A manifesto for smokefree beginnings

December 2023

smoking in pregnancy challenge group

ash
action on smoking and health

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Foreword

The Challenge Group was first established in 2013 to set out a strategy to deliver the Government's ambition to reduce rates of smoking during pregnancy. It was, from the very start, a close synergistic relationship between third sector organisations, the Government and the NHS.

Our goal was always shared, but what the Challenge Group was able to bring was deep expertise, a sharp focus on this single issue and a broad coalition of the willing.

In the decade that has passed, we have seen progress stall and then start to accelerate with rates of smoking in pregnancy falling more rapidly now than they have for many years.

We have bought policy expertise and advocated for change, but we have also built a community of over a thousand supportive health professionals who use our resources to help them champion this agenda in their communities. Thousands more use the aids to practice developed by the Challenge Group, with more than 2 million items being provided to the sector for free over the years.

We have also built a strong national consensus on the need for change and the actions needed to deliver.

A smokefree future for every child is now within reach thanks to the Prime Minister's commitment to create a smokefree generation, but this future will only be realised if the Government delivers on what has already been announced and commits to going even further.

Our hope is that politicians of all parties will rise to the challenge and there will be no need for us to repeat this report on our twentieth anniversary. Until then, the Challenge Group will continue to hold the Government to account and campaign for action to save babies' lives.

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Summary of recommendations

High impact recommendations

1. Pass legislation to raise the age of sale for tobacco by one year, every year, to reduce smoking prevalence in the age cohort most likely to smoke during pregnancy and create a smokefree generation.
2. Introduce a 'polluter pays' levy on tobacco manufacturers to raise funding for the measures needed to deliver a smokefree start for every child.
3. Fully implement the national financial incentive scheme and commit to extending the scheme beyond 2024.
4. Set out a new target for reducing rates of Smoking Status at Time of Delivery (SATOD) to 4% by 2030, putting England on track to deliver a smokefree start for every child before 2040.
5. Ensure NHS tobacco dependence treatment services for pregnant women are fully embedded and sustained long-term.
6. Commit to develop and fund models of care to prevent relapse to smoking postnatally.

Supporting recommendations

7. Commit to support and evaluate pathfinder areas for interventions to address smoking among fathers, partners and other high prevalence groups and communities. This should include interventions in specific settings such as neonatal intensive care units where parents are likely to have above-average smoking rates.
8. Implement and build on the recommendations in the ASH/Challenge Group 2017 report on maternity workforce training:
    - Ensure that all midwives and obstetricians receive dedicated training and assessment on supporting women to stop smoking during pregnancy at an undergraduate and postgraduate level.
    - Align training to current policy drivers (e.g. NHS Long Term Plan and Saving Babies' Lives Care Bundle version 3) to ensure continuous learning and all interventions are covered to meet process and outcome indicators.
    - Training should include appropriate care pathways, discussion around safety incidents and the need for maternity care providers to review and update smoking status throughout pregnancy to ensure individualised care is offered.
    - Set out a strategy to ensure that high quality, evidence-based, regular training is available for relevant professionals, specifically midwives,

obstetricians, GPs, and health visitors. For example, through a 'training the trainer' programme implemented across the system.
    - Ensure that maternity professionals receive dedicated training to equip them to deliver evidence-based advice about nicotine, NRT and vaping.
    - Extend training on CO monitoring and delivering VBA to all professionals working with pregnant women including GPs, midwives, obstetricians, paediatricians, health visitors, mental health service providers, and professionals in children' services.

9. Ensure that all pregnant women and their partners can access 12 weeks of dual-form NRT on prescription via maternity services, stop smoking services, or primary care. This offer should be extended postnatally.

10. Ensure pregnant women struggling to quit smoking can access vape products as an alternative while addressing increases in youth vaping and vaping among never smokers.

11. Explore the possibility of engaging services which are well placed to intervene with women before they become pregnant, such as family planning and sexual health services.

12. Prioritise routine publication of data on Smoking Status at the Time of Booking (SATOB) and smoking status at 36-weeks.

Introduction

This report has been produced by Action on Smoking and Health (ASH) and the Smoking in Pregnancy Challenge Group. It reviews the progress made in reducing maternal smoking rates over the last decade since the Challenge Group was established and sets out the action needed to deliver a smokefree start for every child.

