Smoking in Pregnancy Challenge Group response to Health and Social Care Select Committee: Safety of maternity services in England

About the Smoking in Pregnancy Challenge Group

The Smoking in Pregnancy Challenge Group is coalition of organisations working to reduce rates of smoking in pregnancy. The membership includes Royal Colleges, third sector organisations and academia.

It was established in 2012 in response to a challenge from the then Public Health Minister to produce recommendations on how the smoking in pregnancy ambition contained in the Government's tobacco strategy could be realised. It presented its first report and recommendations in June 2013 and continues to meet annually to review progress.

The Groups' latest report: Review of the Challenge (2018), contains further recommendations for reducing rates of smoking during pregnancy. The Challenge Group is working on a further report into the reasons for the stagnation in the decline of smoking during pregnancy to be published later this year, which we will be happy to share with the Committee.

Introduction

1. 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, smoking or exposure to secondhand smoke during pregnancy is the leading modifiable risk factor for poor birth outcomes, including stillbirth, miscarriage and pre-term birth.

2. Smoking during pregnancy also increases the risk of children developing a number of respiratory conditions, attention and hyperactivity difficulties, learning difficulties, problems of the ear, nose and throat, obesity and diabetes.[1,2,3,4,5,6,7,8,9,10]

3. As well as human costs, there are financial ones. In 2015/16, it was estimated that maternal smoking during pregnancy cost over £20 million through 10,032 episodes of admitted patient care.[11]

4. Given these impacts, reducing rates of smoking in pregnancy is essential to improving safety during pregnancy and achieving the Government's ambition to halve rates of stillbirth and neonatal death by 2025.[12]

5. The Challenge Group welcomed the Government's ambition to reduce rates of smoking at time of delivery (SATOD) to 6% or less by 2022.[13] If this ambition is achieved, analysis shows that in 2022 this would mean that around 30,000 fewer women smoking in pregnancy compared to 2017/18.[14] 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

6. However, SATOD rates have plateaued since 2015, hovering at slightly below 11% nationally.[15] To hit the 6% ambition, from the 2019/20 SATOD rate of 10.4%, would require a rate of decline of roughly 2.2percentage points a year until 2022.[15]

7. Inconsistent implementation of guidance from the National Institute for Health and Care Excellence (NICE)[16,17] and NHS England,[18] is a key factor in this lack of progress on reducing smoking during pregnancy.

8. To help address this, NHS England must ensure comprehensive implementation of the NHS Long Term Plan commitment to introducing an NHS funded smokefree pregnancy pathway for women and their partners including tailored support sessions and treatment.[19] Clear, measurable outcomes must be set to assess trust implementation of this pathway and ensure the Long Term Plan commitment delivers as intended.

9. Additionally, training in the knowledge and skills to address smoking in pregnancy should be a mandatory part of in-service training for midwives and recommended to the wider maternity workforce within NHS Trusts, including ensuring all practitioners involved in continuity of carer have the knowledge and skills to support reductions in smoking during pregnancy.

What the impact has been of the work which has already taken place aimed at improving maternity safety, and the extent to which the recommendations of past work on maternity safety by Trusts, Government and its arm's-length bodies, and reviews of previous maternity safety incidents, are being consistently and rigorously implemented across the country;

10. NICE guidance on smoking in pregnancy has been in place since 2010. Following the Government's 2014 announcement to reduce rates of stillbirth by 50% by 2025, NHS England introduced the Saving Babies' Lives Care Bundle (SBLCB). While the roll out of the Saving Babies Lives' Care Bundle has supported implementation of NICE guidance, there remains inconsistency.

11. Element 1 of the Care Bundle focuses on reducing smoking and set out key recommendations for maternity services including that:
    a. Smoking status of all women must be recorded at their booking appointment.
    b. All women should have their Carbon Monoxide (CO) level monitored at their booking appointment, enabling biological verification of smoking status.
    c. All identified smokers should be referred on an opt out basis to specialist stop smoking support.

12. Analysis of the Maternity Services Dataset shows that in the calendar year 2017, smoking status was recorded at the booking appointment in 87.8% of pregnancies.[20] Women living in more deprived communities and younger women, especially those under 24, had the highest rates of smoking which is consistent with wider demographic information on smoking prevalence.19

13. A full evaluation of SBLCB implementation across 19 trusts found inconsistent implementation of Element 1. While acceptance of CO monitoring was high among women it was only delivered in 70% of booking appointments. Further, of identified smokers, 40% were not referred to a stop smoking service demonstrating clear gaps in implementation of this guidance.[21]

14. The evaluation also highlighted big variations in practice between trusts. Of the 19 trusts included, nine always referred smokers to stop smoking support on an opt out

basis, while seven never or infrequently made referrals.[20] This variation significantly undermines activity to reduce rates of stillbirth and neonatal death.

15. An update to the Care Bundle – Saving Babies' Lives Care Bundle V2 – published in 2019,[22] expanded on the original requirements of Element 1 to include CO monitoring of all women at their 36 week midwifery appointment, additional CO monitoring as appropriate throughout pregnancy and specifically requires maternity staff to be trained to carry out CO monitoring and deliver Very Brief Advice (VBA) on smoking. However, while there has been progress, the variation in practice identified in the original evaluation has continued.

