University Hospitals Sussex
NHS Foundation Trust

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TRUST CLINICAL GUIDELINE

Maternity Smoking & Smoke Free Pregnancy

OVERVIEW

This guideline is to ensure optimal outcomes for mother and birthing parent and baby in pregnancies complicated by smoking and to act as a resource for staff caring for women and people whose needs fall within the scope of this guideline.

This guideline applies to all midwifery, maternity, obstetric, and medical staff caring for pregnant and / or postnatal women and people who currently smoke or have stopped smoking since conception.

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GUIDELINE VERSION	v1.0
RELATED POLICIES	None
RELATED DOCUMENTS	Maternity Vaping Protocol CDL 11592 Protocol for Direct Supply of NRT by Tobacco Dependency Advisors UHS-CG-0012-2023
STANDARDS	NCSCT. (2019) Stopping Smoking in Pregnancy. A briefing for maternity providers. NCSCT Standard Treatment Programme for Pregnant Women. NICE 2023: Tobacco: preventing uptake, promoting quitting, and treating dependence NCSCT. (2019) Stopping Smoking in Pregnancy. A briefing for maternity providers. NCSCT Standard Treatment Programme for Pregnant Women. NICE 2023: Tobacco: preventing uptake, promoting quitting, and treating dependence

SUPERSEDED DOCUMENTS	CG20021 Smoking & Smoking Cessation in Pregnancy Guideline (Legacy West) MP061 Smoking Cessation (Legacy East)
REVIEW DUE	August 2027

Approval		
Joint Obstetrics Guideline Group	Date approved	17/04/2024
Women & Children's Clinical Effectiveness Meeting	Date approved	16/05/2024
Consultation		
Tobacco Dependency Programme Manager – Janice Britz	Date approved	12/6/2024
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Ratification		
Clinical Document Approval Group	Date approved	21st August 2024

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Maternity Smoking & Smoke Free Pregnancy

1.0 Introduction

Smoking in pregnancy is defined as inhaling tobacco products (e.g., cigarettes) while pregnant. Smoking or exposure to second-hand smoke during pregnancy increases the risk of stillbirth, miscarriage, and sudden infant death. Children born to parents who smoke are more likely to develop health problems including respiratory conditions, learning difficulties, and diabetes, and are more likely to grow up to be smokers. (ASH 2021) Smoking in pregnancy is the leading modifiable risk factor for poor birth outcomes.

	Maternal Smoking
Low birth weight	4.1 times more likely
Spontaneous preterm birth	2.6 times more likely

Selvaratnam et al .(2023). Objective measures of smoking and caffeine intake and the risk of adverse pregnancy outcomes.

	Maternal Smoking	Second Hand smoke
Heart Defects	25%more likely	Increased risk
Stillbirth	47% more likely	Possible increase
Miscarriage	32% more likely	Increase risk
Sudden Infant Death	3 times more likely	45% more likely

There is strong evidence that stopping smoking reduces the above risks and improves outcomes for families (RCP 2010). The recommended treatment for stopping smoking is a combination of behavioral support and nicotine replacement therapy (NCSCT 2019).

NICE guidance on Smoking in Pregnancy recognizes that some women will find it difficult to say that they smoke because of the pressure not to smoke in pregnancy is so intense, this in turn makes it difficult to ensure they are offered appropriate support. Development of the Smokefree Pregnancy Journey (figure 1) will support practitioners to follow the pathway for women and people who smoke during pregnancy. A Carbon Monoxide (CO) Test is an immediate and non-invasive biochemical screening method for helping to assess whether someone smokes or is at risk of increased CO levels. CO screening should be performed prior to discussing smoking status.

All health professionals must be consistent on the messaging women and people receive on smoking. The health benefits of stopping completely rather than ‘cutting down’ is recommended in pregnancy. Cutting down diverts smokers from stopping smoking to reducing and may create a false impression of risk reduction (Hastings, Andrade 2014). Women and people who received mixed messages regarding cutting down or stopping completely were much more likely to cut down, rather than give up completely (58% and 14% respectively). (Graham et al., 2014). Any levels of compensatory smoking still increase the risks associated with stillbirth.

2.0 Definitions and abbreviations used within this guideline

UH Sussex - University Hospitals Sussex NHS Foundation Trust	**SFP service -** Smokefree Pregnancy service
NRT - Nicotine Replacement Therapy	**CO -** Carbon Monoxide
USS - Ultrasound Scan	**VBA -** Very Brief Advice
SIDS - Sudden Infant Death Syndrome	**SFT -** Smokefree Team
MIS - Maternity Information System e.g. Badgernet	**MHRA -** Medicines and Healthcare products Regulatory Authority
SBLv3 - Saving Babies Lives version 3	**F2F -** Face to Face
SHS - Second Hand Smoke	**SATOD -** Smoking at time of delivery.
AN - Antenatal	**DAU -** Day Assessment Unit
BSOTS - Birmingham Symptom-Specific Obstetric Triage System	**NCSST -** National Centre for Stop smoking Training
RCP - Royal College of Physicians	**EC -** Electronic Cigarettes
HP - Health Practitioner	**ASH -** Action on Smoking and Health
ANC - Antenatal Clinic	

3.0 Responsibilities

All staff working in the Trust including Tobacco Dependency Treatment Practitioners	• Access, read, understand, and apply this guidance. • Attend any mandatory training pertaining to this guidance.
Managers	• Ensure the guideline is reviewed as required in line with Trust and National recommendations. • Ensure the guideline is accessible to all relevant staff.
Other posts	Overall management and direction of Tobacco Dependency Treatment programmes at UH Sussex Continuous review of processes. Oversight and management of Smoke Free Pregnancy Service: Public health Midwife Tobacco Dependency Specialist Midwife Tobacco Dependency Specialist Midwife

Maternity staff can use any appointment or meeting as an opportunity to ask women and people if they have smoked in the last year. If they have, explain how UH Sussex Smokefree Pregnancy Service can help people to quit and advise them to stop.

