	Average 30-40g lighter
Stillbirth	Double the likelihood	Increased risk
Miscarriage	24%-32% more likely	Possible increase
Preterm birth	27% more likely	Increased risk
Heart defects	50% more likely	Increased risk
Sudden Infant Death	3 times more likely	45% more likely

Source: Passive Smoking and Children, Royal College of Physicians and Royal College of Paediatrics and Child Health, 2010

The community context is also very important. Living in a community where rates of smoking are high makes it less likely women will successfully quit. While one reason for this is likely to be that these women are more highly addicted to smoking, the cultural norms are also an important factor. Communities where smoking rather than quitting is the norm are likely to be less supportive of women who are trying to quit.

There is, therefore, a missed opportunity for services to intervene to support families and communities to become smokefree as part of addressing rates of smoking in pregnancy. Reaching into households and communities requires a new way of working with different kinds of professionals. There are many professionals who have regular contact with families and prospective parents who could play an important role in highlighting the need to quit smoking, the benefits to children and sign-post mothers, fathers and other household members to quit support. Such groups include: health visitors, sonographers, paediatricians and professionals within children's services.



Relapse prevention pilot in Sheffield

Sheffield implemented a pilot programme of smoking cessation support which integrated the role of health visitors to encourage post-partum follow-up and relapse prevention.

Pregnant women's smoking status was ascertained at booking with referral of all smokers to the stop smoking service. At all subsequent antenatal appointments women were offered CO monitoring with appropriate advice to quit and monitoring of quit readiness. This was combined with training for health visitors in using CO monitors and identification of health visitor champions to provide ongoing support to women who quit during pregnancy. Information was shared between the midwifery service and champions on their caseload's smoking status.

Health visitor champions undertook an antenatal visit for women still smokefree at 30-34 weeks and followed up at their birth visit offering ongoing support up to 6-8 weeks after birth. Health visitors also referred fathers/partners to Yorkshire Stop Smoking Service if they wanted to quit.

Out of the pilot cohort, 111 pregnant women achieved a 4 week quit with the specialist midwifery stop smoking service, and 49% remained smokefree at 12 weeks following their quit date.

The integration of health visitors led to 54 women (49%) accepting a referral from the midwifery service for postnatal smoking cessation relapse support with the health visitors. Among these women, 47 new birth visits were completed with 67% of women still smokefree, by 6-8 weeks post-partum 34 visits were completed with 25 women still smokefree.

Learning from the pilot is now being integrated into maternity stop smoking and health visitor services, including all health visitor and 0-19 frontline teams trained in very brief advice.

More targeted and intensive approaches for women from high prevalence communities have also been shown to contribute to reducing rates of smoking. Incentive schemes that provide vouchers to women to support their continued engagement with quit programmes can make a big difference in communities where smoking is common and can have wider impact on the households' women live in.

There is now strong evidence that appropriately structured schemes can more than double the chances of a woman successfully quitting in pregnancy. However, few areas have opted to embed incentive schemes within their overall cessation programme. One of the reasons for this is the perceived hostility of the public to such approaches. A survey conducted by YouGov for ASH found that public support for incentive schemes increases when people have more information about the effectiveness of schemes. When provided with no further information, only 33% of the public support incentive schemes to help pregnant women quit smoking and 37% oppose. However, when told that there is peer reviewed evidence that it can improve the chances of a woman quitting, public support rises to 44%, with 27% opposing.

CASE
STUDY

Embedding an incentives scheme across Greater Manchester

Greater Manchester have established an ambitious comprehensive making smoking history programme with a strong focus on reducing rates of smoking in pregnancy. GM currently has higher rates of smoking in pregnancy than the national average but aim to reduce this to below the national ambition by 2021. While their broad tobacco control strategy will contribute to this decline they have a specific programme of activity for pregnant women. Alongside a programme of work to fully implement NICE guidance across GM they have also introduced an evidence-based incentive scheme to further support women to achieve smokefree pregnancies and sustain smokefree childhoods.