ASH is a public health charity that works to eliminate the harm caused by tobacco. ASH was established in January 1971 by the Royal College of Physicians.

The Smoking in Pregnancy Challenge Group is a coalition of charities, royal colleges and academic organisations committed to reducing rates of smoking in pregnancy. The Group is jointly chaired by Dr. Clea Harmer, Chief Executive of Sands, and Professor Linda Bauld of the SPECTRUM Research Consortium and the University of Edinburgh. The Challenge Group presented its first report and recommendations in June 2013 and meets regularly to review progress and further develop solutions.

Why ending maternal smoking should be an urgent priority

When a woman smokes during pregnancy, or when she is exposed to secondhand smoke, oxygen to the baby is restricted making the baby's heart beat faster and exposing the baby to harmful toxins. As a result, smoking or exposure to secondhand smoke during pregnancy is a leading cause of poor birth outcomes, including stillbirth, miscarriage and birth defects. This exacerbates existing health inequalities as women from more deprived backgrounds are more likely to smoke – and therefore smoke during pregnancy – and be exposed to secondhand smoke during pregnancy. The impact of this is summarised in the table below.

Smoking during pregnancy also increases the risk of children developing respiratory conditions; attention and hyperactivity difficulties; learning difficulties; problems of the ear, nose and throat; obesity; and diabetes.[1] [2] The Royal College of Physicians estimated that exposure to secondhand smoke was responsible for between 5,000 and 11,000 hospital admissions for children in 2015/16.[3]

Impact of smoking and exposure to secondhand smoke during pregnancy

	Maternal Smoking	Secondhand smoke exposure
Low birthweight	2 times more likely	Average 30-40g lighter
Heart Defects	25% more likely	Increased risk
Stillbirth	47% more likely	Possible increase
Preterm birth	27% more likely	Possible increase
Miscarriage	32% more likely	Increased risk
Sudden Infant Death	3 times more likely	45% more likely

Zhao L et al. Parental smoking and the risk of congenital heart defects in offspring: An updated meta-analysis of observational studies. 2020; RCP. Hiding in plain sight: treating tobacco dependency in the NHS. 2018; Pineless BL et al. Systematic review and meta-analysis of miscarriage and maternal exposure to tobacco smoke during pregnancy. 2014; RCP & RCPCH. Passive Smoking and Children. 2010

Pregnant women who smoke require more care which leads to additional costs on NHS trusts compared to non-smokers. It is estimated that maternal smoking cost the NHS over £20 million in 2015/16 through 10,032 episodes of admitted patient care.[3] Additionally, many of the child health conditions caused by maternal smoking (asthma, obesity, diabetes) require long-term NHS treatment.

These harms are in addition to the significant risks smoking poses to health for all women of childbearing age. Smoking is the primary cause of preventable illness and premature death in England, accounting for approximately 74,600 deaths in 2019, including 12% of all deaths among women.[4] Up to two in three life-long smokers will die prematurely from smoking, losing on average about 10 years of life.[5] [6] Pregnancy is a key opportunity to intervene with women who smoke to help them quit.