16. Evidence is clear that systematic implementation of this guidance across trusts would deliver greater declines in smoking during pregnancy. For example, in the North East an evaluation of the BabyClear programme which involved systematic implementation of these practices across eight acute trusts and 12 local authorities increased referrals to stop smoking support by 2.5 times and the proportion of women quitting by delivery nearly doubled. Babies of mothers who had quit smoking by delivery had a significantly higher birth weight compared to babies born to women who smoked throughout pregnancy, equivalent to 210g at 40 weeks.[23] This demonstrates the immediate returns on investment from comprehensive implementation of this national guidance.

17. The NHS Long Term Plan commitment to an NHS funded smokefree pregnancy pathway for women and their partners, including tailored support sessions and treatment,[19] should help address current inconsistencies. However, NHS England must ensure that clear, measurable standards are in place for delivery, ensuring funding cannot be diverted from this and enabling assessment of trust's delivery against this commitment. While progress has understandably slowed due to COVID-19, it is now essential for work to progress, including commencement of this pathway in early adopter trusts due to be in place this financial year.

How effective the training and support offered to maternity staff is, and what improvements could be made to them to improve the safety of maternity services.

18. All midwives and obstetricians should be trained so that they:
    - have the knowledge and skills to undertake practical action to address smoking, such as CO monitoring and referral to stop smoking services;
    - are able to have a brief and meaningful conversation to increase the likelihood women will quit smoking (very brief advice).

19. Training maternity staff to conduct CO monitoring and deliver VBA to pregnant women is a requirement of the SBLCB v2 and essential to ensuring that women are effectively encouraged and supported to quit. This training should be consistently delivered through both undergraduate and post-graduate, and workplace training to ensure women receive consistent messages from healthcare professionals.

20. However, a Challenge Group report on the training needs of the maternity workforce in relation to smoking that both midwives and obstetricians lack the training to engage women in meaningful conversations about their smoking and motivate them to access quit support. Addressing smoking therefore is unlikely to receive the priority it warrants as the leading modifiable risk factor for poor pregnancy outcomes.[24]

21. Knowledge of the impacts of smoking in pregnancy is taught in undergraduate midwifery and medical curricula, however this is rarely assessed and skills training, equipping maternity professionals to deliver interventions such as VBA, is not being effectively taught.

22. This lack of skills training to practically addressing smoking, was identified in professional focus groups as a clear barrier to effectively supporting women. For example: *"Like I don't know what carbon monoxide levels mean. I don't know whether that's bad or good…" Obstetric Registrar.*[23]

23. Medical and midwifery schools should address these gaps in training, to ensure these skills are both taught and assessed. Professional organisations, including the Royal College of Obstetricians and Gynaecologists should include assessment of knowledge and skills on addressing smoking during pregnancy in clinical examinations and look to accredit smoking in pregnancy training materials as part of continuing professional development.

24. In the workplace, NHS Trusts must provide training for maternity staff including skills training such as CO monitoring and referral to stop smoking support, alongside simple behaviour change techniques such as VBA.

25. In addition to the training curricula and opportunities available, workplace barriers are preventing maternity professionals from developing their knowledge and skills. Focus groups with midwives highlighted that reductions in mandated study days, insufficient staffing levels to cover study days and the costs of training were barriers which NHS trusts should address amongst their staff.[23]

26. Local Maternity Systems should look to address these institutional barriers across all local maternity services and collaborate with trusts and local stop smoking services to ensure that high quality, regular training is available and time for staff to complete this training is protected. Particular consideration should be given to mandatory in-service training for midwives, and for professionals delivering the continuity of carer programme who are working with vulnerable women with the highest smoking rates.

The role and work of the Healthcare Safety Investigation Branch in improving the safety of maternity services, and the adequacy and appropriateness of the collection and analysis of data on maternity safety.

27. SATOD is currently the only regularly reported national indicator of smoking during pregnancy. However, given the time of collection, it is a poor indicator of a woman's smoking behaviour throughout pregnancy and evidence suggests it does not provide robust data on prevalence, with 2019/20 data showing that recording of 'unknown' smoking status varied between CCGs from 0.1% to 36% unknown smoking status.[15]

28. Additionally, SATOD is inadequate for supporting improvements in service delivery as it provides no baseline against which to evaluate the impact of interventions delivered during pregnancy. The current lack of demographic data is a further limitation of SATOD, preventing systematic identification of population sub-groups where rates of smoking during pregnancy remain high which could enable targeting of additional support.

29. The Challenge Group therefore welcomed the commitment in the 2017 Tobacco Control Plan that: *"NHS England will include the recording of the outcome of Carbon*

Monoxide screening within the Maternity Services Dataset (MSDS), which is the standard record of maternity care to accurately measure actual smoking behaviour beyond self-reporting bias"[25] as this would tie smoking status to full maternity records enabling comparison of smoking status from booking to 36 weeks and delivery. This comparison is essential to evaluating the impact of work done to support women to quit during pregnancy and identifying trusts which may need more support to fully implement SBLCB. The MSDS would also provide demographic data enabling targeting of support services for women in high prevalence groups.

30. However, while progress is being made on data collection, this remains inconsistent between trusts. The welcome commitment in the NHS Long Term Plan to provide NHS funded specialist stop smoking support to pregnant women and their partners would benefit from robust data demonstrating the effectiveness of these interventions for reduce smoking during pregnancy.

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