4.0 Smokefree Pregnancy Pathway - Antenatal care

The smokefree pregnancy pathway follows the recommended NCSCT standard treatment programme for pregnant women and people.

Standard treatment programme (ncsct.co.uk)

Smokefree Pregnancy Service has been designed specifically for pregnant women and people and can provide flexible support (face to face appointments /phone calls/posting NRT).

- Contact via telephone within 24- 48hrs (working Days)
- Offer of Face-to-Face appointment within 5 working days.
- NRT offered and behavioural support from first contact. (see Protocol for direct supply of NRT by tobacco dependency advisors)
- Weekly telephone/F2F appointments until 28 days post quit.
- Regularly contact post quit as required. At least monthly.

4.1 Additional scans and monitoring

- Those who are smoking at booking are offered serial growth USS from 32/40 gestation every 4 weeks until birth in line with Saving Babies Lives Care Bundle v3.1. See maternity SGA &FGR guideline.
- Consider aspirin provision for smokers as per recommendation on Saving Babies Lives Care Bundle v3.1 Appendix 1.
- A non-smoker who has 2 more high CO>10 ppm readings with no cause identified. Make referral to ANC for review by obstetrician and consideration of scan.

If the client indicates they may decline the referral, please advise the pregnant smoker that she will still be offered an appointment with the SFT as part of the high-risk pathway to reduce the risks associated with smoking in pregnancy.

Figure 1: Smokefree Pregnancy Pathway UH Sussex

4.2 Referral: Opt-out basis

Referrals should be made using an 'Opt-Out' method. The criteria for referral are:

- Current smoker/ Shisha user: Anyone who has smoked in the 14 days immediately prior to admission / booking is classed as a smoker (NHS Digital Definitions, 2024)
- Raised CO ≥ 4 PPM who identify as a smoker.
- Ex-Smoker/Early quitters within last 6 weeks (quit since conception - due to the risk of relapse).

NB: Exclusive users of EC are not required to be referred unless they have smoked tobacco since conception. If people are keen to stop using an EC support can be provided by the SFT on an individual basis.

All those eligible for referral must have a Smokefree Pregnancy referral generated and sent via MIS – this is to ensure that all eligible for referral are included in reports and to ensure appropriate monitoring and support can be given in response to the identified risks.

Explain that it is normal practice to refer pregnant people to their local specialist stop smoking service as soon as possible in their pregnancy, best practice is via an immediate telephone call or inform them that they will be referred, and the service will contact her within the next working day.

Smokefree pregnancy service will provide feedback to midwifery teams via email each month on the following topics.

- CO compliance
- Smoking status and lifestyle report updates.
- Referrals received and missed referrals.
- When people fail to engage on 3+ occasions.
- VBA and requests for support with engagement.
- Successful quits

4.3 Community Midwives' role in supporting people who are undergoing a quit attempt

If a pregnant smoker is undertaking a quit attempt with the support of the SFT they should be asked about her quit attempt and given positive reinforcement on the benefits of being smokefree for them and their baby; these conversations should be recorded on the woman and person's MIS.

A multidisciplinary approach is required, and this will provide motivation for the pregnant smoker to compliment the behaviour change techniques plus NRT used by the SFT.

If a smoker opted-out of a referral to the SFT or has not engaged with the stop smoking service:

1. Ask them about their smoking status at every contact and update on MIS via Lifestyle report.
2. Explain the risks of smoking during pregnancy and the benefits of quitting for their baby.
3. Offer another referral to the service.
4. Continue to offer CO monitoring at each Antenatal contact in line with NICE guidance NG902 and record smoking status changes.

5. Discuss and encourage quit progress and verify quits by recording COs alongside new smoking status.

See Appendix 3 for community stop smoking services (for referring/ signposting partners).

4.4 CO monitoring test procedure

Pregnant women and people should be offered CO monitoring at each antenatal appointment regardless of their smoking status with the outcome recorded in MIS.

The result should be discussed and a question on smoking status asked. CO monitoring should be part of routine assessment and be carried out before the topic of smoking is raised.

Explain that CO affects the body's ability to transport oxygen around the body, which reduces the oxygen available to the baby but is also a marker for a woman and person's exposure to smoking. Cigarette smoke contains over 7000 chemicals of which hundreds are toxic and may also cause damage to the fetus.

Raised CO readings are linked to poor fetal outcomes due to hypoxia which are associated with miscarriage, growth restriction and developmental problems, placental insufficiency and fetal loss (Reeves and Bernstein, 2008).