The consequences of inaction

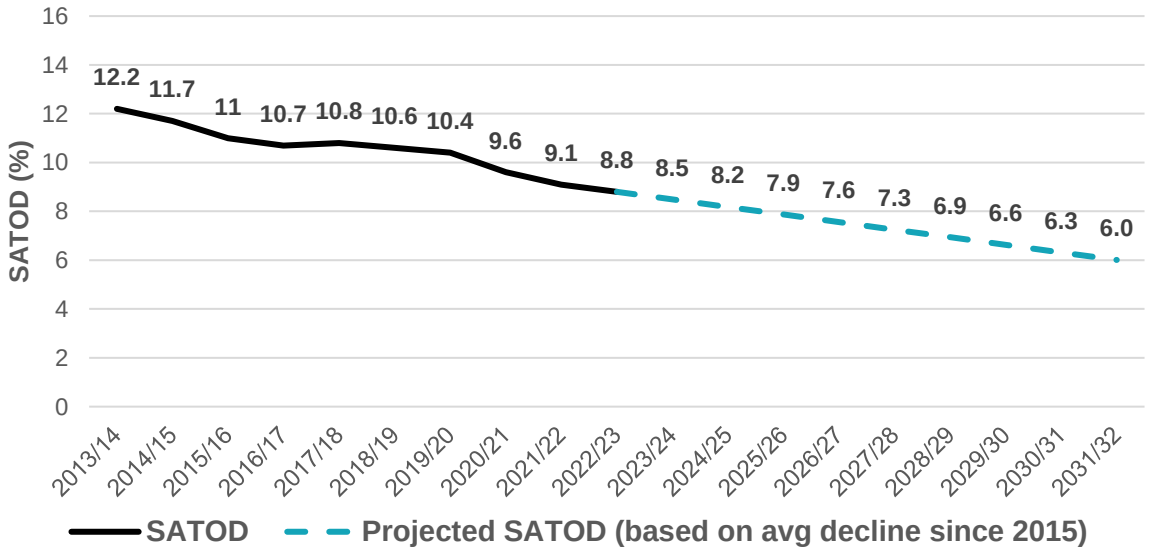
In 2018, the Challenge Group estimated[7] that achieving the Government ambition to reduce rates of smoking during pregnancy (SATOD) to 6% by 2022 would mean:

- 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.

However, while SATOD rates are declining, the Government has missed the 6% ambition and isn't on track to hit it until around 2032, a decade later than hoped for. In 2022/23, 8.8% of women smoked during pregnancy, equating to around 50,000 babies born to mothers who smoke.[8] Without urgent action to reduce maternal smoking rates thousands of families will suffer devastating preventable consequences. This will also negatively impact the Government's ambition to halve stillbirths and neonatal mortality in England.

Progress in reducing SATOD rates has improved over the last three years as new funding has been made available to support women to quit during pregnancy and better training and data gathering has been embedded. With more investment and a new financial incentive scheme we hope this new trend can be maintained and accelerated.

Projected progress in reducing SATOD rates



High level view of progress

Below we have assessed national progress across the priority areas identified in previous Challenge Group reports.

Priority areas	Rating	Progress
Delivering on the national ambition.		In 2017, the Government set an ambition to reduce rates of Smoking Status at Time of Delivery (SATOD) to 6% or less by 2022. The most recent data for 2022/23 show that this target has been missed, with 8.8% of pregnant women currently smoking during pregnancy. At the current rate of decline, the 6% target won't be reached until 2032, a decade later than hoped for. However, there are signs that progress is gathering pace. Current service and policy changes need to be sustained and extended to ensure this progress is realised.
Stopping the start by reducing the number of women going into their first pregnancy as smokers.		The Government has announced that it will create a smokefree generation by increasing the age of sale for tobacco by one year, every year, so that anyone born on or after 1 January 2009 will never be legally sold tobacco. This goes further than the Challenge Group recommendation to raise the age of sale to 21 but will not come into force until 2027. Once implemented, this is likely to significantly accelerate progress towards all maternities being smokefree. It is important that more is done in the meantime to reduce the number of young people taking up smoking. There is also more that could be done to engage services which are well placed to intervene with women before they become pregnant, such as family planning and sexual health services.
Establishing stop smoking support for all pregnant women who smoke.		Since 2016, the NHS has published three iterations of the Saving Babies' Lives Care Bundle, a set of recommendations for reducing perinatal mortality. The Care Bundle has played a key role in improving the implementation of clinical guidance on supporting women to quit smoking during pregnancy. The NHS Long Term Plan (LTP) commits to delivering an opt-out smokefree pregnancy pathway for expectant mothers. It is vital that these services are fully implemented and sustained long-term to realise the benefits which are starting to emerge in the data. In April, the Government announced a national financial incentive scheme which will be offered to all pregnant women who smoke by the end of 2024. This builds on the work done in areas like Greater Manchester and South Tyneside.
Utilising nicotine to support smoking cessation during pregnancy in line with clinical		Nicotine replacement therapy (NRT) is a safe form of treatment during pregnancy and widely prescribed for smoking cessation in the UK. However, efforts to maximise the use of nicotine to support quitting among pregnant women have been undermined by widespread misconceptions among professionals and service users that nicotine is responsible for the health harms of smoking.

