NHS James Paget University Hospitals NHS Foundation Trust | NHS Norfolk and Norwich University Hospitals NHS Foundation Trust | NHS The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust | NHS Norfolk and Waveney Acute Hospital Collaborative

SmartStart
Smoking in Pregnancy: Norfolk and Waveney LMNS Clinical Guideline

Document Control:

For Use In:	All three acute Trusts, within the Norfolk and Waveney Integrated Care Board (ICB): Norfolk and Norwich University Hospital NHS Foundation Trust James Paget University Hospital NHS Foundation Trust Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
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None	Not applicable

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

This document was developed in partnership with James Paget University Hospital, Norfolk and Norwich University Hospital, Queen Elizabeth Hospital, Norfolk &

Waveney Integrated Care Board (ICB), Norfolk & Waveney Local Maternity and Neonatal System (LMNS) and Norfolk County Council.

The following were consulted during the development of this document:

- Divisional Director of midwifery
- Smoking Cessation Improvement Manager
- Strategic Integration Improvement Manager and Trust Lead for Health Inequalities
- LMNS Transformation Midwife
- Fetal wellbeing lead
- Saving Babies Lives Lead Midwife
- LMNS Practice Innovation Midwife
- Norfolk County Council Public Health Team

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g., changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a clinical guideline applicable to the Norfolk and Waveney Local Maternity and neonatal systems within the acute collaborative of Norfolk and Norwich University Hospital, James Paget University Hospital and Queen Elizabeth hospital Kings Lynn; please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