The smokefree pregnancy incentive scheme targets a defined group of vulnerable women (including teenage pregnancy, living in areas of high deprivation, living in areas of high smoking rates, smoked at point of delivery in last pregnancy) living in communities where smoking rates are highest, and who would find it hardest to maintain a quit without additional support.

The decision to adopt an incentive scheme across GM targeted at those women who need the highest level of support is intended to accelerate the rate of change across GM and support improved abstinence postpartum.

The GM programme combining the full implementation of NICE guidance with an incentive scheme is unique in the UK and will be fully evaluated by experts from Stirling University with final results expected in 2021 with interim finding available later in 2019

Recommendations: Action where smoking in pregnancy rates are high

- » National and local government and NHS organisations should seek to better engage a wider group of health and care professionals in reducing rates of smoking in pregnancy, and to engage whole household not only pregnant women. Approaches should include:
 - ~ Improve training to better engage with families who smoke
 - ~ Supporting pilots to gain a better understanding of how a wider group of professionals, in particular health visitors, can motivate more parents who smoke to quit
 - ~ Engaging commissioners in efforts to explore how professionals can be best supported to deliver brief advice within existing contracts
 - ~ Producing materials to support professionals in their engagement with families.
 - ~ Supporting pilot activity to better understand how peer support models could help more young mothers to quit
- » The Government should introduce a national incentive scheme to support pregnant women to quit, learning from the best evidence on how to achieve success. Until a scheme can be put in place, they should proactively encourage local areas to introduce their own schemes in line with the evidence base.

4.3 Continuous improvement on data collection

The appropriate collection of data is a vital tool for ensuring that cessation services are appropriate and effective. Since 2013, much progress has been made nationally and locally on collecting data. Further commitments set out in the Tobacco Control Plan were very welcome. But there remain areas where progress is necessary.

The Tobacco Control Plan commitments that: *“NHS England will include the recording of the outcome of Carbon Monoxide screening within the Maternity Services Dataset, which is the standard record of maternity care to accurately measure actual smoking behaviour beyond self-reporting bias.”* This is being taken forward and along with the data captured of smoking status at booking, is a major opportunity that will greatly enrich our current understanding of women who are smoking during pregnancy and the support that they might need. The recent experimental data reported on smoking from this data set had returns from the vast majority of trusts but only had smoking status recorded for 54% of pregnancies. If this is to be a meaningful source of data then there must be a high level of local completion and national reporting. The Challenge Group looks forward to this happening in the near future.

SATOD provides no demographic data about women. Since 2010 (when the last Infant Feeding survey was conducted, a survey that contained detailed questions on smoking) there have been no national robust measures of demographics of women who smoke in pregnancy. Given the sharp social and age gradients in smoking rates among pregnant women, policy and practice would benefit from having more insights into the demographics. It is hoped the Maternity Services Dataset will be able to provide these insights in the future.

While the Challenge Group welcomes improved data via the Maternity Services Dataset we continue to have concerns about the collection and reporting of data at time of delivery. Collecting data only at this time is imperfect. It can be a poor time to ask about smoking, particularly where there have been complications during the birth. We recommend looking at options to screen women at around 36 weeks. This would provide an additional opportunity to connect women with stop smoking support and provide accurate information about possible increased risks during and directly after labour, such as wound healing. The Challenge Group is aware that in some areas local practice is moving towards screening at 36 weeks, and therefore national data requirements can follow this developing local practice.

CASE STUDY

Wakefield's approach to using data

This case study illustrates how improvements in data coordination can translate into improvements in outcomes for women.

In aiming to reduce smoking rates among pregnant women an opt-out referral system was introduced for the local maternity service to refer to the stop smoking service, Smokefree Yorkshire Wakefield. However, uptake of support from Smokefree Yorkshire Wakefield remained low with many women dropping out. Data on these women were being recorded but held separately by the different services and was not joined together.