guidelines and evidence.		E-cigarettes (vapes) are increasingly being utilised by stop smoking services to support pregnant smokers to quit. E-cigarettes appear to be just as safe as nicotine patches and more effective for smoking cessation during pregnancy. However, attempts to maximise the impact of vaping for smoking cessation have been hindered by misperceptions about nicotine, a lack of knowledge about the health impacts of vaping and widespread concerns about youth vaping. There is a need for dedicated training to equip maternity professionals to deliver evidence-based advice about NRT, nicotine and vaping. The Government must also move quickly to respond to the rise in youth vaping. While vaping is a much safer alternative for women who smoke it should be avoided for those who can on a precautionary basis.
Increasing the provision of appropriate training to maternity and other health professionals.		Progress has been made in providing appropriate training to staff in maternity services, driven by the successive iterations of the Saving Babies Lives' Care Bundle, NICE guidance and the rollout of the NHS Long Term Plan. However, efforts to mainstream training in maternity services are often limited by a lack of expertise and knowledge, staff turnover and competing institutional priorities. There continue to be major gaps in the postgraduate and undergraduate training of maternity professionals which reduces their ability to appropriately support women to stop smoking in pregnancy. Additionally, there are a range of other professional groups outside of maternity who are well placed to intervene with women before and after pregnancy, and where a further assessment of training would be appropriate. Many of these issues were raised in the 2017 Challenge Group report into maternity workforce training[9] and have still not been addressed.
Supporting quitting among partners and household members who smoke.		Women who live with someone else who smokes are more likely to smoke/be exposed to secondhand smoke throughout pregnancy, less likely to successfully stop if they smoke and more likely to relapse if they manage to quit.[2] Consequently, supporting partners and other household members to quit smoking is central to reducing rates of maternal smoking. However, there is no coherent strategy for addressing smoking among partners/household members. In addition, there are a lack of evidence-based interventions which could be implemented at scale. The NHS Long Term Plan initially committed to extending the stop smoking support for pregnant women to dads/partners but this is not part of the funded national programme, nor is data being gathered on this. Locally, different approaches are being taken but in general, partners will be referred to separate community-based services. There is scope to improve the evidence-base and show more leadership in this area.
Preventing women relapsing to smoking postnatally or		Nearly half of women who quit smoking during pregnancy relapse post-partum.[10] Consequently, the postnatal period is a crucial opportunity to ensure that women are supported to stay smokefree. To benefit their own health, their children as they grow and any future pregnancies. However, there is no coherent national approach to relapse prevention, reducing the potential

between pregnancies.		benefits of intervening during pregnancy. Health visiting services are well placed to address this gap if provided with the right handover, training and funding to do so.
Improving data collection to ensure that smoking status is recorded throughout pregnancy.		There have been significant improvements in the collection of data on smoking status during pregnancy over the last decade. This has consisted of a push to improve the reliability of SATOD data and mandatory collection of smoking status at booking and 36 weeks. However, despite being collected since 2018, data on smoking at booking and 36 weeks are still not published annually, making it difficult to assess the effectiveness of the stop smoking support women receive during pregnancy. Data from the new NHS tobacco dependence treatment services is still improving but in due course this will provide a further data source to assess the quality and consistency of support.
Building the evidence base		There has been significant progress in building a robust evidence base for which interventions are effective for addressing smoking during pregnancy, most notably the smokefree pregnancy programme in Greater Manchester which provided the model for the new NHS tobacco dependence treatment services. However, there is a lack of evidence concerning effective stop smoking interventions in the pre-, inter- and postnatal periods. This has prevented the development of a comprehensive package of interventions to support women to quit smoking and stay smokefree before, during and after pregnancy. There is particular need for more evidence around: • Supporting women to quit during the preconception period. • Preventing relapse to smoking postnatally. • Supporting parents of children in neonatal intensive care units to quit smoking. • Partner/family stop smoking interventions. • NRT and vaping for cessation during pregnancy.
Tackling smoking in high prevalence communities.		Smoking during pregnancy continues to be an expression of other existing inequalities. Smoking rates are highest in younger more disadvantaged women and hence smoking in pregnancy is concentrated in this group. This is acknowledged in the NHS Core20PLUS5 approach, but dedicated investment is needed to accelerate progress among women facing multiple challenges, particularly for women with co-occurring mental health and substance use issues.