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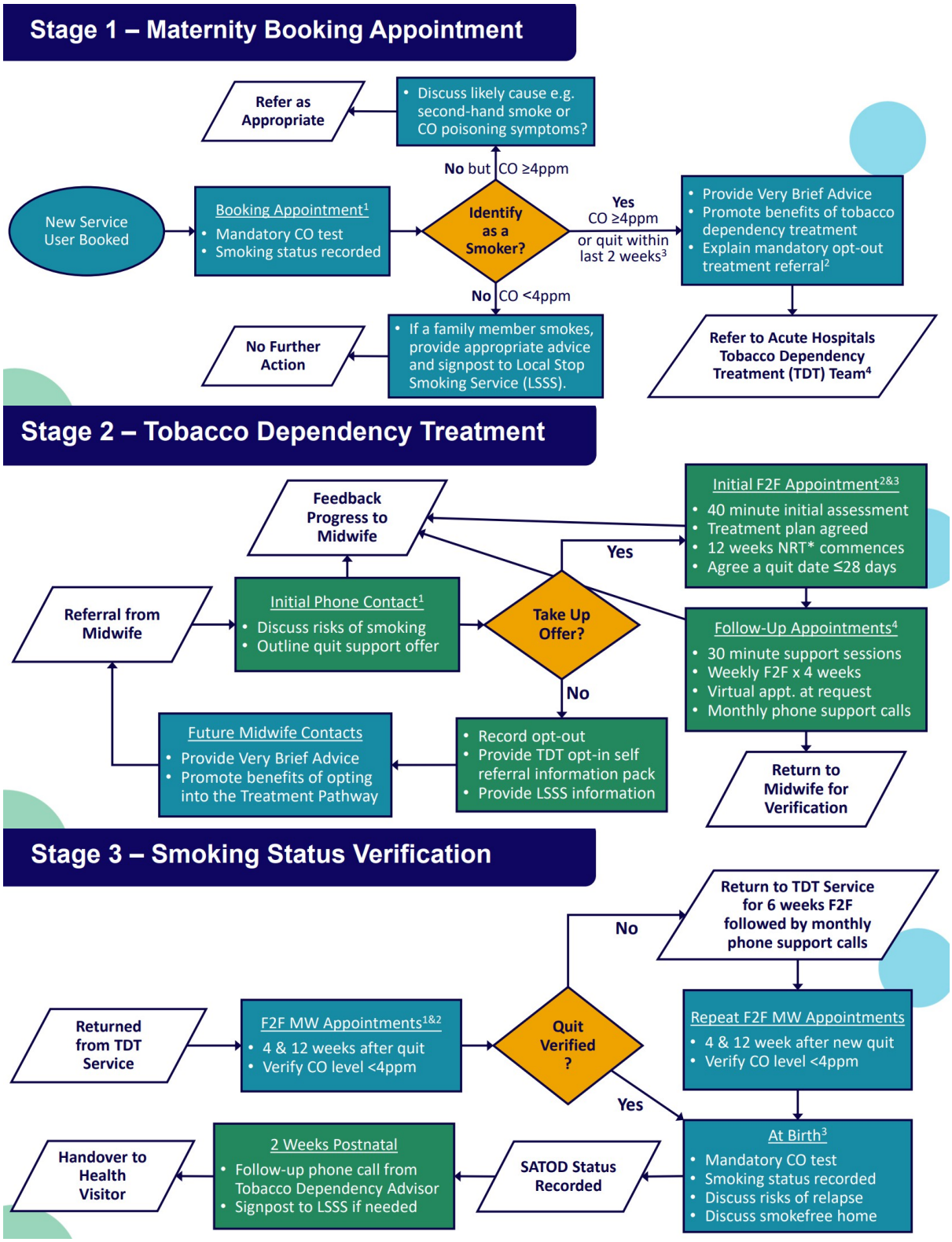
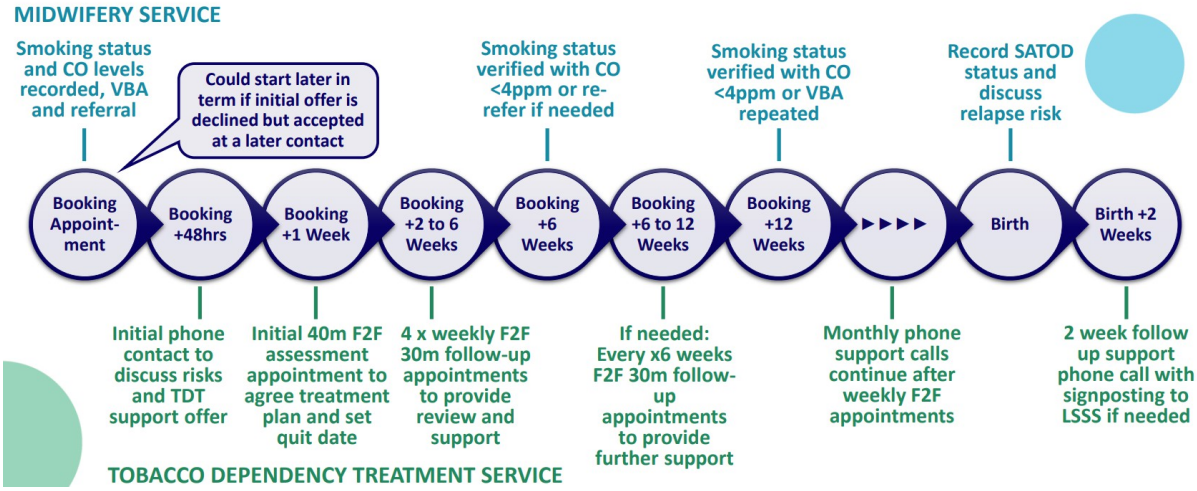
Quick reference



Contact Timeline



1. Introduction

1.1 Rationale

The purpose of this guideline is ensuring equitable care to improve the health of the unborn babies of women/birthing people who smoke, the women/ birthing people themselves, their partners, children, and others in their household. The guideline will outline the standard practice in all Trusts across Norfolk and Waveney, ensuring there is no inequity in service. This guideline will ensure compliance with national and local policies and strategies in relation to smoking in pregnancy and smoking cessation. Furthermore, it enhances all roles within maternity care in promoting public health messages and interventions.