To understand why so few women were coming through to receive support from the stop smoking service an integrated client toolkit was introduced combining anonymised data from different services. This included records of smoking status at booking, client contacts, outcomes with Yorkshire Smokefree Wakefield and smoking status at the time of delivery. This enabled practitioners to look at the whole system and analyse outcomes.

The integrated toolkit highlighted a problem with the recording of opt-outs and referrals on the maternity system which has since been corrected. Further issues with client contacts and dropout rates were identified leading to changes in the way midwives discuss stop smoking support with pregnant women.

The impact of these changes has been:

- ~ referrals of pregnant smokers have increased from 45% to 58%,
- ~ the number of women opting-out of a referral at booking has decreased from 45% to 30%,
- ~ the number of women setting a quit date has increased from 34% to 46%.

Recommendations: Improve the quality of data monitoring locally and nationally

- » NHS Digital and Public Health England should work together to ensure the smoking parts of the Maternity Services Dataset are completed by all Trusts. This includes; the NICE recommendation to screen at booking and that every opportunity is taken to develop policy based on insights generated by the dataset.
- » The Challenge Group continues to believe that the Government should move towards 36 weeks as the measure for smoking in pregnancy. Moves should be made to establish this as part of the Maternity Transformation Programme.

4.4 Use of nicotine in pregnancy

For all smokers, quit success is more likely if they are supported to consistently access enough nicotine to help manage their cravings when trying to stop smoking. Studies into support for pregnant women routinely find that they are reluctant to use Nicotine Replacement Therapy during pregnancy and for women who are nicotine dependent, this could undermine their quit attempt. One of the reasons for low levels of use is concern among both pregnant women and professionals that use of nicotine could be risky for the development of the baby. However, UK evidence to date does not support these concerns.

E-cigarettes have emerged as a popular choice for smokers trying to quit but there are indications that e-cigarette use is lower among pregnant smokers trying to quit than smokers making a quit attempt in general. Again, this is due to concern and uncertainty about their safety among pregnant women and professionals. There is currently little evidence on the safety or efficacy of using e-cigarettes in pregnancy for smoking cessation. However, given how damaging smoking is to both the mother and baby, completing switching to e-cigarettes may have benefits for women struggling to stop smoking.

CASE STUDY

Using e-cigarettes as part of quit support in Leicester

The Stop Smoking Service in Leicester were seeking new ways to further bring down rates of smoking among pregnant women. Around 27% of women are smoking when they come to their first booking appointment in Leicester and through full implementation of NICE guidance on smoking in pregnancy locally they have been successful in bringing the rate of smoking at time of delivery down to around 11%. In this context they were keen to find innovative ways to bring their rates down further and have started to proactively offer women the option to use an e-cigarette in their quit attempt. As part of this approach all midwives are trained to understand what e-cigarettes are, the risks and benefits of using one, and the key messages they should be providing to pregnant women around e-cigarettes

To date the numbers of women choosing to use an e-cigarette with the service are small. In 2016/17 85 out of 228 pregnant service users used an e-cigarette, with or without NRT with a success rate of 60%. This compares with a success rate of 32% for NRT alone (139 women out of 228 used NRT only). This is not proof that e-cigarettes are more effective than NRT in helping pregnant women to quit but it does illustrate, from local service data only, that they can be effective aids when combined with behavioural support.

The service has gathered some of the views of pregnant women in their service regarding e-cigarettes:

"I know it's not without risks, but it's got to be safer than smoking when you look at the chemicals in each" (quitter – initially NRT, then e-cig only)

"It gives me the freedom to smoke, without actually smoking" (quitter, e-cig only)

"It helps me to manage social situations where everyone else is smoking" (quitter, dual user)

"The patches help, but I've only ever had slip ups when I've not had my e-cigarette – I can cope if I forget to put my patch on but not if I forget my e-cigarette" (quitter, dual user)

"I decided not to use one because I felt like I would be replacing one habit with another" (quitter, no medication used)

The service is continuing to work with pregnant women and support them to use e-cigarettes where this is their choice and will continue to monitor and evaluate their approach.