1. Explain the rationale for offering CO testing. You can use this leaflet "Test your breath" 38830_hi res.pdf (ash.org.uk)

   The leaflet is available in multiple languages. Explain that CO is a poisonous gas, and that CO screening is a simple breath test part of antenatal care. That cigarette smoke, environmental factors such as pollution from car exhaust fumes, faulty gas appliances and second-hand tobacco smoke can result in raised CO readings. The client should be informed that the raised level can be reversed by avoiding these factors.

2. With consent, ask the client to perform the test using the following method for CO testing:
   - Explain the procedure clearly to the patient. See User Guide Appendix 4 for visual guide. Use Trust approved interpreters if this is required.
   - Turn the monitor on
   - Assemble D piece and insert straw
   - Press the female icon and the machine will start to count down. Ask the woman and person to:
     - Take a deep breath and hold it until the machine is ready (the machine will count down from 15 seconds). DO NOT talk to the woman and person while they are holding their breath.
     - Blow slowly into the machine on the 3rd beep
3. Explain the results – see Appendix 2 for reference.
4. Ask about smoking status – "Have you smoked tobacco in the last 2 weeks?"
5. Document the results and any action you have taken – refer all smokers not currently engaging with smokefree services.

4.5 Equipment for CO testing

Maternity staff undertaking CO testing will be issued with: A CO monitor (individual serial number logged on Maternity Stop Smoking database) Plastic D-pieces (to be replaced monthly) Disposable straw mouth pieces (single use)

Each Midwife, Maternity Support Worker and Tobacco Dependency Treatment Practitioner is responsible for the safe keeping of their equipment. The responsibility for reporting faults, damage or loss of equipment rests with individual staff members unless the equipment is registered to a particular unit (Delivery Suite, ANC, triage, Postnatal Areas), where the unit manager will hold responsibility for equipment.

4.6 Infection control

Staff are responsible for wiping the CO monitor with a clinical non-alcohol wipe between patients. Single use mouthpieces should be removed and disposed of as clinical waste. If the woman and person have an obvious respiratory infection, CO monitoring should not be performed.

Alcohol wipes and hand sanitizer should not be used when performing CO testing.

(use of alcohol can result in false positive results).

4.7 Interpretation of CO reading

4.7.1 Reading below 4ppm - Normal reading in pregnancy

Confirm smoking status, as some smokers can present a low CO reading. If quit within the last 2 weeks, refer on an opt-out basis to smokefree pregnancy service,

4.7.2 Reading 4ppm+ - Raised result

This requires further discussion from the health professional. Midwives should follow: ‘Ask, Advise, Act’ pathway to deliver VBA, starting with asking about smoking status.

Try to establish the possible cause:

- Smoking cigarettes is the most common cause.
- Environmental (faulty gas boiler, cooker, car exhaust or from paint stripper).
- Non-disclosure.
- Exposure to second hand smoke.
- Certain occupations in which may be exposed to high CO.
- Women and people who are lactose intolerant who have been exposed to dairy foods will give a raised result.

If no cause is identified, then give VBA and make referral to smokefree pregnancy team via MIS referrals.

Record this action on MIS. If a woman and person "opts" out of the referral on that day, this should also be recorded. Then a month later a text to be sent encouraging contact and offering support and free NRT.

4.7.3 Reading above 10ppm in a non-smoker or 30 ppm in a smoker with symptoms of carbon monoxide poisoning

Do you have any symptoms of CO EXPOSURE?	
Symptom	% reporting this symptom
Headache	90%
Nausea and vomiting	50%
Vertigo	50%
Alterations in consciences	30%
Subjective Weakness	20%

Department of Health 2013

4.7.4 Women and people with symptoms of CO exposure:

- Refer to A&E for blood analysis.
- Assess fetal wellbeing via DAU or maternity triage.

4.7.5 Reading above 10ppm and non-smoker exposed to cigarette smoke:

- This is a high reading for someone not exposed to cigarette smoke.
- Advise women and people to contact Gas safety line 0800 300 363.

4.7.6 CO reading>10ppm on consecutive occasions:

- Ensure machine is calibrated correctly (unnecessary on Bedfont piCObaby Smokerlyzer – contact SFT for any fault queries)
- Give VBA.
- Refer to CO flowchart for consideration of CO symptoms.
- Refer to smokefree team to offer appointment/discussion.
- Refer to ANC for consultant review and to discuss need for serial scans.
- Offer and record CO reading at next contact.

N.B. Staff need to be aware that CO has a short half-life, this means that CO levels will reduce by half after around 3-4 hours. Be aware they may not have been exposed for some time so the result may be less than the typical exposure levels i.e. due to prolonged waits in ANC/triage, appointments at the end of the day.

4.8 35+0- 36+6 weeks

All women and people should be offered CO testing, their smoking status confirmed and documented in the lifestyle report on MIS.

This data is used to evidence our SBLv3.1 compliance data. Midwives are encouraged to discuss repeat referral to SFT, abstinence for birth and Smokefree Homes. As part of the Birth Preferences, they should be encouraged to request NRT to make any inpatient stay more comfortable due to our Smokefree hospital agenda. The latest smoking status should inform the SATOD.

5.0 Declined referrals and non-compliance.

Those who:

- Decline the opt-out referral following MIS referral submission.
- Do not engage after 3 contact attempts following referral.
- Consecutively DNA 3 appointments with the Smokefree Pregnancy Service.

Push notifications will be sent via MIS by the SFT explaining the risks of smoking and open-door guideline should they wish to access the service in the future. Women and people and families will be signposted to self-help materials. The named midwife and any other relevant healthcare professional will be informed via email.

