JOINT STRATEGIC NEEDS ASSESSMENT 2015/16

CHILDREN AND YOUNG PEOPLE
(STARTING WELL AND DEVELOPING WELL)

CHAPTER: Preconception and Pregnancy

TOPIC: Smoking in Pregnancy and at Time of Delivery

Why is this important?

Smoking in pregnancy is a cause of ill health for the mother and baby and is the single biggest modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health.

Life Stage	Additional Burden
Prenatal	More complications in pregnancy and at birth Increased likelihood of miscarriage Increased likelihood of still birth
Postnatal	Increased risk of preterm and low birth weight babies Increased risk of Sudden Infant Death Syndrome (SIDS)
Infancy	Slower rates of development Increased likelihood of illness
Childhood	Increased likelihood of lower educational attainment Increased likelihood of illness
Adolescence	Increased likelihood of becoming a smoker
Early Adulthood	More likely to smoke during pregnancy
Later Adulthood	More likely to need health and social care services early.

(Smoking in Pregnancy Challenge Group, October 2015)

Smoking in pregnancy accounts for:
- 5 to 8% of premature births
- 13 to 19% of cases of low birth weight in babies carried to full term
- 5 to 7% of preterm-related deaths
- 23 to 34% of sudden unexpected deaths in infancy (SUDI)

(Dietz PM, England LJ, Shapiro-Mendoza CK Ton VT et al. Infant morbidity and mortality attributable to prenatal smoking in the U.S. *American Journal of Preventative Medicine* Published online June 8, 2010)

Children of mothers who smoked in pregnancy are at increased risk of:
- infant mortality
- congenital malformations
- a number of respiratory conditions
- attention and hyperactivity difficulties
- learning difficulties
- problems of the ear, nose and throat

(The Royal College of Physicians (2010) Passive smoking and children: A report by the Tobacco Advisory Group)

Failure to prevent smoking in pregnancy results in increased costs throughout the system from before a child is born and for the rest of his/her life.

Smoking In Pregnancy Challenge Group, Smoking Cessation in Pregnancy, a Review of the Challenge. October 2015
http://www.ash.org.uk/files/documents/ASH_979.pdf

Treating mothers and their babies (0-12 months) with problems caused by smoking during pregnancy is estimated to cost the NHS between £20 million and £87.5 million each year (Godfrey C. et al., Estimating the costs to the NHS of smoking in pregnancy for pregnancy women and infants, 2010. York: Dept. of Health Sciences, The University of York).

Smoking in pregnancy accounts for 5% to 8% of preterm births. The consequences of being born preterm can be substantial and include a range of physical, neurodevelopmental and behavioural sequelae. The Chief Medical Officer's recent report estimated the wider societal costs of preterm birth including health and social care, education and parental expenses and loss of productivity to be £51,656 per child. Using this estimate the **wider societal cost** of smoking in pregnancy in Greater Manchester contributing to preterm births is estimated between **£6.7 and £10.7 million**. (Annual Report of the Chief Medical Officer 2012 (2013) *Our children deserve better: Prevention pays).*

"Smoking at the time of delivery" is a key performance indicator in the Public Health Outcomes Framework. The Tobacco Control Plan for England (2011), *Healthy Lives, Healthy People*, stated that nationally, we should aim to reduce smoking in pregnancy and smoking at the time of delivery, from 14% to 11% by 2015. The data below shows that nationally, and in Manchester, we have been unable to achieve this so far. The current tobacco plan comes to an end in 2015 and a new strategy is planned. Manchester must take its direction from the new Tobacco Control Plan, further refined by local data and local priorities.

The Manchester Picture

Smoking in pregnancy
Smoking and smoking in pregnancy follows a social gradient and is therefore more common in areas of higher deprivation. Manchester is likely to have a higher number of mothers who smoke during pregnancy because there are a higher number of young mothers – in 2013 Manchester had 21.4 per 1,000 mothers who were aged below 20 compared to a rate of 19.3 for the North West and 17.4 for England (Office for National Statistics).

The Infant Feeding Survey 2010 captured information on smoking during

pregnancy as part of the survey.
http://www.hscic.gov.uk/catalogue/PUB08694/Infant-Feeding-Survey-2010-Consolidated-Report.pdf

Three categories of smoking behaviour were used in the report as follows:

Smoking before or during pregnancy is the percentage of women who smoked at all in the two years before they completed Stage 1 of the survey. This roughly covers the period of their pregnancy plus the year before conception.