Recommendations: Maximise the use of nicotine as a quitting aid

- » Department of Health should develop a sophisticated communications strategy to ensure both health care professionals and women have a better understanding of the potentially positive role of nicotine containing products, such as NRT and e-cigarettes, in a quit attempt.
- » Commissioners need to ensure services are providing pregnant smokers with the right levels of NRT and supporting their choice to use e-cigarettes if that is their preferred way to quit.
- » Health Education England should work to improve training and understanding of the role of nicotine (separate from tobacco) is needed for key professionals including obstetricians, midwives, primary care professionals and health visitors.

4.5 Training needs

In 2017 Action on Smoking and Health on behalf of the Challenge Group published a review of midwifery and obstetrics training. This found major gaps in the post graduate and under graduate training of professionals which reduces their ability to appropriately support women to stop smoking in pregnancy. The review found a higher level of training and understanding among midwives, however, both midwives and obstetricians generally lack the training to engage women in meaningful conversations about their smoking and motivate them to access quit support. In addition to training gaps in these skills there are also gaps in understanding around the use of nicotine and in the practical delivery of CO screening.

The report also noted that there are other professional groups that are important to smokefree pregnancies and where a further assessment of training would be appropriate, in particular health visitors. The Challenge Group welcomes the currently commissioned work by PHE to assess and address this gap for health visitors.

Recommendations: Increase the proportion of maternity workforce trained to address smoking in pregnancy

- » The Maternity Transformation Programme should continue to work with the Smoking in Pregnancy Challenge Group to implement the recommendations made in the 2017 report 'Smokfree Skills', in particular:
 - ~ Address training gaps around the development of skills to support pregnant women who smoke not only the knowledge of harms
 - ~ Development of short training resources to support local delivery of training
 - ~ Embedding training at undergraduate level on both the knowledge and skills needed to address smoking in pregnancy
- » Public Health England, NHS England and Health Education England should review the content of mandatory midwifery training in relation to smoking and develop a plan to address gaps.