This guideline applies to all women/ birthing people who smoke and are:
- pregnant
- in the postnatal period

Smoking is recognised as the most significant modifiable risk factor for poor outcomes in pregnancy, including miscarriage, stillbirth, and neonatal death (Marufu, et al. 2015; NICE, 2018; Royal College of Physicians, 2018). Smoking is also highlighted as a contributing factor towards pregnancy complications, including placental abruption, premature birth, and low birthweight (MBBRACE-UK, 2018), and is associated with problems in infancy such as increased risk of Sudden Infant Death Syndrome (SIDS), and in childhood such as chest and ear infections, learning difficulties and asthma (RCOP, 2010). Public Health England (2015) states “Smoking in pregnancy causes significant harm to both the mother and baby and is the single most important modifiable risk factor during pregnancy. There is no safe level of exposure to tobacco smoke while in the womb”.
Saving Babies’ Lives Version 3 recognises reducing smoking in pregnancy as a one of five key elements to improve neonatal outcomes (NHS England, 2019). This element provides a practical approach to reducing smoking in pregnancy in accordance with NICE guidance (2018) by offering carbon monoxide (CO) testing throughout pregnancy, identifying smokers and those exposed to CO and providing referral to specialist smoking cessation services.
In 2021/2022 in the East of England 1 in 12 women/birthing people smoked, approximately 4,918; in Norfolk 12.1% of women/birthing people smoked in their pregnancy (OHID, 2023). Reducing the smoking in pregnancy rate across Norfolk and Waveney is expected to reduce the associated complications, thereby reducing the preterm birth rate, low birth weights, placental abruptions, and sudden infant death rate.

1.2 Objective

This guideline has been produced to provide information to midwives, doctors, maternity support workers and other healthcare professionals involved in the care of women/birthing people who smoke or are exposed to carbon monoxide during pregnancy and the appropriate management including referral pathways. The aim of this guideline is to improve the health and outcomes of women/birthing people who smoke and their unborn babies, their partners, and their children.

The objective of the guideline is to:

- Standardise care for pregnant smokers.
- Ensure care is in line with national guidance.
- Ensure all staff have easy access to local guidance when required.

This has been produced on behalf on the Norfolk and Waveney Local Maternity & Neonatal System, in collaboration with the three acute trusts to provide guidance for members of the multidisciplinary team across James Paget University Hospital, Norfolk and Norwich University Hospital and Queen Elizabeth Hospital.

1.3 Scope

This guideline seeks to inform staff of the protocol and pathway for pregnant women/birthing people who smoke, have quit smoking in the last 2 weeks or have a CO ≥4ppm. All women/birthing people will be referred to SmartStart, the maternity in-house stop smoking services (unless opted out) where they will be provided with behavioural support and pharmacotherapy as per the pathway shown in point 3. Partners or family members who smoke will not receive the SmartStart pathway but will be supported through external stop smoking services and provided information pertinent to pregnancy, puerperium, and the impact of second-hand smoke.

1.4 Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
Pregnant smokers	A pregnant person who smokes tobacco, regardless of the amount of tobacco they smoke (or smoked within the last 14 days)
Smoking cessation	The act of stopping smoking
Small for gestational age	A baby that has not grown to its full potential based on individualised growth charts
NCSCT	National Centre for Smoking Cessation and Training
SmartStart	Name of new maternity Tobacco Dependence Treatment service in Norfolk and Waveney
DNA	Did not Attend
ppm	Parts per million
IT	Information technology
CMW	Community midwife
CO	Carbon Monoxide
SCMW	Smoking Cessation Midwife
LMNS	Local Maternity & Neonatal System
LSSS	Local Stop Smoking Service
MTDS	Maternity Tobacco Dependency Service
TDA	Tobacco Dependency Advisor
MAU	Maternity Assessment Unit
MIS	Maternity Information System
MSW	Maternity Support Worker

NRT	Nicotine Replacement Therapy
USS	Ultrasound Scan
VBA	Very Brief Advice
MTDP	Maternity Tobacco Dependence Programme
PROMPT	Practical Obstetric Multi-Professional Training
MTDA	Maternity Tobacco Dependence Advisor

2. Responsibilities

All staff working within maternity services in the acute provider collaborative of Norfolk and Waveney LMNS should ensure they remain up to date with this clinical guideline. All health care professionals working within maternity services should adhere to the guidance, promoting and referring as appropriate to the service.

Role	Responsibility
Tobacco Dependence Advisors	Provides direct care and appropriate contacts as per the maternity 'SmartStart' pathway
'SmartStart' lead midwife	Provides clinical supervision and indirect support for TDA's and a point of guidance and escalation of concerns within the trust
Tobacco Dependence Advisor Team Lead	Provides line management for TDA's, as well as guidance, support and escalation of concerns or barriers to providing an effective service

3. Processes to be followed.

3.1 At Booking

At booking, all women/birthing people should be assessed for exposure to carbon monoxide, including past and present smoking status and offered a breath test for CO monitoring.

- If a woman/birthing person blows a CO reading of 4 parts per million (ppm) or above, midwives will follow the 'Ask, Advise, Act' pathway to deliver VBA, starting with asking about smoking status, impact of CO exposure in pregnancy on the health and wellbeing of both the women/birthing person and unborn, and the benefits of stopping smoking.

- Women/birthing people should be advised to quit smoking completely and not just cut down, as there is no evidence that cutting down provides any benefit to the unborn (RCOG, 2015).

- Referral to SmartStart, the in-house Maternity Tobacco Dependency Treatment Programme (MTDTP), is on an opt-out basis and should be made for all current smokers (including use of shisha), ex-smokers who have stopped smoking within the previous 2 weeks and anyone who has a CO reading of ≥4ppm.

- Emphasise that CO monitoring is routine for women/birthing people throughout their pregnancy who smoke, are quitting, used to smoke, or have tested at or above 4 parts per million (ppm) at their first antenatal appointment, at each contact, as per NICE guidelines (NG209) and Saving Babie Lives version 3: Element 1.

- All women/birthing people to be provided with “Test Your Breath” information leaflet (ASH: Smoking in Pregnancy Challenge Group. Appendix 1).

- If a patient has a high CO reading ≥10ppm and is identified as a non-smoker, please refer to the Emergency Department for medical review and advise of possible CO poisoning and refer to Health and Safety Executive Gas Safety line: 0800 300 363.

- Referrals to SmartStart at booking will be sent through Trust-specific Maternity Information Systems on an automatic referral, where possible, with manual referrals, where not possible.

- Women/birthing people will require referral for serial USS, as per Trust guidelines and an individualised risk assessment.

- Where other household members smoke, educate about the impact of second-hand smoke and signpost to LSSS.

- All conversations, CO testing results and referrals to be documented accurately on MIS, including if a patient declines or CO testing is unavailable (e.g., equipment fault, non-testing during Covid-19 pandemic).

- Midwives and maternity support workers to ensure they have the correct and working equipment, including disposables. Smoking Cessation Specialist Midwife or the Community Matron to be first point of contact for procurement.

3.2 Antenatal Assessments

Assessment of smoking status and CO monitoring to be offered at all routine antenatal appointments, attendance to MAU/Triage (unless CO testing within 1 week) and on antenatal admission to the antenatal ward, for all smokers, those who are quitting, ex-smokers, or have received a high CO recording at their first antenatal appointment.

- Women/birthing people will be asked about their smoking status at each appointment with the offer of support always made available to them. This is especially important if there are smoking related complications e.g., small for gestational age.

- Continue to follow VBA, promote the in-house service, and make referral to SmartStart if the woman/birthing person wishes, even if they have previously declined treatment. Referral can be made at any point in the pregnancy.

- In-house specialist stop smoking services will follow local processes and work in collaboration with, and give feedback to, midwifery teams around engagement or non-engagement with services and quit attempts.

- If a women/birthing people has taken up the offer of support following referral and has engaged with the service, they will be asked about their quit attempt and given positive reinforcement on the benefits of being smoke free for them and their baby. These conversations will be recorded in a woman/birthing person's notes.

- If woman/birthing person does not take up the offer of smart Start support, record this, provide self-referral information and provide local stop smoking support information. Accept their decision in an impartial manner and re-offer support and referral at subsequent contacts.

- Check that woman/birthing person has serial USS arranged.

3.3 Inpatient Care.

All pregnant smokers who receive inpatient care must be assessed for and offered Nicotine Replacement Therapy from admission, in line with Trust protocol.

- Continue to follow VBA, offer CO monitoring, and make referral to SmartStart if the individual would like support.

- Complex cases to be liaised with the Smoking Cessation Specialist Midwife for the Trust, or the medical team caring for the woman/birthing person where a Smoking Cessation Specialist Midwife is not available.

3.4 Intrapartum Admission.

Assessment of smoking status should be established as part of routine labour admission.

- This should be documented on the MIS in the 'Pre-delivery' section of the woman/birthing persons notes.

- The risk of relapse should be discussed if a successful quit has occurred, and woman/birthing person should be informed a TDA will make phone contact at 2 weeks postnatal to follow-up.

- All women/birthing people should be offered pharmacotherapy including vapes and Nicotine Replacement Therapy (NRT) in line with NICE guidance, to enable them to be smoke free during their admission.

- Women/birthing people should be given advice on the importance of keeping a smoke free home and offered referral to the local stop smoking service on discharge.

- Information on smoking status should be routinely shared with postnatal teams, including the Health Visiting service.

3.5 Postnatal discharge

Assessment of smoking status at postnatal discharge to community and final discharge from maternity services.

- Continue to have meaningful discussions about the impact of smoking in the puerperium, in particular the increased risk of sudden infant death syndrome (SIDS) and the impact on infant health.

- Continue to refer to LSSS on an opt-out basis for current smokers (including use of shisha), ex-smokers who have stopped smoking within the previous 2 weeks.

- Document conversations and referrals on the MIS

- Risk of relapse should be discussed with women who have achieved a quit

- The importance of a Smoke Free home should be discussed prior to discharge.

- 2 weeks postnatally, a follow up phone call will be made from the Tobacco Dependency Advisor (TDA), with signposting to local stop smoking services if needed.

3.6 Care after bereavement.

- Any pregnancy loss should be communicated to SmartStart by the maternity team so that sensitive and timely contact can be made.

- In the event of a pregnancy loss, smoking cessation services will continue along the pathway, if the mother wishes to continue.

- Smoking cessation services in this case would need to provide sensitive care, mindful of the mothers' preferences of the locality of where support is provided. Every effort should be made to facilitate this choice.

- Smoking cessation services should be promoted to the mother in the case of a loss to reduce the risk of loss in a subsequent pregnancy.

3.7 Care following admission to the Neonatal Unit.

- In the event a woman/birthing person gives birth prematurely whilst on the programme, support from a TDA will continue with the location of the delivery of this service to suit mother's needs, including delivering the service on the neonatal unit.
- Encouragement to remain on the Tobacco Dependence Pathway will be given, alongside advise on the importance of a smoke free home. Research has found that neonatal unit admission may provide a teachable moment for smoking cessation advice.

3.8 Maternity Tobacco Dependency Treatment Service

- The In-house stop smoking services will make contact by phone to women/birthing person referred within 48 hours to build on the advice given by midwives and outline the quit support offer, where this falls within normal working hours.
- Women/birthing people who opt-out during the initial contact will be sent information on smoking and pregnancy, with Tobacco Dependency Treatment opt-in self-referral information pack and local stop smoking service information. The opt-out must be recorded.
- At the initial appointment, a woman/birthing persons addiction to nicotine will be assessed, an individualised treatment plan will be agreed, and a quit date will be agreed which will be within 28 days of the appointment. 12 weeks pharmacotherapy will be commenced. This will be a 40-minute face to face appointment. Email feedback on progress will be sent to named midwife after every contact.
- Weekly follow-up support sessions will be offered and will be face-to-face, unless requested to be virtual by the woman/birthing person. These will be 30-minute appointments for 4 weeks following the quit date, after which monthly phone support calls will take place.
- 4 and 12 weeks after the quit, women/birthing people will be seen by their midwife to verify if a successful quit has occurred. The quit is verified if CO level <4ppm. If the quit is not verified, the woman/birthing person will return to the TDT service for face-to-face appointments every 6 weeks, followed by monthly phone support calls.
- Smoking in Pregnancy Team Lead to hold regular, monthly meetings with Trusts to discuss caseloads of MTDA and ensure the embedding of the MTDA and TDT service.

3.9i E-Cigarettes and Vaping.

- Evidence has shown that the use of e-cigarettes and vaping is significantly less harmful than smoking tobacco products and women should not be discouraged from using these products if they help them to remain smoke-free.

- There is currently no evidence to suggest that the use of an e-cigarette will compromise pregnancy or breastfeeding.
- Women/birthing people who choose to use e-cigarettes should be advised to buy products from a reputable source.
- Guidance recommends that women/birthing people who choose to use an e-cigarette to help them stop smoking should also be referred to smoking cessation services, where they can receive behavioural support and have access to other pharmacological forms of nicotine replacement therapy (NRT).
- The latest information on e-cigarettes and vaping for healthcare professionals and women/birthing people can be found at https://smokefreeaction.org.uk/

3.9ii Pharmacotherapy Provision.

NRT is to be provided by a TDA or midwife trained to the NCSCT standards only. NRT vouchers will be generated by the TDA's via the Pharm Outcomes system, which women/birthing people will use to collect NRT from community pharmacies. Midwives or Doctors providing NRT for inpatients should follow inpatient Trust protocol.

4 Training & Competencies

All midwives, obstetric doctors, and maternity support workers to attend a mandatory yearly update in PROMPT .

• All multidisciplinary staff providing maternity care to women/birthing people to complete Saving Babies' Lives Element 1 e-learning module.

• All maternity staff to have completed a SiP Competency Assessment - maternity staff.docx SiP Competency Assessment - maternity staff.docx

• Further e-learning available at www.ncsct.co.uk.