The role of the Smoking in Pregnancy Challenge Group

The Challenge Group brings together the leading voices in tobacco control, public health, maternal health and child health; professionals in maternity, health visiting and stop smoking services; and academic experts. Since its inception, the Group has sought to build a clear consensus about the importance supporting pregnant women to have a smokefree pregnancy and a healthy baby. This has been achieved through:

1. Close collaboration with the maternity sector, in particular the professional royal colleges, to promote examples of good practice and share learning. The Challenge Group maintains a network of around 1,000 maternity professionals who receive regular updates containing links to resources, guidance, events and resources.
2. Supporting implementation of stop smoking support for pregnant women through practical resources and guidance. A range of resources are available on the Challenge Group website with key materials (such as 'test your breath' cards) available to bulk order free of charge for use with women and families. In total, approximately 2 million Challenge Group resources have been distributed to over 145 maternity units with support from Improving Performance in Practice (iPiP).
3. Building and promoting the evidence on the harms of maternal smoking and effective interventions to help people quit before, during and after pregnancy. This has included developing '*evidence into practice*' briefings on Carbon Monoxide (CO) testing, financial incentives and supporting partners to quit smoking.
4. Advocating for more support to help pregnant women quit smoking and stay quit long term. The Challenge Group has played a key role in securing a significant expansion of the support provided to pregnant women to quit smoking and stay smokefree, in addition to a national commitment to reduce SATOD rates in the last Tobacco Control Plan. But there is more to do.

A changing landscape

The landscape for supporting women to stop smoking during pregnancy has transformed over the last decade. While the Challenge Group has played an important role in setting the strategic direction, this change has been driven by the thousands of health professionals across the country working to support pregnant women and families to be smokefree. Below we summarise some of the key changes over the last decade.

High priority placed on tackling maternal smoking

The biggest change over the last decade has been the development of a clear consensus on the urgent need to tackle maternal smoking by offering pregnant women comprehensive support to quit. The 2011 Tobacco Control Plan included a target for reducing smoking during pregnancy but was missing a clear strategy to deliver. Following this, in 2012 the then-Public Health Minister, the Rt Hon Anne Milton, challenged the maternity sector to identify ways to make further progress in this area, leading to the formation of the Smoking in Pregnancy Challenge Group. Since then, the Challenge Group has worked closely with maternity professionals and academic experts to make evidence-based recommendations on what is needed to tackle smoking during pregnancy.

There is now a clear understanding in the sector, nationally, regionally and locally that addressing women's smoking is a priority for securing safe pregnancies. Additionally, reducing maternal smoking is now a clear political priority. In 2017, the Government set out a national ambition to reduce smoking in pregnancy rates to 6% or less, along with a recent commitment to introduce a national financial incentive scheme for all pregnant women who smoke, and the NHS has made this a core priority for maternity services through the Saving Babies' Lives Care Bundle and NHS Long Term Plan tobacco dependence treatment services.

Embedding carbon monoxide testing in routine maternity care

Carbon monoxide (CO) testing is a non-invasive way of identifying someone's smoking status and starting a medicalised, non-judgemental conversation about the harms of smoking and the benefits of quitting. Evidence shows that due to stigma pregnant women often deny or under-report the number of cigarettes smoked[11] [12], so having an objective way of identifying smoking status during pregnancy is vital for connecting women with stop smoking support. CO testing all women at their antenatal booking appointment has been recommended by NICE since 2010 and over the last decade there has been a consistent effort to improve implementation in maternity services.

Since 2016, implementation has been driven by three iterations of the Saving Babies Lives Care Bundle, a package of interventions developed by the NHS to reduce stillbirth and perinatal mortality. Element 1 of the Care Bundle focuses on reducing smoking during pregnancy by identifying pregnant smokers through CO testing pregnant women at their antenatal booking appointment and offering them opt-out referral to stop

smoking support. The Care Bundle has proven highly effective at improving the implementation of CO testing and an evaluation published in 2018 found that implementation of CO testing was "almost universally accepted" across the early adopted Trusts, although there are still challenges in some areas. CO monitoring was temporarily paused during the COVID-19 pandemic but has since been reintroduced. A new evaluation of Care Bundle implementation is currently underway and will be published in early 2024.