5. Further building the research agenda

Research gap (potential methodology)	Ongoing research to help fill gap (funder; PI & affiliation)
<p>1. E-cigarettes</p> <ul style="list-style-type: none"> a. Estimating prevalence of use (survey) b. Understanding barriers and facilitators of use (survey and qualitative) c. Efficacy/effectiveness/cost effectiveness (RCT) d. Risks of E-cigarettes in pregnancy (observational) 	<ul style="list-style-type: none"> a. Longitudinal cohort survey examining E-cigarette beliefs and behaviours – ‘PLS 2017’ (CRUK; Sue Cooper, University of Nottingham, UK) b. Longitudinal cohort survey – ‘PLS 2017’ (as above) c. Effectiveness RCT – ‘PREP’ trial (NIHR HTA; Peter Hajek, Queen Mary’s University, UK) d. PREP trial collecting adverse event data (as above)
<p>2. Relapse prevention</p> <ul style="list-style-type: none"> a. Intervention development studies (qualitative, modelling, feasibility and acceptability testing) b. Efficacy/effectiveness/cost effectiveness (RCT) 	<ul style="list-style-type: none"> a. Postpartum relapse prevention intervention development project – ‘PreS’ (MRC; Caitlin Notley, University of East Anglia, UK) b. Remaining research gap
<p>3. Social network and community interventions</p> <ul style="list-style-type: none"> a. Intervention development studies (qualitative, modelling, feasibility and acceptability testing) b. Efficacy/effectiveness/cost effectiveness (RCT) 	<ul style="list-style-type: none"> a. Social network intervention development project funded by CRUK, larger study planned b. Research gap
<p>4. SHS exposure and smokefree homes</p> <p><i>There is evidence of self-reported short-term reduction in SHS exposure among non-smoking pregnant women from interventions involving healthcare workers, though these are relatively high cost and with no cost-effectiveness data</i></p> <ul style="list-style-type: none"> a. Intervention development studies for low cost and scalable interventions (qualitative, modelling, feasibility and acceptability testing) b. Efficacy/effectiveness/cost effectiveness of low cost and scalable interventions (RCT) 	<ul style="list-style-type: none"> a. REFRESH study completed https://www.ashscotland.org.uk/go-smoke-free/refresh-project/ b. with promising results, but small scale study so further research required
<p>5. Digital interventions</p> <p><i>A meta-analysis of RCTs show SMS text messaging and computer based interventions are effective but evidence for mobile apps is lacking with only one app trial to date</i></p> <ul style="list-style-type: none"> a. Intervention development studies for mobile apps (qualitative, modelling, feasibility and acceptability testing) b. Efficacy/effectiveness/cost effectiveness of mobile apps (RCT) 	<ul style="list-style-type: none"> a. Research under review but more studies needed b. Research gap
<p>6. Incentives</p> <ul style="list-style-type: none"> a. Effectiveness and cost effectiveness (RCT) <p><i>A Cochrane review found a statistically significant benefit for financial incentives compared to controls</i></p>	<ul style="list-style-type: none"> a. Effectiveness and cost effectiveness RCT – ‘CPIT III’ (multiple funders; David Tappin and Linda Bauld (co-PIs), Universities of Glasgow and Stirling, UK) b. Greater Manchester also implementing incentives in practice, as is NHS Greater Glasgow and Clyde, with implementation research underway

<p>7. Effective pharmacotherapy use</p> <p><i>A Cochrane review found a non-statistically significant benefit for NRT from high quality RCTs. Insufficient dosing and poor adherence identified as key reasons for low efficacy.</i></p> <ul style="list-style-type: none"> a. Development studies for interventions targeting adequate dosing of NRT and high adherence (qualitative, modelling, feasibility and acceptability testing) b. Efficacy/effectiveness/cost effectiveness of NRT use interventions (RCT) 	<ul style="list-style-type: none"> a. Development studies (qualitative, modelling, feasibility and acceptability testing) 'N-READY' programme (NIHR PGfAR; Tim Coleman, University of Nottingham, UK) b. Efficacy and effectiveness/cost effectiveness RCT – 'N-READY' programme (as above; planned)
<p>8. Smokeless tobacco products in Black and Minority Ethnic groups</p> <ul style="list-style-type: none"> a. Intervention development studies (qualitative, modelling, feasibility and acceptability testing) b. Efficacy/effectiveness/cost effectiveness (RCT) 	<ul style="list-style-type: none"> a. PhD studentship at the University of York conducting feasibility work, linked to the NIHR funded ASTRA (smokeless tobacco in South Asia and the UK) programme b. Some elements to be included in the ASTRA programme
<p>9. Targeting smoking behaviour of partners and household members</p> <p><i>A systematic review of nine intervention studies concluded that there are very few effective interventions for pregnant smokers that target their partners and there have been few intervention studies since</i></p> <ul style="list-style-type: none"> a. Intervention development studies (qualitative, modelling, feasibility and acceptability testing) b. Efficacy/effectiveness/cost effectiveness (RCT) 	<ul style="list-style-type: none"> a. Research gap - although also explored in the REFRESH study mentioned above b. Research gap
<p>10. Identifying effective behaviour change techniques (BCTs)</p> <ul style="list-style-type: none"> a. Conceptual work identifying pregnancy specific BCTs (conceptual review, observational) b. Assessing the association between BCT delivery and abstinence (experimental or observational) 	<ul style="list-style-type: none"> a. Development of a smoking in pregnancy inventory of BCTs (NIHR CLAHRC; Tim Coleman, University of Nottingham, UK) b. Not aware