All contacts from the SFT will be added to MIS including DNA information.

6.0 Partners / household members who smoke - Second Hand Smoke (SHS)

SHS - is harmful to health. Exposure to SHS is causally linked to sudden infant death.

Having a partner or living with someone who smokes can also make quitting smoking during pregnancy challenging. Exposure to second-hand smoke is dangerous in pregnancy and postnatally and linked with adverse outcomes (see Table 1, Introduction).

Partners should be encouraged to stop smoking and provided with information about services available to them (See Appendix 3 for referral to community services).

7.0 Nicotine Replacement Therapy (NRT) and electronic cigarettes

Nicotine replacement therapy (NRT) works by reducing urges to smoke and other withdrawal symptoms, thereby making stopping smoking easier. Long-term studies have found no harm to the fetus from using NRT in pregnancy (NCSCT 2019).

Combination NRT (typically the patch plus another form of NRT) is the most effective medication option and is suitable for pregnant women. Stop-smoking medications such as Varenicline (Champix) and Bupropion (Zyban) are not licensed for use in pregnancy.

7.1 Electronic cigarettes/vaping

Research has demonstrated clear evidence EC are at least 95% less harmful than a cigarette (PHE, 2015).

A Cochrane review in Dec 2022 (Hartmann et. al, 2022) found high certainty evidence that using ECs with nicotine increases quit rates at 6 months or longer compared to NRT.

ECs produce no carbon monoxide which is detrimental to unborn fetus resulting in poorer outcomes such as stillbirth, preterm and small for gestational age babies. ECs do not contain tar and thousands of other toxic chemicals doing in cigarettes. ECs give smokers the nicotine they crave but protect them from the toxins they would inhale from a cigarette.

Given EC have only been around for about a decade, we do not yet have the longitudinal studies to show long term effects. Evidence is clear that ECs are at least 20 times safer than continuing to smoke (PHE 2015).

There is a risk of fire from the electrical elements of EC and a risk of poisoning from ingestion of e-liquids. These risks appear to be comparable to similar electrical goods and potentially poisonous household substances. All staff should be aware of the fire hazard associated with the use and recharging of e-cigarettes. E-cigarettes are not to be used in an oxygen rich environment.

Smokers choosing to switch to an EC should be supported by the health professional.UHSx will be taking part in the national ‘swap to stop 'scheme beginning April 2024. (See Maternity Vaping Protocol CDL 11592)

8.0 Care within the maternity unit

Any pregnant smoker with a planned admission should be informed that NRT can be provided to support temporary abstinence. Women and people who have smoked throughout their pregnancy are likely to experience symptoms of nicotine withdrawal during their hospital stay.

8.1 Triage/DAU/MAU/BSOTS

- Please perform a CO measurement as part of routine observations. These may need to be included on a separate observation note but should be clearly recorded on MIS for every admission. Update smoking status.
- Please ask all Triage patients “Have you smoked tobacco in the last two weeks”. A lifestyle update should be completed on MIS. Smoking status should be recorded.
- Provide Very Brief Advice (VBA)
- Offer and refer smokefree team to smokers if not engaging. This can be done via MIS referrals.

How to refer to SFT via MIS see user guide Appendix 4.

8.2 Admission

A CO should be performed within 2 hrs of admission if clinically possible. Clients who are identified as smokers should be given VBA and offered for NRT to support with withdrawal symptoms. NRT should be started as soon as possible, ideally within 2 hours of admission.

NRT is to be stored on the delivery suites/ wards as stock in the clinical rooms and prescribed where needed.

All pregnant smokers should be asked on the drug rounds: *"Would you like any nicotine products such as patches or gum?"* This is to promote a smokefree environment both within the hospital grounds and on-going for postnatal discharge.

8.3 NRT selection based on Fagerstrom assessment tool

The higher the score, the more dependent the smoker is, indicating the need for higher starting doses of NRT and robust weekly support.

How soon after you wake do you smoke?	Within 5 minutes 6-30 mins 31-60 mins More than 1 hr	3 2 1 0
How many cigarettes per day do you smoke?	10 or less 11-20 21-30	1 2 3

Smokes:	**More than 10 per day**	**Less than 10 per day**
Patch	16hr/25mg	16hr/15mg
Plus one of the following		
Nicorette Microtab	2mg	2mg
Lozenge	4mg	2mg
Gum	4mg	2mg
Quick mist Mouth spray	1mg	1mg
Nicorette Inhalator	15mg	15mg
Nasal Spray	10mg/ml indicated	10mg/ml indicated

UHSx is a Smokefree Hospital and service users need to be made aware of this.

Staff should not be facilitating childcare for smoking parents to go off the ward. Treat the nicotine dependence to enable them to stay on the ward.

The Smokefree Pregnancy Service Tobacco Dependency Treatment Practitioners should be made aware of the admission so they can visit the client on the wards and offer behavioural support alongside NRT treatments if they are working within the hospital setting that day.

8.4 Labour

Women and people can safely continue to use NRT while in labour. The midwife should document this and ensure that sufficient supply is available for the duration of the stay.

Midwives are responsible for documenting the SATOD (Smoking at Time of Delivery). Women and people should be asked if they have used tobacco products in the previous 14 days.