Smoking throughout pregnancy is the percentage of women who smoked in the two years before they completed Stage 1 of the survey, and who were smoking at the time of their baby's birth. It included women who may have given up smoking before or during their pregnancy, but who had restarted before the birth.

Gave up smoking before or during pregnancy is the percentage of women who smoked in the two years before they completed Stage 1 of the survey and who gave up during this period and had not restarted before the birth of the baby.

The Infant Feeding Survey showed that in 2010, around a quarter of mothers (26%) in the UK smoked in the 12 months before or during their pregnancy, which was down from a third (33%) in 2005. Lower levels of smoking were seen in all countries in the UK.

12% of mothers continued to smoke throughout their pregnancy, down from 17% in 2005. Of mothers who smoked before or during their pregnancy, over half (54%) gave up at some point before the birth.

The highest levels of smoking before or during pregnancy were found among mothers in routine and manual occupations (40%) and among those aged under 20 (57%).

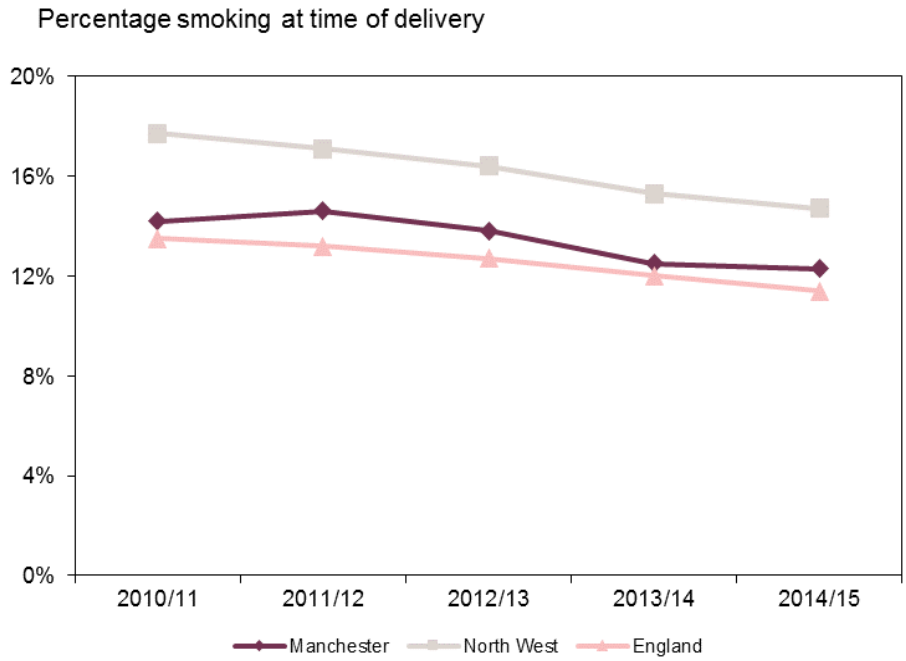
Mothers aged under 20 were also the least likely to have given up smoking at some point before or during pregnancy (38%), but by socio-economic group, mothers who had never worked were the least likely to have done so (29%). Almost nine in ten mothers (88%) who were smoking before or during pregnancy received some type of information on smoking. Midwives were the most common source of information, mentioned by 85% of mothers who had received information.

Almost a third of mothers (32%) lived in a household where at least one person smoked during their pregnancy, including just under one in five (19%) where only other people smoked (not the mother herself).
At Stages 2 and 3 (when babies were around four to six months old and eight to ten months old respectively), three per cent of infants lived in a household where at least one person ever smoked in the home.

Smoking at the time of delivery

Since 2010, the percentage of women smoking at the time of delivery has been decreasing year on year in Manchester. This follows the North West and national trends.
In 2014/15, 12.3% of Manchester mothers were smokers at the time of delivery, compared to 14.7% for the North West and 11.4% for England.

Smoking at time of delivery	Manchester	North West	England
2010/11	14.20%	17.70%	13.50%
2011/12	14.60%	17.10%	13.20%
2012/13	13.80%	16.40%	12.70%
2013/14	12.50%	15.30%	12.00%
2014/15	12.30%	14.70%	11.40%
Source: Fingertips			



Source: Calculated by KIT East from the HSCIC return on Smoking Status At Time of delivery, 2015

HSCIC data shows smoking status at the time of delivery by Clinical Commissioning Group (CCG). In 2014/15, the percentage of mothers smoking at the time of delivery is higher in North Manchester (16.9%) and South Manchester (13.5%) CCGs than in Central Manchester CCG (6.9%).
http://www.hscic.gov.uk/catalogue/PUB17668

Smoking status at time of delivery, by Commissioning Region, Area Team and Clinical Commissioning Group (CCG), Annual 2014/15

CCG Area	Number of maternities	% smoking at time of delivery
North Manchester	3046	16.9%
Central Manchester	3059	6.9%
South Manchester	2185	13.5%

What would we like to achieve?