RCT = Randomised controlled trial; CRUK = Cancer Research UK; NIHR = National Institute for Health Research; HTA = Health Technology Assessment; MRC = Medical Research Council; PGfAR = Programme Grants for Applied Research; CLAHRC = Collaborations for Leadership in Applied Health Research and Care

6. Full 2018 Challenge Group recommendations

1. Address variation in local implementation of NICE guidance

- » Public Health England and NHS England should review the implementation of NICE guidance across the country and assess the barriers and enablers to full implementation.
- » NHS Improvement and NHS England should work to reduce the variation in performance between CCGs and ensure there is a joined up national plan in line with recommendations in the Government's Tobacco Control Plan.
- » Public Health England should work with local authorities to ensure that local strategies reduce rates of smoking among the most disadvantaged and that families who need to can access stop smoking support before, during and after pregnancy.
- » Public Health England and NHS England should support local leadership to tackle smoking in pregnancy through Local Maternity Systems and the promotion of Smokefree Pregnancy Champions in every local area.
- » Local authorities, CCGs and Trusts should explore ways to work collaboratively across LMS footprint to realise economies of scales in implementing NICE guidance on smoking in pregnancy.

2. Action where smoking in pregnancy rates are high

- » National and local government and NHS organisations should seek to better engage a wider group of health and care professionals in reducing rates of smoking in pregnancy, and to engage whole household not only pregnant women. Approaches should include:
 - ~ Improve training to better engage with families who smoke
 - ~ Supporting pilots to gain a better understanding of how a wider group of professionals, in particular health visitors, can motivate more parents who smoke to quit
 - ~ Engaging commissioners in efforts to explore how professionals can be best supported to deliver brief advice within existing contracts
 - ~ Producing materials to support professionals in their engagement with families.
 - ~ Supporting pilot activity to better understand how peer support models could help more young mothers to quit
- » The Government should introduce a national incentive scheme to support pregnant women to quit, learning from the best evidence on how to achieve success. Until a scheme can be put in place, they should proactively encourage local areas to introduce their own schemes in line with the evidence base.

3. Improve the quality of data monitoring locally and nationally

- » NHS Digital and Public Health England should work together to ensure the smoking parts of the Maternity Services Dataset are completed by all Trusts. This includes; the NICE recommendation to screen at booking and that every opportunity is taken to develop policy based on insights generated by the dataset.
- » The Challenge Group continues to believe that the Government should move towards 36 weeks as the measure for smoking in pregnancy. Moves should be made to establish this as part of the Maternity Transformation Programme.

4. Maximise the use of nicotine as a quitting aid

- » Department of Health should develop a sophisticated communications strategy to ensure both health care professionals and women have a better understanding of the potentially positive role of nicotine containing products, such as NRT and e-cigarettes, in a quit attempt.
- » Commissioners need to ensure services are providing pregnant smokers with the right levels of NRT and supporting their choice to use e-cigarettes if that is their preferred way to quit.
- » Health Education England should work to improve training and understanding of the role of nicotine (separate from tobacco) is needed for key professionals including obstetricians, midwives, primary care professionals and health visitors.

5. Increase the proportion of maternity workforce trained to address smoking in pregnancy

- » The Maternity Transformation Programme should continue to work with the Smoking in Pregnancy Challenge Group to implement the recommendations made in the 2017 report 'Smokfree Skills', in particular:
 - ~ Address training gaps around the development of skills to support pregnant women who smoke not only the knowledge of harms
 - ~ Development of short training resources to support local delivery of training
 - ~ Embedding training at undergraduate level on both the knowledge and skills needed to address smoking in pregnancy
- » Public Health England, NHS England and Health Education England should review the content of mandatory midwifery training in relation to smoking and develop a plan to address gaps.