A “yes” reply should be recorded as “smoker”. Those using electronic cigarettes ONLY do not classify as “smoker”. The accuracy of SATOD is crucial to improving services and national reporting. Please ensure that the information is collected and recorded accurately. At least one CO recording around the time of birth should be recorded to verify smoking status and CO exposure.

8.5 Postnatal care

Encouragement should be given to those who have remained abstinent during their hospital stay and NRT continued to be made available. Smoking status should be communicated at handover and between maternity and neonatal care teams. CO reading should be taken and recorded on MIS at least once during the birth admission.

Ongoing smokefree support and re-referral should be offered to recently delivered smokers. The smokefree team can support families up to 28 days into the postnatal period. All partners who smoke should be signposted to the local Smokefree Pregnancy services.

9.0 Sudden Infant Death syndrome (SIDS)

Exposure to second and third-hand smoke can significantly increase a baby’s risk of SIDS. (The Lullaby Trust 2020). Reinforce the benefits of staying smokefree and having a smokefree home. Women and people who smoke should be given clear instructions on how to reduce their baby’s exposure to second and third-hand smoke.

For further information on smoking and SIDS risk, please refer to guidance from: The Lullaby Trust - Safer sleep for babies, Support for families

10.0 Infant feeding

All women and people should be encouraged to breastfeed, regardless of smoking status.

When supporting breastfeeding mothers, use the opportunity to raise awareness of the physiology of breastfeeding when smoking, i.e. that nicotine will be found in breast milk and that smoking can

reduce the quantity of breast milk and increase the risk of colic, which may help some women to remain non-smokers.

NRT is safe to use while breastfeeding. Patches do not need to be removed for feeds.

E-cigarettes may be used while breastfeeding. There are no known risks from exposure to e-cigarettes vapor – however, as newborn lungs are small and fragile, it is advisable that e-cigarettes are used outside or in ventilated areas.

11.0 Staff training

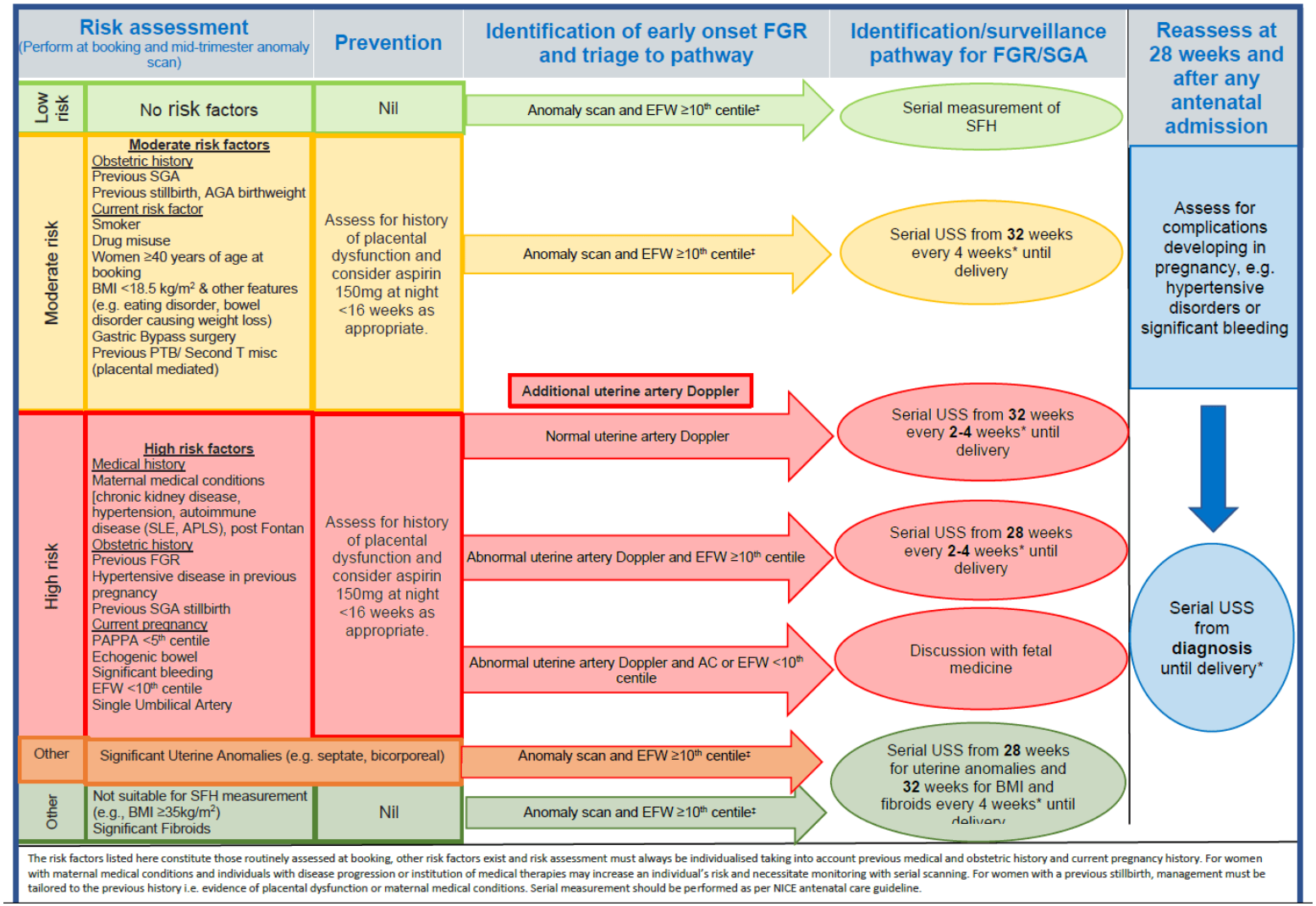
- All staff undertaking CO screening should be trained in the use of the CO monitor and interpretation of results.
- Every 3 years - completion of the Saving Babies Lives care bundle - Element 1.
- Annually - completion of 'VBA for pregnant women smoking'. Using the NCSCT (National Centre for Smoking Cessation and Training) template.
- Training must include learning from incidents, service user feedback and local learning.
- Training must include local clinical guidance and care pathways.

