



Smokefree Skills:  
An assessment of maternity workforce training

## Foreword

Time and again as this report was developed, stakeholders, midwives, obstetricians and others would agree that the issue of smoking in pregnancy was extremely important. The oft repeated phrase was that this importance “goes without saying”. This, it seems, is the crux of the problem.

Smoking in pregnancy causes unnecessary stillbirth and sudden infant deaths. It impacts on a baby’s development in the womb meaning that they are more likely to be born underweight or at risk of other health problems. This report has found that health professionals know all of this. They are taught this at midwifery and medical schools and see the impact in their clinical practice. What they find less clear is how they could, or should, be helping individual women with the problem.

Midwives are clear they are not shying from this conversation because it is too confronting or awkward for them, but because they simply do not know what advice they should provide. Many obstetricians are unsure what their role is altogether. There is a myth among these professionals that they are expected to deliver complicated, lengthy support to a woman to quit smoking. But NICE guidance is clear that there are a few straightforward things they need to do:

- Ask and record smoking status, verifying it with a carbon monoxide monitor
- Advise women briefly about the importance of quitting
- Act to refer them to quit services

Where professionals are trained to deliver this short conversation with women in a way that motivates them to seek help or quit on their own, they can have a positive impact on the health of mothers and babies both now and long into the future.

It is that simple, but so important. Without well trained staff who understand not only the harms from smoking but how to communicate these to women, then it will be an uphill battle to bring the rates of smoking in pregnancy in this country down further.

This report makes clear that the importance of smoking in pregnancy cannot ‘go without saying’. This means embedding training of these skills into undergraduate curricula and examinations, and following this up with regular post-graduate training.

Of course, training and skills are only one part of the story, and as we seek to make sure that all our maternity staff are able to fulfil their role we must continue to ensure that the systems are in place to support them; from appropriate recording systems and monitoring equipment through to the quit services that women need to be referred to.

However, if we can get these first conversations right with pregnant women, if we can ensure that from the time they seek care in their pregnancy to the time they give birth, and beyond, every professional provides the same measured advice, we will be on the way.



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## Executive summary

### Overview

This report has been produced by Action on Smoking and Health (ASH) in collaboration with the Smoking in Pregnancy Challenge Group. It seeks to identify the current barriers to full training of the maternity workforce to enable them to deliver NICE guidance on smoking in pregnancy and sets out recommendations for change.

The findings and recommendations have been informed by the insights of stakeholders from Government, the voluntary sector, and professional groups, an overview of existing research, focus groups, and a national survey of midwives and obstetricians. [For comprehensive details of the findings please see the full report.](#)

While many of the findings may be relevant to other UK nations, the assessment and recommendations relate to midwives and obstetricians in England.

### Key findings

#### Importance of a trained workforce

- Smoking is the leading modifiable risk factor for poor pregnancy outcomes and addressing it is a national priority for maternity services.
- All health care professionals who come into contact with pregnant women who smoke have a role to play in addressing smoking, but they must be supported through appropriate training.

#### Existing training

- There is a common assumption among key stakeholders that knowledge and skills to address smoking are embedded in both training and practice of health professionals. They are not. As such, addressing smoking is unlikely to receive the priority it warrants as the leading modifiable risk factor for poor pregnancy outcomes.
- Many midwives and obstetricians do not feel they have adequate training or knowledge to address smoking in pregnancy. While most obstetricians and midwives have received training on the harms of smoking at some point, practical skills, such as delivering simple behaviour change techniques and very brief advice, are not being effectively taught.
- While training relating to smoking in pregnancy does feature in undergraduate midwifery and medical syllabuses, knowledge gained is rarely tested in assessments. Medical curricula often fail to include practical action necessary to address smoking.
- Publication of NICE guidance alone is not sufficient to bring about change. Guidance, with associated actions, needs to be communicated through training.

#### National mandating of training

- There is currently limited scope for mandating training in undergraduate curricula and in training of postgraduate/post-registration workforce. There are a number of relevant national initiatives and upcoming reviews of curricula, training, and standards for undergraduates and postgraduates which could be levers to achieve change.

## **Local barriers**

- While training to address smoking in pregnancy could lead to long term resource savings, existing pressures on staff time are reducing opportunities for training.
- There is confusion surrounding the actions required to address smoking by health professionals. Midwives and obstetricians are deterred from addressing smoking due to the mistaken belief that in doing so, they are then expected to support a woman through her quit attempt. In actuality, professionals are only expected to administer carbon monoxide (CO) monitoring, deliver very brief advice, and make a referral for specialist support.
- Many midwives and obstetricians see addressing smoking as an issue only for midwives, however all professionals need to reinforce and ensure consistency of messages, and deliver very brief advice to maximise the chances of engagement with specialist services and of positive outcomes.

## **Facilitators to training**

- There is a clear appetite for training amongst both midwives and obstetricians. Professionals are keen to improve their skills particularly in relation to practical actions to take when encountering a pregnant woman who smokes.
- Most professionals see their current employer as key to providing training and believe training should be delivered through protected time at work and not in their own time.
- A variety of methods for training appear to be acceptable to midwives and obstetricians to address smoking. Consideration needs to be given to methods beyond e-learning modules as these will not suit all professionals or contexts.