Appendix 1

RAG rating of progress against 2015 detailed recommendations

Data collection

2015 Recommendation	Rating
1. The new tobacco control strategy should include a strong commitment to ensuring that effective data collection takes place across the system. This should include a requirement that smoking status is collected at booking visit and throughout pregnancy and that it is recorded and validated using CO Screening.	Green
2. The new tobacco control strategy should set a timetable for NHS England to move to collecting smoking status at approximately 36 weeks gestation and validating this through CO screening.	Amber
3. A briefing should be produced by NHS England, Public Health England and the Health and Social Care Information Centre outlining best practice for collecting the new Maternity and Children's Data Set. This should be produced without delay.	Amber
4. The Department of Health should task Local Area Teams with bringing all CCGs to the same standards of data collection and implement support plans to address areas identified as having high rates of smoking in pregnancy and/or poor data collections.	Amber
5. NHS England should ensure that CCGs commission and clinical/medical directors deliver adequate systems, equipment and training to collect and record CO readings during antenatal appointments and that appropriate time is allocated for this.	Amber
6. Data systems should seek to capture better information on relapse rates and whether a women's partner smokers.	Red
7. Local authorities and local NHS organisations should establish how they can better share data regarding pregnant women who smoke.	
8. Following the cancellation of the Infant Feeding Survey, the Government should consider alternative ways to collect ongoing data to record the age and socio-economic status of pregnant smokers. Such data is essential to understanding smoking in pregnancy rates and where work in this area should be prioritised.	Green

Implementation of NICE Guidance

2015 Recommendation	Rating
<i>Audit of guideline implementation</i>	
1. PHE Centres, building on existing practice, should commission an audit to investigate the extent to which the NICE guidance on Smoking in Pregnancy has been implemented in local trusts. They should support CCGs and trusts found to have gaps.	Amber
2. All trusts and CCGs should sign the NHS Statement of Support for Tobacco Control which includes a commitment to implement NICE guidance relating to smoking.	Amber
3. NHS England must ensure that all CCGs commission maternity services to meet NICE Guidance on Smoking in Pregnancy.	Amber

Identifying and referring smokers

- | | |
|---|-------|
| 1. CCGs and local authorities should work in partnership to ensure that there is an effective and robust referral pathway for pregnant smokers. | |
| 2. CCGs should ensure that CO monitors are provided for midwifery staff, to enable routine CO screening during pregnancy, and that clear procedures are in place for the regular calibration of the CO monitors where needed. | Amber |
| 3. CCGs should include a requirement in service specifications that all women are screened for CO at booking and that midwives are given the time, training and tools to do this. Standards should ensure that midwives give very brief advice on cessation to identified smokers and promptly refer those with a CO score of 4 or higher to local Stop Smoking Services (SSS). | |

Supporting pregnant women to quit

- | | |
|---|-------|
| 1. Localities need to increase the number of pregnant women that smoke who have specialist interventions through stop smoking services. The following suggestions for practice should improve this outcome: <ul style="list-style-type: none"> Local authorities and stop smoking services should ensure that there is sufficient expertise available to meet the needs of all pregnant smokers. Women should be involved in the development of services and health and wellbeing boards should review whether their needs are being met as part of the joint strategic need assessment. Local authority commissioners should include a requirement in service specifications that all women are phoned by the local SSS within one working day of receiving a referral and seen within one week. Local stop smoking services should offer intensive support programmes for pregnant smokers up to the point of delivery and up to two months post-partum (or longer if appropriate to prevent relapse). Local authorities and the NHS should follow the NICE guidance on NRT provision to pregnant women. Stop smoking services should develop close working links and cross referral pathways with third sector organisations at community level who provide on-going support and advice to young families and young women. | |
| 2. Health and wellbeing boards should prioritise reducing the prevalence of smoking during pregnancy, ensuring that there are clear and streamlined pathways in place to identify and support pregnant smokers, and that services meet the needs of the local population. | |
| 3. Local authority tobacco control plans should ensure that the wider activity of tobacco control supports work to reduce smoking in pregnancy e.g. through work with children's centres, activity to support smokefree homes, delivery of stop smoking services to parents and grandparents, work with target populations with high smoking rates and teen pregnancies. | |
| 4. Local commissioners and national standard setting organisations should give more consideration to the role Health Visitors can play in supporting pregnant women to quit smoking prior to birth and maintain abstinence following birth. | Amber |