Attendance figures will be recorded and held within the MPDT. All staff are required to confirm competency via the medical devices form.

SFT will have further training.

- All Tobacco Dependency Treatment Practitioners and Specialist Midwives will undertake full NCSST practitioner level 2 training annually.
- Completion of specialist modules on smokefree pregnant/smokefree home/vaping.
- NCSST competency form completed annually.
- Attend national webinars and share learning with midwifery teams.
- Attendance to behaviour change course/motivational interviewing as available.

Appendix 1: Saving Babies Lives v3.1 Care Bundle document and risk assessment



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Appendix 2: CO Testing flowchart – Interpretation of Result

Symptoms of CO poisoning:

- Headache
- Nausea and Vomiting
- Vertigo
- Alteration in consciousness
- Subjective weakness
- Flu-like symptoms (no pyrexia)

CO Screening in Pregnancy

CO Level <4ppm

Non-Smoker

- Normal result.
- CO at each subsequent contact.
- Record smoking status at each contact.

Smoker

- Give VBA.
- Discuss short half-life & CO will be higher at time of cigarette.
- Refer to SFP team.
- CO at each subsequent contact.
- Record smoking status at each contact.

CO Level >4ppm

Non-Smoker

- Discuss signs/symptoms of CO poisoning.
- Identify possible source.
- Discuss Second Hand smoke.
- Encourage CO detector in home.
- Give gas safety number.
- CO at each subsequent contact.
- Refer to SFP team if identifies as a smoker or to explore source.
- Record smoking status at each contact.

Smoker

- Give VBA
- Refer to SFP Team.
- Discuss risks of smoking in pregnancy.
- CO at each subsequent contact.
- Record smoking status at each contact.

Non-Smoker CO Level >10ppm

No symptoms of CO exposure:

- Discuss second smoke.
- Encourage CO detector in home.
- Give gas safety number.
- Refer to SFP team if identifies as a smoker or to explore source.
- CO at each subsequent contact.
- Record smoking status at each contact.

2 consecutive CO>10ppm:

- Refer to ANC for discussion of serial growth scans from 32/40.

Smoker >30ppm

No symptoms of CO poisoning:

- Give VBA
- Refer to SFP Team.
- Discuss risks of smoking in pregnancy.
- Encourage CO detector in home.
- Give gas safety number.
- CO at each subsequent contact.
- Record smoking status at each contact.

Have symptoms of CO poisoning:

- As above PLUS -
  - **Refer immediately to A&E.**
  - Assess fetal wellbeing and follow up.

Gas Safety Number

0800 300 363

Appendix 3: Community Services

West Sussex

https://www.westsussexwellbeing.org.uk/topics/smoking/services-for-west-sussex

Stop smoking services (brighton-hove.gov.uk)