Opt-out stop smoking support for *all* pregnant women who smoke

Referring all pregnant women who smoke to stop smoking support on an opt-out basis is the most effective way to increase engagement with stop smoking services. This approach has been recommended by NICE since 2010 and implementation has been driven by the Saving Babies' Lives Care Bundle since 2016. However, for many years this was limited by lack of coordination between NHS maternity services and community stop smoking services with variations in delivery.

The rollout of NHS tobacco dependence treatment in maternity services committed to in the NHS Long Term Plan (LTP) is expected to address this issue. Rather than being referred to an external community stop smoking service, pregnant women who smoke should receive NHS-commissioned support alongside their maternity care. This approach, which is based on the smokefree pregnancy programme in Greater Manchester, is expected to significantly increase engagement with stop smoking support. Rollout of NHS tobacco dependence treatment services has coincided with a steady decline in SATOD rates after many years of plateauing.

The Challenge Group has worked closely with NHS England and individual maternity services to support the LTP rollout by promoting case studies, sharing training materials, developing practical resources and running training events.

National commitment to reduce SATOD rates in the 2017 Tobacco Control Plan

The Government's commitment to address smoking in pregnancy was shown by setting an ambitious and highly challenging target in the 2017 Tobacco control plan for England to reduce rates of smoking in pregnancy to 6% or less by 2022. While the Government has not met this deadline, it has set a clear vision to drive action in Government and across the system. This has been key to the progress made in reducing maternal smoking with rates falling for the last three years. Without this scale of commitment, it is possible that SATOD would have continued to plateau.

Emergence of vaping

Over time, e-cigarettes (vapes) have become the most popular aid to quitting smoking in England and have contributed to declines in smoking rates since 2013.[13] [14] An NIHR-funded randomised control trial has found that vapes appear to be as safe as nicotine patches during pregnancy and are more effective for smoking cessation. [15] [16]

Additionally, vapes are increasingly being used as a stop smoking aid in many services. While licensed nicotine replacement (NRT) products such as nicotine patches, gum and inhalers are the recommended option, for some women trying to quit smoking during pregnancy, e-cigarettes may be an important part of the mix of support they need.

In recent years, concerns have grown about the growth in popularity of vaping among children and young people. This urgently needs to be addressed and the Government has set out proposals to restrict the availability, marketing and appeal of vapes to young people. It is also important to ensure that pregnant women (aged 18+) who choose to vape are doing so to help them quit smoking. Although the vast majority of adult vapers are using e-cigarettes to quit or cut down their smoking, a small minority (6.7%) have never smoked.[17] Vaping is not risk-free, particularly for people who have never smoked, so reducing the use of vapes among non-smokers during pregnancy is important on a precautionary basis.

National financial incentive scheme

Financial incentives involve providing pregnant women who smoke (and in some cases their partners/significant others) financial incentives to quit smoking and stay smokefree, usually in the form of shopping vouchers. A 2019 Cochrane review of the evidence on financial incentives found that they are a highly effective way of supporting pregnant women to quit smoking during pregnancy and remain quit post-partum, with women receiving incentives more than twice as likely to quit compared to those in non-incentivised groups.[18]

The Challenge Group has been calling for financial incentives for many years and has worked closely with experts to develop a set of lessons for practice to support local areas to trial incentives. In April 2023, the Government announced that all pregnant women who smoke will be offered financial incentives in the form of vouchers alongside behavioural support by the end of 2024. [19] This should prove highly effective for increasing engagement of pregnant smokers with stop smoking support.

Looking to the future

This is the Challenge Group's fourth national report making recommendations to comprehensively address smoking in pregnancy. The recommendations below build on those made in previous reports, while reflecting the changing context, evidence-base and progress. We have identified some high impact actions that will rapidly accelerate progress and some more detailed ones that will help to underpin progress.