## **Recommendations**

### **Training requirements**

- All midwives and obstetricians should be trained so that they:
  - o have the knowledge and skills to undertake practical action to address smoking, such as CO monitoring and referral to smoking cessation services;
  - o are able to have a brief and meaningful conversation to increase the likelihood of a positive outcome.
- Training should reach all midwifery and obstetric staff so that they can provide a consistent message for women.
- Training should be embedded in both the undergraduate and postgraduate setting.

### **Nursing and Midwifery Council**

1. Include reference to knowledge and skills for addressing smoking in pregnancy in the new pre-registration standards for midwives which are currently under development, and any post-registration standards that may come into effect in future.

## **General Medical Council**

2. Include elements related to addressing smoking, as the leading modifiable risk factor for morbidity and mortality, in the Medical Licensing Assessment.

## **NHS England/Public Health England**

3. Ensure that training related to addressing smoking in pregnancy is promoted at a national level in particular, through current mechanisms such as the Maternity Transformation Programme.
4. Take action to promote effective local pathways and support local co-ordination for addressing smoking in pregnancy that include appropriate training of local maternity staff by NHS Trusts. The Local Maternity Systems may be an effective facilitator for this activity.
5. Develop a short training resource, for example a video, that can be circulated to trusts for inclusion in mandatory in-service training for midwives, induction for rotating medical staff and during multi-professional training events, as a baseline for all staff that can be supplemented with other methods as necessary.
6. Participate in the consultations for current and upcoming reviews pertinent to training of the maternity workforce and ensure that the importance of training to address smoking in pregnancy is highlighted.
7. Explore the current and potential role of other relevant health professionals who provide care for pregnant women, such as maternity support workers, health visitors, nursery nurses, ultrasonographers and family nurse practitioners, and the scope for improving any training for them to address smoking in pregnancy.
8. Work with NHS Trusts to ensure that up to date resources are made available to front line staff on options for pregnant women who smoke including e-cigarettes, for example the resources produced by the Smoking in Pregnancy Challenge Group.

## **Royal College of Midwives**

9. Continue to promote training related to smoking in pregnancy, such as the i-learn module Very Brief Advice on Smoking for Pregnant Women, to membership.
10. Via workforce representatives, monitor the level of support midwives are obtaining to address smoking in pregnancy and advocate for optimising this support.
11. Participate in the consultations for current and upcoming reviews pertinent to training of the maternity workforce and ensure that the importance of training to address smoking in pregnancy is highlighted.

## **Royal College of Obstetricians and Gynaecologists**

12. Include training to address smoking in pregnancy in the specialty training curriculum which is currently being reviewed.
13. Include assessment of knowledge and skills related to addressing smoking in pregnancy in the Objective Structured Clinical Exam for the MRCOG.

14. Consider a training resource, either using novel or available resources, to support learning and ensure that the obstetric workforce outside of specialty training can access training related to addressing smoking in pregnancy.
15. Explore CPD accreditation for any learning resources related to addressing smoking in pregnancy.
16. Participate in the consultations for current and upcoming reviews pertinent to training of the maternity workforce and ensure that the importance of training to address smoking in pregnancy is advocated.

### **Royal College of General Practitioners**

17. Continue to ensure that the current review of the training curriculum includes elements to address smoking in general, and smoking in pregnancy, wherever relevant.
18. Develop an online learning resource on addressing smoking, which includes smoking in pregnancy.
19. Explore the role of examination in relation to assessment of knowledge and skills related to addressing smoking, including smoking in pregnancy.

### **Midwifery schools**

20. Embed training to address smoking in pregnancy in undergraduate curricula.
21. Continue to include theoretical knowledge related to smoking in pregnancy, as well as practical aspects such as CO monitoring and referral for stop smoking support. Ensure that behaviour change techniques such as motivational interviewing and very brief advice are included to connect the two in a meaningful way.
22. Assess these competencies to ensure that learning has been effective.

### **Medical schools**

23. Embed training to address smoking in general in their undergraduate curricula.
24. Continue to include theoretical knowledge related to smoking in general, as well as practical aspects such as CO monitoring and referral for stop smoking support. Additionally, include behaviour change techniques such as motivational interviewing and very brief advice to connect the two in a meaningful way.
25. Ensure that implications of smoking and pregnancy are covered during Obstetrics and Gynaecology attachments.
26. Assess these competencies to ensure that learning has been effective.

### **Local organisations**

27. NHS Trusts must provide training for staff working in maternity to address smoking in pregnancy including practical aspects such as CO monitoring and referral for stop smoking support, alongside simple behaviour change techniques such as very brief advice.

28. NHS Trusts must ensure that protected training time is used for this, with particular consideration given to mandatory in-service training for midwives, induction for rotating medical staff and multidisciplinary training opportunities.
29. Clinical Commissioning Groups must commission to ensure that care pathways for pregnant women meet NICE guidance PH26 on smoking in pregnancy and after childbirth which includes training of maternity staff to an appropriate level.
30. Local authorities must work collaboratively with local NHS systems to ensure joined up provision of services for pregnant women who smoke and to promote and support the need for appropriate levels of training of maternity staff.

### **Third sector organisations**

31. The Smoking in Pregnancy Challenge Group and its members must continue to advocate for a fully trained maternity workforce with respect to addressing smoking in pregnancy.
32. Participate in the consultations for current and upcoming reviews pertinent to training of the maternity workforce.
33. Efforts could be made to make the existing NCSCT on-line training module, Very Brief Advice on Smoking for Pregnant Women, available via the NHS eLFH platform to further increase access to this resource.

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