NICE National Institute for Health and Care Excellence

NICE Pathways

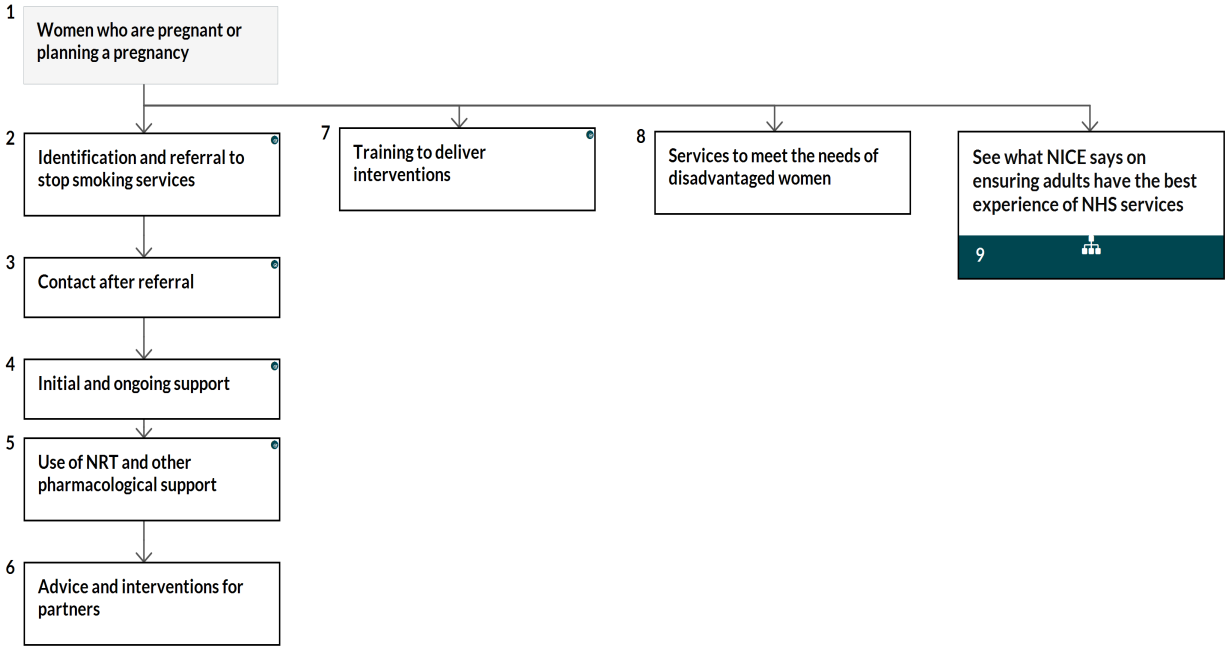
Stopping smoking in pregnancy and after childbirth

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/smoking
NICE Pathway last updated: 12 August 2019

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Women who are pregnant or planning a pregnancy

No additional information

2 Identification and referral to stop smoking services

Actions for midwives at the first maternity booking and subsequent appointments

Assess the woman's exposure to tobacco smoke through discussion and use of a CO test. Explain that the CO test will allow her to see a physical measure of her smoking and her exposure to other people's smoking. Ask her if she or anyone else in her household smokes. To help interpret the CO reading, establish whether she is a light or infrequent smoker. Other factors to consider include the time since she last smoked and the number of cigarettes smoked (and when) on the test day. (Note: CO levels fall overnight so morning readings may give low results.)

Provide information (for example, a leaflet) about the risks to the unborn child of smoking when pregnant and the hazards of exposure to secondhand smoke for both mother and baby. Information should be available in a variety of formats.

Explain about the health benefits of stopping for the woman and her baby. Advise her to stop – not just cut down.

Explain that it is normal practice to refer all women who smoke for help to quit and that a specialist midwife or adviser will phone and offer her support. (Note: a specialist adviser needs to offer this support to minimise the risk of her opting out.)

Refer all women who smoke, or have stopped smoking within the last 2 weeks, to evidence-based stop-smoking services. Also refer those with a CO reading of 7 ppm or above. (Note: light or infrequent smokers should also be referred, even if they register a lower reading – for example, 3 ppm.) If they have a high CO reading (more than 10 ppm) but say they do not smoke, advise them about possible CO poisoning and ask them to call the free Health and Safety Executive gas safety advice line on: 0800 300 363.

Use local arrangements to make the appointment and, in case they want to talk to someone over the phone in the meantime, give the NHS Pregnancy Smoking Helpline number: 0800 1699 169. Also provide the local helpline number where one is available.

If her partner or others in the household smoke, suggest they contact evidence-based stop-smoking services. If no one smokes, give positive feedback.

At the next appointment, check if the woman took up her referral. If not, ask if she is interested in stopping smoking and offer another referral to the service.

If she accepts the referral, use local arrangements to make the appointment and give the NHS Pregnancy Smoking Helpline number: 0800 1699 169. Also provide the local helpline number where one is available.

If she declines the referral, accept the answer in an impartial manner, leave the offer of help open. Also highlight the flexible support that many evidence-based stop-smoking services offer pregnant women (for example, some offer home visits).

If the referral was taken up, provide feedback. Review at subsequent appointments, as appropriate.

Where appropriate, for each of the stages above record smoking status, CO level, whether a referral is accepted or declined and any feedback given. This should be recorded in the woman's hand-held record. If a hand-held record is not available locally, use local protocols to record this information.

Context

Some women find it difficult to say that they smoke because the pressure not to smoke during pregnancy is so intense. This, in turn, makes it difficult to ensure they are offered appropriate support.