High impact recommendations

1. **Pass legislation to raise the age of sale for tobacco by one year, every year, to reduce smoking prevalence in the age cohort most likely to smoke during pregnancy and create a smokefree generation.**

The Government has announced that it intends to raise the age of sale for tobacco products by one year, every year, from 2027 so that anyone born on or after 1 January 2009 will never be legally sold tobacco products. This is welcome and recognises that tobacco is a uniquely lethal product which kills up to 2 in 3 long term users when used as intended.

Very few people start smoking after they are 21, with 4 in 5 starting before the age of 20, mostly as children.[20] The only way to make smoking history is to stop people starting in the first place. Young women are most likely to smoke during pregnancy, with 31% of those aged 18-19 smoking compared to 8.6% of those aged 30-34.[21] Raising the age of sale will have a rapid impact on the youngest maternities, most likely to be from disadvantaged circumstances, with the impact growing over time.

When the age of sale was increased from 16 to 18 in the UK[22] and from 18 to 21 in the US[23], rates of smoking in the impacted groups fell by around a third. It is expected that progressively raising the age of sale would have a similar or greater impact.

It is estimated that raising the age of sale could reduce rates of smoking by at least a third among the impacted age group. Around 7,000 women aged 19 and under are currently recorded as smokers at their antenatal booking appointment each year. Raising the age of sale could therefore mean that by 2028 around 2,300 fewer women are smoking at the start of their pregnancy. The impact of this measure will grow over time as an increasing proportion of maternities are among the cohort impacted by the rising age of sale. Since around 30,000 pregnant women aged 24 and under are currently recorded as smokers, by 2033, this could mean around 10,000 fewer women are smoking at the start of their pregnancy compared to rates today. This measure will therefore play a pivotal role in creating a smokefree generation and delivering a smokefree start for every child.

Young women are also the most likely to be exposed to secondhand smoke by their partners, with 20% of young men (aged 18-34) smoking in 2019, compared to 15.7% of men overall.[24] Reducing smoking among young men should also help to protect women from secondhand smoke and make it more likely that the next generation grow up in a smokefree home.

It is therefore vital that legislation to raise the age of sale is passed into law during the current Parliament. A similar proposal has recently been abandoned by the new coalition Government in New Zealand, an example of short-term political concerns taking precedence over long-term savings and human lives. However, this presents England and the other UK nations with an opportunity to cement their role as world leaders in tobacco control by passing legislation to create the first smokefree generation. We urge the Government to seize it.

2. **Introduce a 'polluter pays' levy on tobacco manufacturers to raise funding for the measures needed to deliver a smokefree start for every child.**

Women who grow up in households and communities where smoking is the norm are much more likely to smoke themselves and go on to smoke during pregnancy. Until this is addressed, maternity and stop smoking services will face an uphill battle to support pregnant smokers to quit and stay smokefree long-term. Addressing this will require a comprehensive tobacco control programme to reduce smoking rates in the most disadvantaged communities with the highest rates of smoking. More funding is also needed to ensure bespoke support is in place for the most vulnerable women, particularly those with mental health and substance use issues.

The funding for this could be secured by imposing a 'polluter pays' levy on tobacco manufacturers who created the smoking epidemic and continue to make record profits – around £900 million a year in the UK alone – by selling a product which kills two in three people when used as intended by the manufacturer. A levy implemented alongside profit controls on tobacco manufacturers could raise around £700 million a year for tobacco control and health promotion activity without changing the price to the consumer.[25] This proposal has overwhelming public support, with 76% of adults in England in favour, compared to only 7% against.[26]

3. **Fully implement the national financial incentive scheme and commit to extending the scheme beyond 2024.**

The Challenge Group has welcomed the Government's announcement that all pregnant women who smoke will be offered financial incentives in the form of vouchers alongside behavioural support by the end of 2024. This bold proposal has the potential to accelerate progress towards a smokefree start for every child.

However, currently the scheme is only funded until the end of 2024 which risks creating significant uncertainty for services that want to offer incentives. The national scheme should be confirmed as an established part of the support package for pregnant women following the next election.