Training

2015 Recommendation	Rating
1. CCGs and local authorities alongside SSS and Trusts need to implement the NICE guidance in relation to training. All midwives, and other health professionals working with women who smoke while pregnant, should have training on smoking cessation that is appropriate to their role.	
2. Health Education England should ensure that appropriate training is in the core curricula for all health professionals who come into contact with pregnant women and part of pre-registration training for midwives.	Red
3. Local Education Training Boards should specify education on smoking in pregnancy, CO Screening and brief intervention training for all midwives be a mandatory part of continued professional development.	
4. CCGs and Local authorities should ensure that all practitioners who assist pregnant women to stop smoking are sufficiently trained, achieving full NCSCCT certification and completing the NCSCCT specialty pregnancy online module, or training to an equivalent standard.	
5. Medical Royal Colleges, Health Education England, the National Centre for Smoking Cessation and Training, service managers and voluntary organisations – among others – must promote brief advice training for doctors, nurses, health visitors, administrative staff, sonographers and other medical practitioners who work with pregnant women and their partners.	Green
6. Service managers need to embed proper support and supervision into clinical practice. Less experienced staff should be supported through mentoring and learning from more experienced trained staff.	

Communication between health professionals

2015 Recommendation	Rating
1. Public Health England and NHS England should maintain their senior officer champions to ensure that every opportunity to tackle smoking in pregnancy is taken.	Green
2. The Smokefree Action Coalition (SFAC) should explore ways to support PHE and NHS England through providing forums where professionals are able to share good practice. PHE should explore how this could be sustainably resourced.	Green
3. The SFAC should continue to support this agenda through the Smoking in Pregnancy Challenge Group and the wider activity of member organisations.	Green
4. The CLear partnership should routinely review items in the CLear model to ensure that smoking in pregnancy is considered comprehensively across local government services and policy.	Green
5. Offices of tobacco control, where they exist, should continue to support their region to reduce smoking in pregnancy levels by developing protocols, encouraging partnership working and sharing good practice. Where there is no office of tobacco control PHE Centres should endeavour to support localities to prioritise and take action.	Green
6. The Department of Health should task the National Screening Committee with including CO screening as part of its antenatal screening programme.	Red

Communication with the public

2015 Recommendation	Rating
1. Members of the Challenge Group, Public Health England and the Department of Health should maintain and disseminate the key messages document to ensure all relevant organisations speak about smoking in pregnancy with common messages.	Green
2. CO Screening leaflets for pregnant women and professionals should continue to be made available and used locally.	Green
3. Public Health England should build and expand upon the Start4Life brand, ensuring that all pregnant women are aware of the risks of smoking in pregnancy, the benefits of quitting, the support available to help them quit, and the importance of CO screening.	Green
4. Public Health England and NHS England should work with the Challenge Group to develop a communication strategy for England. This should aim to co-ordinate national activity and support and inform the development of local activity.	Amber
5. Public Health England should continue to support the development of digital interventions and make recommendations to local organisations about what interventions are effective for work with pregnant women.	Amber
6. Local areas should consider the evidence around incentive schemes to help pregnant women quit smoking and make appropriate decisions about local service delivery.	Amber
7. Where it is known that a mother is trying to conceive, health professionals and others who have contact with her and her partner and family should identify smoking status, provide very brief advice, and offer referral to stop smoking services.	Amber
8. Professionals who come into contact with pregnant women and their families should clearly communicate to the partners of pregnant women the benefits to the child from quitting smoking	Red

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