The Tobacco Control Plan for England (Healthy Lives, Healthy People March 2011) set three national ambitions around tobacco control and one of these relates to smoking in pregnancy.
https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england

"To reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015."

The Smoking in Pregnancy Challenge Group has advocated for continued action on this target and has recommended a more ambitious target of 6% that Manchester would also want to work towards.

Smoking in Pregnancy Challenge Group, Smoking Cessation in Pregnancy, A Call to Action, 2013
http://www.ash.org.uk/pregnancy2013

Manchester would work towards achieving this, in addition to implementing recommendations made by the National Institute for Health and Care Excellence (detailed below) for addressing the issue of smoking during pregnancy (PH26).

The Healthy Child Programme (Department of Health 2009) sets out universal standards to support local delivery encompassing smoking status of either parent. It advises that family members who smoke should be referred into specialist services and encouraged to provide smoke-free environments.

In Manchester all the tobacco control work is under review and actions will be developed following a review of current activity and systems in place. Partnership working will be needed to tackle smoking in pregnancy and second hand smoke.

A key action for Manchester will be to ensure there is robust collection of data that includes CO testing, smoking status at booking in for antenatal care and smoking at the time of delivery.

Consideration will be given as to how to support midwives to better advise and support pregnant smokers to stop smoking, how we can encourage more teenage pregnant smokers to give up smoking and how we can work closely with local children's centres to offer stop smoking support within children's centres.

The National Institute for Health and Clinical Excellence (NICE PH26 2010) released updated guidance on "Quitting smoking in pregnancy and following childbirth."

Smoking: stopping in pregnancy and after childbirth NICE guidelines [PH26] Published date: June 2010 https://www.nice.org.uk/guidance/ph26

The recommendations within this document will be considered as part of the review into provision of services in Manchester.

NICE Recommendations include:

- Identifying pregnant women who smoke and referring them to Stop Smoking Services. This is aimed at midwifery and includes biomechanically measuring levels of carbon monoxide in all pregnant women and referring those who smoke to services.

- All other health and social care professionals, such as GPs, health visitors, sonographers and youth workers should identify pregnant women who smoke and refer them to Stop Smoking Services.

- Stop Smoking Services to contact all women by phone and attempting to see those whose contact was not possible at key maternity appointments. It also recommends offering appointments at other venues, including home visits. There are also recommendations on how to relay information to pregnant women on the phone.

- Provide initial on-going support including the provision of interventions throughout pregnancy and after delivery. It recommends the use of Carbon monoxide testing and the provision of support to women who recently quit, including the use of Nicotine Replacement Therapy when needed.

- Ensure services meet the needs of disadvantaged pregnant women who smoke, including collaboration with agencies who support women with complex needs, such as substance misuse services, teenage pregnancy support and mental health services.

- Ensure partners and others, related to pregnant women, who smoke, are offered stop smoking support and advice on passive smoking.

- Training should be provided to relevant professionals on delivering stop smoking interventions to pregnant women, namely midwives. All other relevant professionals should be trained on how to deliver brief interventions to initiate a referral to stop smoking services

- Midwives to continue assessment and reporting of smoking status by contact with pregnant smokers within clinics and home visits.

What do we need to do to achieve this?

Manchester will need to work closely with partners in all sectors to drive a plan of activity that considers the recommendations made by the National Institute for Health and Care Excellence, and results in fewer women smoking while they are pregnant. We are currently reviewing our tobacco control work in

Manchester and a refreshed and innovative strategy will be launched in 2016. The reduction of smoking in pregnancy will remain a priority area of work.

What are we currently doing?

We are currently working with partners in Public Health England and Greater Manchester to shape the future tobacco control strategy for Manchester. A team of staff will deliver some targeted community health promotion across the city between January and March 2016. Wellbeing Services are being redesigned and the smoking cessation offer within that will be redefined.

All three Manchester hospital maternity services have received public health funding to support women to stop smoking to during this period of review of tobacco control work in Manchester.

Community and Stakeholder Views

Community and stakeholder views were sought as part of the council's public budget consultation in 2014/15. We will need to continue to work closely with partners to develop our new ways of working.

References and Links

(within document)

Other JSNA Topics that this links to

Infant mortality

Maternity – Antenatal Care / Pregnancy / Postnatal Care

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Date of latest version: