Action on Smoking and Health – Written evidence (PRT0077)

This consultation response is on behalf of Action on Smoking and Health (ASH).

ASH is an independent public health charity set up by the Royal College of Physicians in 1971 to advocate for evidence-based policy measures to reduce the harm caused by tobacco. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK.

Disclaimer: Action on Smoking and Health (ASH) has no past or current, direct or indirect links to, or funding from, the tobacco industry.

Introduction

Smoking is one of the leading modifiable risk factors for a range of poor maternal outcomes including preterm birth, with smoking during pregnancy increasing the risk of preterm birth by 27% according to analysis done by the Royal College of Physicians.[i] Reducing rates of smoking before, during and between pregnancies is one of the most effective interventions for reducing the number of preterm births.

Variation in care and health inequalities

The ethnic and socioeconomic inequalities seen in relation to preterm birth and how these could be reduced.

The highest rates of smoking during pregnancy are among young women from the most deprived backgrounds. Booking data from 2018/19 shows that smoking rates among women in the most deprived decile are over five times greater than those in the least deprived decile (24% and 4.3% respectively), with a clear gradient across the deciles. This disparity is clearly visible geographically, with women from the most deprived areas

much more likely to smoke than those in the least deprived. For example, 19.4% of women in Blackpool were smokers at the time of delivery in 2022/23 compared to 3.4% of those in Westminster.[ii] High rates of smoking among younger, more deprived women correspond with significantly higher rates of infant mortality than in the general population.

Additionally, mothers from lower socioeconomic backgrounds are significantly more likely to have babies born preterm and have higher rates of preterm infant mortality compared to mothers from higher socioeconomic backgrounds.[iii] [iv] Evidence suggests that smoking is an important contributor for both of these outcomes.

Prevention

Primary prevention and treatment for preterm birth.

Reducing rates of smoking before, during and between pregnancies is one of the most effective interventions for preventing preterm birth. Major progress has been made in reducing maternal smoking over the last decade, but rates are still too high with 8.8% of women smoking during pregnancy in 2022/23.

ASH and the Smoking in Pregnancy Challenge Group – a coalition of health and baby charities working to reduce maternal smoking – have published a set of recommendations for reducing maternal smoking rates.[v]

1. **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.

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

We have 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 2024/25 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.

3. **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, 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. 16. 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.

4. **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. It is vital that these services are fully embedded and 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.

5. **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.

6. **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 (NICUs) where parents are likely to have above-average smoking rates. Although we don't have national data on smoking rates among parents of babies in NICUs, one study involving 32 parents found that 31% were current smokers and 28% were recent ex-smokers (quit during pregnancy).[vi] This is far higher than the average smoking rates in the population. Therefore, NICUs may present viable setting for interventions to support new parents to quit smoking, particularly given that parents of babies born preterm are likely to be disproportionately represented in the NICU. 47% (15) of parents in the study stated that they would welcome smoking cessation support during the NICU stay.

Further recommendations

- Improve the quality and consistency of training offered to midwives, obstetricians and other maternity professionals on supporting women to stop smoking during pregnancy at an undergraduate and postgraduate level.
- Ensure that all pregnant women and their partners can access 12 weeks of dualform NRT on prescription via maternity services, stop

smoking services, or primary care. This offer should be extended postnatally.

- 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.

27 March 2024

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[i] RCP. Hiding in plain sight: treating tobacco dependency in the NHS, 2018
[ii] NHS Digital. Statistics on Women's Smoking Status at Time of Delivery: England.
[iii] McHale P, Maudsley G, Pennington A, Schlüter DK, Barr B, Paranjothy S, Taylor-Robinson D. Mediators of socioeconomic inequalities in preterm birth: a systematic review. BMC Public Health. 2022 Jun 7;22(1):1134.
[iv] Venkatesan T, Rees P, Gardiner J, Battersby C, Purkayastha M, Gale C, Sutcliffe AG. National trends in preterm infant mortality in the United States by race and socioeconomic status, 1995-2020. JAMA pediatrics. 2023 Oct 1;177(10):1085-95.
[v] Action on Smoking and Health & the Smoking in Pregnancy Challenge Group. A manifesto for smokefree beginnings. December 2023
[vi] Nichols A, Clarke P, Notley C. Parental smoking and support in the NICU. Archives of Disease in Childhood-Fetal and Neonatal Edition. 2019 May 1;104(3):F342-.