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6. Monitoring Compliance

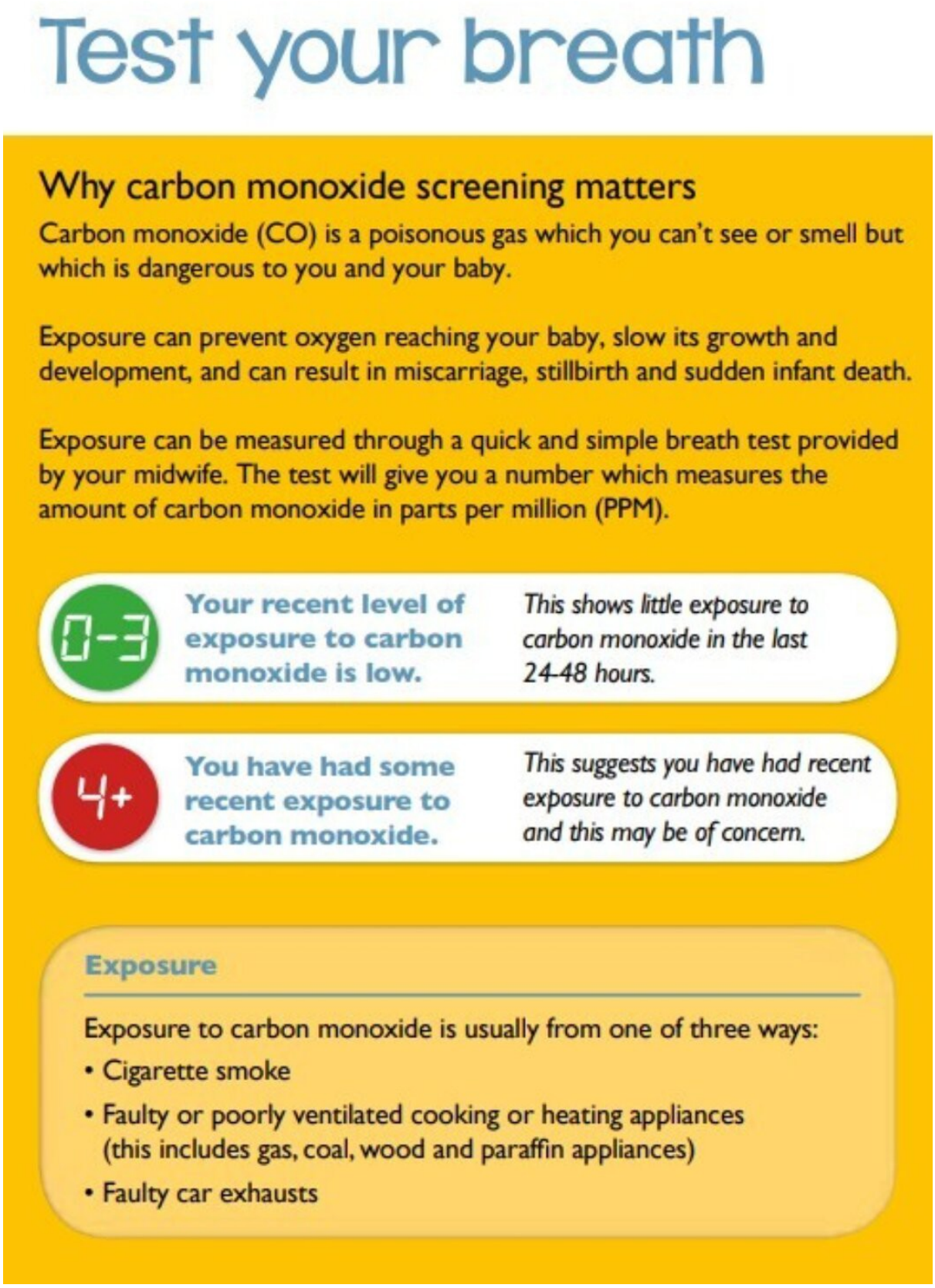
Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Percentage of women/birthing people recorded as having CO measured at booking.	Audit of all women/birthing people included on MIS and included in maternity services data set and submitted to NHS digital	Smoking cessation lead	Maternity clinical governance	
Percentage of women/birthing people where CO measured at 36 weeks gestation	Audit of all women/birthing people included on MIS and included in maternity services data set and submitted to NHS digital	Smoking Cessation lead	Maternity clinical governance	
Percentage of women/birthing people identified as requiring referral to Smart start, referred on an opt out basis and received specialist support.	Audit of all women/birthing people included on MIS and included in maternity services data set and submitted to NHS digital.	Smoking cessation lead	Maternity clinical governance	
Percentage of women/birthing people on Smart start at 4 and 12 weeks after quit date which has been verified by CO monitoring.	Audit of all women/birthing people included on MIS and in maternity services data set and submitted to NHS digital.	Smoking cessation lead	Maternity clinical governance	
Smoking at time of delivery. (SATOD rate).	Audit of all women/birthing people included on MIS and in maternity services data set and submitted to NHS digital.	Smoking cessation lead	Maternity clinical governance	
Percentage of women/birthing people recorded as entering in-house Smart start, recorded as successful quit at delivery, verified by CO monitoring.	Audit of all women/birthing people included on MIS and in maternity services data set and submitted to NHS digital.	Smoking cessation lead	Maternity clinical governance	

The audit results are to be discussed at relevant governance meetings (to review the results and recommendations for further action. Then sent to the Clinical Audit Department who will ensure that the actions and recommendations are suitable and sufficient.

7. Appendices

Appendix



8. Equality Impact Assessment (EIA)

Type of function or policy	New

Division		**Department**	Maternity Services
Name of person completing form		**Date**	

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race	Nil	Nil	n/a	No
Pregnancy & Maternity	Nil	Nil	n/a	No
Disability	Nil	Nil	n/a	No
Religion and beliefs	Nil	Nil	n/a	No
Sex	Nil	Nil	n/a	No
Gender reassignment	Nil	Nil	n/a	No
Sexual Orientation	Nil	Nil	n/a	No
Age	Nil	Nil	n/a	No
Marriage & Civil Partnership	Nil	Nil	n/a	No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?				

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.