NHS Helpline and free App

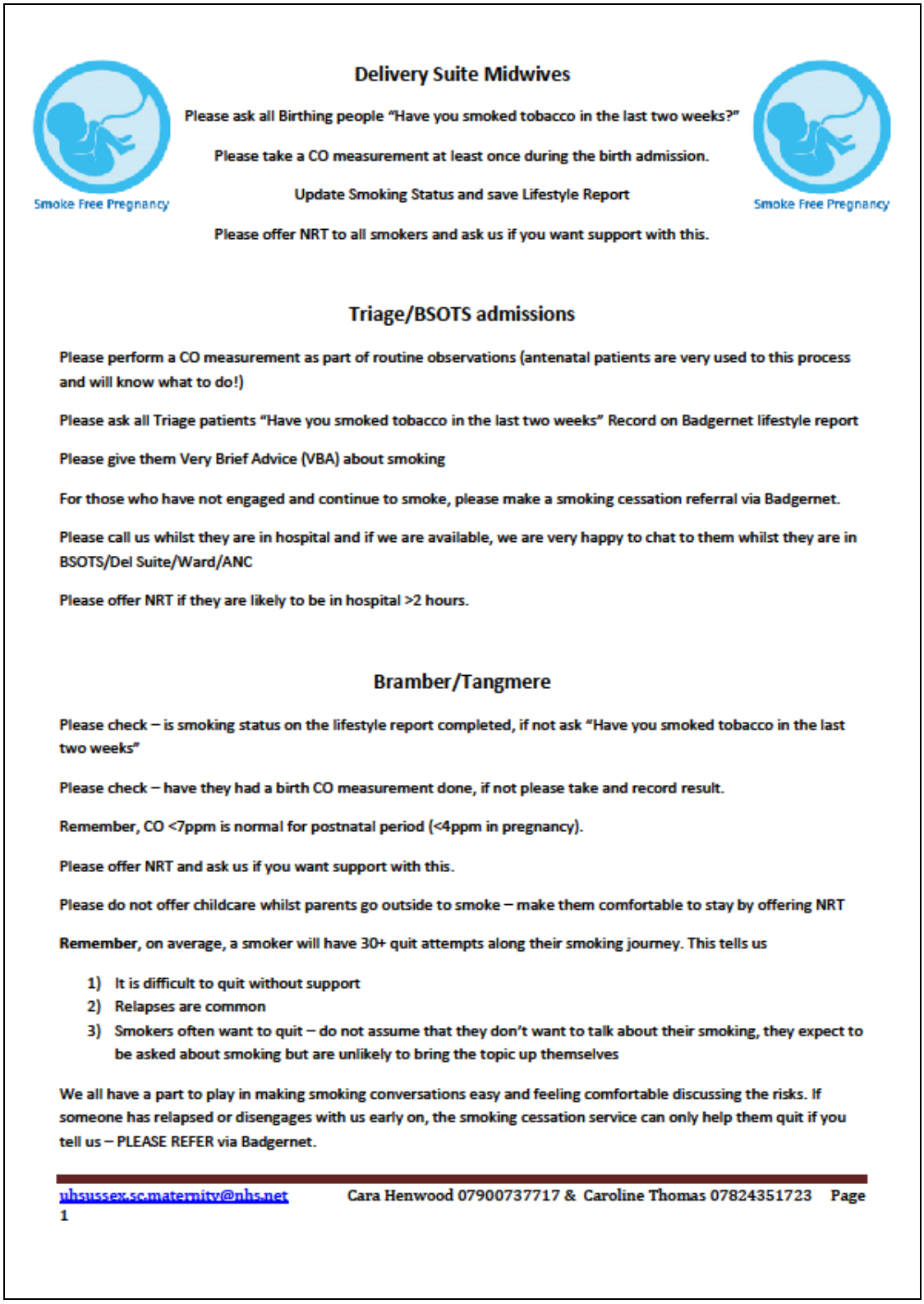
Quit smoking - Better Health - NHS (www.nhs.uk)

Brighton and Hove City Council

Help to stop smoking (brighton-hove.gov.uk)

Appendix 4: User guide including how to perform a CO measurement

Double click on image for full document:



Smoke Free Pregnancy

Delivery Suite Midwives

Please ask all Birthing people "Have you smoked tobacco in the last two weeks?"

Please take a CO measurement at least once during the birth admission.

Update Smoking Status and save Lifestyle Report

Please offer NRT to all smokers and ask us if you want support with this.

Smoke Free Pregnancy

Triage/BSOTS admissions

Please perform a CO measurement as part of routine observations (antenatal patients are very used to this process and will know what to do!)

Please ask all Triage patients "Have you smoked tobacco in the last two weeks" Record on Badgernet lifestyle report

Please give them Very Brief Advice (VBA) about smoking

For those who have not engaged and continue to smoke, please make a smoking cessation referral via Badgernet.

Please call us whilst they are in hospital and if we are available, we are very happy to chat to them whilst they are in BSOTS/Del Suite/Ward/ANC

Please offer NRT if they are likely to be in hospital >2 hours.

Bramber/Tangmere

Please check – is smoking status on the lifestyle report completed, if not ask "Have you smoked tobacco in the last two weeks"

Please check – have they had a birth CO measurement done, if not please take and record result.

Remember, CO <7ppm is normal for postnatal period (<4ppm in pregnancy).

Please offer NRT and ask us if you want support with this.

Please do not offer childcare whilst parents go outside to smoke – make them comfortable to stay by offering NRT

Remember, on average, a smoker will have 30+ quit attempts along their smoking journey. This tells us

1) It is difficult to quit without support
2) Relapses are common
3) Smokers often want to quit – do not assume that they don't want to talk about their smoking, they expect to be asked about smoking but are unlikely to bring the topic up themselves

We all have a part to play in making smoking conversations easy and feeling comfortable discussing the risks. If someone has relapsed or disengages with us early on, the smoking cessation service can only help them quit if you tell us – PLEASE REFER via Badgernet.

uhsussex.sc.maternity@nhs.net Cara Henwood 07900737717 & Caroline Thomas 07824351723 Page 1

Appendix 5: Monitoring

Team responsible for monitoring: Specialist Tobacco Dependence Midwives, Public Health Midwife, Matrons, and team leaders.

Data will be reported monthly to the Tobacco Patient Level Data Collection.

Evidence of compliance with Saving Babies Lives is submitted quarterly to the implementation tool provided by SBLV3.1.
MISyear5-update-July-2023.pdf

A highlight report with locally agreed KPIs will be presented at the bimonthly UHSx/NHS Sussex TDT Facilitative and Partnership Meeting.

Minimum Quarterly report to be written and sent to Director and Heads of Midwifery and disseminated as appropriate.

Reports and data to be presented as required to local and national Smokefree Pregnancy and health improvement agencies.