4. **Set out a new target for reducing rates of Smoking Status at Time of Delivery (SATOD) to 4% by 2030, putting England on track to deliver a smokefree start for every child before 2040.**

The Government has not achieved the ambition set out in the last Tobacco Control Plan to reduce SATOD rates to 6% or less by 2022. However, as noted above, the existence of this clear ambition has been important for driving progress. Although Government is still committed to 6%, the lack of a timeline means that this is no longer an effective target for driving national activity. There is a need for a new target to galvanise national and local activity to reduce maternal smoking rates.

In 2021 the Challenge Group called for Government to set an ambition for a smokefree start for every child by 2030. The slow decline in rates of smoking among pregnant women mean that this is no longer a realistic target. The Government should set a target of 4% of women smoking in pregnancy by 2030 to get us on track to deliver a smokefree start for every child before 2040. Progress towards a smokefree start for every child should be reviewed following implementation of the smokefree generation policy.

5. **Ensure NHS tobacco dependence treatment services for pregnant women are fully embedded and sustained long-term.**

The NHS is currently rolling out tobacco dependence treatment services for pregnant women who smoke as part of the NHS Long Term Plan (LTP). These services should be fully implemented by the end of 2023/24. Once established, this will mean that all pregnant women who smoke will be offered opt-out support to quit smoking alongside their maternity care.

Implementation has been slower than planned due to the impact of COVID but services within maternity settings have now been widely established and the maternity pathway is ahead of similar programmes in mental health and acute settings. The link between the new services and the Saving Babies Lives Care Bundle and the continued political commitment shown through the roll out of a national incentive scheme provides reasons to be optimistic that these services will be maintained as businesses as usual when the transformation period ends this financial year.

There are further opportunities to extend these services to support women to maintain quit attempts in the post-natal period and to support partners and other household members to quit.

6. **Commit to develop and fund models of care to prevent relapse to smoking postnatally.**

High rates of relapse to smoking postnatally reduce the potential benefits of intervening to support women to quit during pregnancy and increase the risk of women smoking during subsequent pregnancies and children being exposed to secondhand smoke in the home.

There is an urgent need for development and implementation of an evidence-based support offer to prevent women relapsing to smoking post- and inter-natally. Health visiting services are well placed to address this gap if provided with the right handover, training and funding to do so. Some services are also trialling innovative approaches to prevent relapse, such as digital offers of support.

Supporting recommendations

7. Commit to support and evaluate pathfinder areas for interventions to address smoking among fathers, partners and other high prevalence groups and communities. This should include interventions in specific settings such as neonatal intensive care units where parents are likely to have above-average smoking rates.

8. Implement and build on the recommendations in the ASH/Challenge Group 2017 report on maternity workforce training:
    - Ensure that all midwives and obstetricians receive dedicated training and assessment on supporting women to stop smoking during pregnancy at an undergraduate and postgraduate level.
    - Align training to current policy drivers (e.g. NHS Long Term Plan and Saving Babies' Lives Care Bundle version 3) to ensure continuous learning and all interventions are covered to meet process and outcome indicators.
    - Training should include appropriate care pathways, discussion around safety incidents and the need for maternity care providers to review and update smoking status throughout pregnancy to ensure individualised care is offered.
    - Set out a strategy to ensure that high quality, evidence-based, regular training is available for relevant professionals, specifically midwives, obstetricians, GPs, and health visitors. For example, through a 'training the trainer' programme implemented across the system.
    - Ensure that maternity professionals receive dedicated training to equip them to deliver evidence-based advice about nicotine, NRT and vaping.
    - Extend training on CO monitoring and delivering VBA to all professionals working with pregnant women including GPs, midwives, obstetricians, paediatricians, health visitors, mental health service providers, and professionals in children' services.
9. Ensure that all pregnant women and their partners can access 12 weeks of dual-form NRT on prescription via maternity services, stop smoking services, or primary care. This offer should be extended postnatally.
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11. Explore the possibility of engaging services which are well placed to intervene with women before they become pregnant, such as family planning and sexual health services.
12. Prioritise routine publication of data on Smoking Status at the Time of Booking (SATOB) and smoking status at 36-weeks.

Suggested citation

Action on Smoking and Health & the Smoking in Pregnancy Challenge Group. A manifesto for smokefree beginnings. December 2023

References

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