Issue being monitored	Monitoring method	Responsibility	Frequency	Reviewed by and actions arising followed up by
As above.	Audit	Public health Midwife/ Tobacco dependency Midwife	Monthly audits and Quarterly reports will be produced	Quality and Safety Meeting

Appendix 6: Guideline version control log

Change Log – Maternity Smoking & Smoke Free Pregnancy

Version	Date	Author(s)	Comment
1.0	April 2024	Caroline Thomas – Public health Midwife Cara Henwood –Tobacco Dependency Specialist Midwife Juliette Golding- Tobacco Dependency Specialist Midwife	New Trust wide guideline replacing: • CG20021 Smoking & Smoking Cessation in Pregnancy Guideline (Legacy West) • MP061 Smoking Cessation (Legacy East)

Appendix 7: Due regard assessment tool

To be completed and attached to any guideline when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	Age	*No*	
	· Disability	*No*	
	· Gender (Sex)	*No*	
	· Gender Identity	*No*	
	· Marriage and civil partnership	*No*	
	· Pregnancy and maternity	*No*	
	· Race (ethnicity, nationality, colour)	*No*	
	· Religion or Belief	*No*	
	· Sexual orientation, including lesbian, gay and bisexual people	*No*	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	*No*	
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	*N/A*	
4.	**Is the impact of the document likely to be negative?**	*No*	
5.	**If so, can the impact be avoided?**	*N/A*	
6.	**What alternative is there to achieving the intent of the document without the impact?**	*N/A*	
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the guideline should continue in its current form?**	*N/A*	
8.	**Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA principles (fairness, respect, equality, dignity and autonomy)?**	*Yes*	

If you have identified a potential discriminatory impact of this guideline, please refer it to [Insert Name], together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact uhsussex.equality@nhs.net 01273 664685).

Appendix 8: Template dissemination, implementation and access plan

To be completed and attached to any guideline when submitted to Corporate Governance for consideration and TMB approval.

	Dissemination Plan	Comments
1.	Identify:	
	Which members of staff or staff groups will be affected by this guideline?	Maternity Support Workers, Midwives and Obstetricians.
	How will you confirm that they have received the guideline and understood its implications?	We have a dissemination process that involves publicising this update via social media, staff work emails, noticeboards and safety huddles.
	How have you linked the dissemination of the guideline with induction training, continuous professional development and clinical supervision as appropriate?	Staff are shown where to access clinical documents as part of their induction. Awareness of where guidance is located is confirmed at appraisals.
2.	How and where will staff access the document (at operational level)?	Will be made available on SharePoint.

		Yes/No	Comments
3.	Have you made any plans to remove old versions of the guideline or related documents from circulation?	Yes	Archiving is a standard part of the uploading procedure.
4.	Have you ensured staff are aware the document is logged on the organisation's register?	Yes	We have a dissemination process that involves publicising this update via social media, staff work emails, noticeboards and safety huddles.

Appendix 9: Additional guidance / information

Action on Smoking and Health. Smoking, pregnancy, and fertility. London: ASH, 2021

Selvaratnam R,Sovio U,Cook E,Gaccioli F, Charnock-Jones, Smith G. Objective measures of smoking and caffeine intake and risk of adverse pregnancy outcomes. International journal of Epidemiology. 2023.

RCP & RCPCH. Passive Smoking and Children, 2010.

Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.

NCSCT. Dependence on smoking.
https://www.ncsct.co.uk/usr/pub/Dependence%20on%20Smoking%20.pdf

https://www.ncsct.co.uk/usr/pub/NCSCT%20Standard%20Treatment%20Programme%20for%20Pregnant%20Women.pdf

NCSCT. Resumption of face-to-face stop smoking consultations and carbon monoxide (CO) monitoring. London: NCSCT 2021

NCSCT. Dependence on smoking.
https://www.ncsct.co.uk/usr/pub/Dependence%20on%20Smoking%20.pdf

National Institute for Health and Care Excellence (NICE). Tobacco: preventing uptake, promoting quitting and treating dependence. (NG209. 2021.) Overview | Tobacco: preventing uptake, promoting quitting and treating dependence | Guidance | NICE

Graham, H. et al (2014) Cutting Down: Insights from Qualitative Studies of Smoking in Pregnancy. Health Social Care Community, 22 (3): 259-67.

NHS Digital
Appendix 1: Definitions - NHS Digital

Hastings.G.,D.E Andrade, M.2014. Should smokers to advised to cut down as well as quit? No. British Medical Journal,348.10.1136/BMJ.G2787.

Reeves S, Bernstein I. Effects of maternal tobacco-smoke exposure on fetal growth and neonatal size. Expert Rev Obstet Gynecol. 2008;3(6):719-730.

NHS England: Saving Babies Lives Version Three. PRN00130-saving-babies-lives-version-three-2023.pdf

Smoking in Pregnancy Challenge Group. Use of electronic cigarettes before, during and after pregnancy. A guide for maternity and other healthcare professionals. 2019.

PHE 2015. E-cigarettes: an evidence update A report commissioned by Public Health England. E-cigarettes: an evidence update (publishing.service.gov.uk)

Hartmann-Boyce J, Lindson N, Butler AR, McRobbie H, Bullen C, Begh R, Theodoulou A, Notley C, Rigotti NA, Turner T, Fanshawe TR, Hajek P. Electronic cigarettes for smoking cessation. Cochrane Database of Systematic Reviews 2022, Issue 11. Art. No.: CD010216. DOI: 10.1002/14651858.CD010216.pub7.

See also / Linked documents

Maternity Vaping Protocol CDL 11592

Protocol for Direct Supply of NRT by Tobacco Dependency Advisors UHS-CG-0012-2023