A CO test is an immediate and non-invasive biochemical method for helping to assess whether or not someone smokes. However, it is unclear as to what constitutes the best cut-off point for determining smoking status. Some suggest a CO level as low as 3 parts per million (ppm), others use a cut-off point of 6–10 ppm.

It is important to note that CO quickly disappears from expired breath (the level can fall by 50% in less than 4 hours). As a result, low levels of smoking may go undetected and may be indistinguishable from passive smoking. Conversely, environmental factors such as traffic emissions or leaky gas appliances may cause a high CO reading – as may lactose intolerance.

When trying to identify pregnant women who smoke, it is best to use a low cut-off point to avoid missing someone who may need help to quit.

Actions for others in the public, community and voluntary sectors

Who should take action?

Those responsible for providing health and support services for the target group of women. This does not include midwives (see above). It does include:

- GPs, practice nurses, health visitors and family nurses.
- Obstetricians, paediatricians, sonographers and other members of the maternity team (apart from midwives).
- Those working in youth and teenage pregnancy services, children's centres and social services.
- Those working in fertility clinics, dental practices, community pharmacies and voluntary and community organisations.

What action should they take?

Use any appointment or meeting as an opportunity to ask women if they smoke. If they do, explain how evidence-based stop-smoking services can help people to quit and advise them to stop.

Offer those who want to stop a referral to evidence-based stop-smoking services.

Use local arrangements to make a referral. Record this in the hand-held record. If a hand-held record is not available locally, use local protocols to record this information.

Give the NHS Pregnancy Smoking Helpline number in case they want to talk to someone over the phone in the meantime: 0800 1699 169. Also provide the local helpline number where one is available.

Those with specialist training should provide pregnant women who smoke with information (for example, a leaflet) about the risks to the unborn child of smoking when pregnant. They should also provide information on the hazards of exposure to secondhand smoke for both mother and baby and on the benefits of stopping smoking. Information should be available in a variety of formats.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Smoking: supporting people to stop

1. Identifying people who smoke

2. Referral to smoking cessation services

Antenatal care

5. Risk assessment – smoking cessation

3 Contact after referral

Evidence-based stop-smoking services specialist advisers should:

- Telephone all women who have been referred for help. Discuss smoking and pregnancy and the issues they face, using an impartial, client-centred approach. Invite them to use the service. If necessary (and resources permitting), ring them twice and follow-up with a letter. Advise the maternity booking midwife of the outcome.
- Attempt to see those who cannot be contacted by telephone. This could happen during a routine antenatal care visit (for example, when they attend for a scan).
- Address any factors which prevent the women from using smoking cessation services. This could include a lack of confidence in their ability to quit, lack of knowledge about the services on offer, difficulty accessing them or lack of suitable childcare. It could also include a fear of failure and concerns about being stigmatised.
- If women are reluctant to attend the clinic, consider providing structured self-help materials or support via the telephone helpline. Also consider offering to visit them at home, or at another venue, if it is difficult for them to attend specialist services.
- Send information on smoking and pregnancy to those who opt out during the initial telephone call. This should include details on how to get help to quit at a later date. Such information should be easily accessible and available in a variety of formats.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Smoking: supporting people to stop

2. Referral to smoking cessation services

4 Initial and ongoing support

Actions for evidence-based stop-smoking services specialist advisers

During the first face-to-face meeting, discuss how many cigarettes the woman smokes and how frequently. Ask if anyone else in the household smokes (this includes her partner if she has one).

Provide information about the risks of smoking to an unborn child and the benefits of stopping for both mother and baby.

Address any concerns she and her partner or family may have about stopping smoking and offer personalised information, advice and support on how to stop.

If partners or other family members are present at the first face-to-face meeting, encourage those who smoke to quit. If they smoke but are not at the meeting, ask the pregnant woman to suggest they contact evidence-based stop-smoking services and provide her with contact details (for example, telephone and address card).

Provide the woman with intensive and ongoing support (brief interventions alone are unlikely to be sufficient) throughout pregnancy and beyond. This includes regularly monitoring her smoking status using CO tests. The latter may encourage her to try to quit – and can also be a useful way of providing positive feedback once a quit attempt has been made.

Biochemically validate that the woman has quit on the date she set and 4 weeks after. Where possible, use urine or saliva cotinine tests, as these are more accurate than CO tests and can detect exposure over the past few days rather than hours. When carrying out these tests, check whether the woman is using NRT as this may raise her cotinine levels. Note: no measure can be 100% accurate. Some people may smoke so infrequently – or inhale so little – that their intakes cannot reliably be distinguished from that due to passive smoking.

If the woman says that she has stopped smoking, but the CO test reading is higher than 10 ppm, advise her about possible CO poisoning and ask her to call the free Health and Safety Executive gas safety advice line on: 0800 300 363. However, it is more likely that she is still smoking and any further questions must be phrased sensitively to encourage a frank discussion.

If she stopped smoking in the 2 weeks prior to her maternity booking appointment, continue to provide support, in line with the recommendations above and evidence-based stop-smoking

services practice protocols.

Record the method used to quit smoking, including whether or not she received help and support. Follow up 12 months after the date she set to quit.

Establish links with contraceptive services, fertility clinics and ante- and postnatal services so that everyone working in those organisations knows about local evidence-based stop-smoking services. Ensure they understand what these services offer and how to refer people to them.

Context

Studies have shown that the following interventions are effective in helping women who are pregnant to quit smoking:

- cognitive behaviour therapy
- motivational interviewing
- structured self-help and support from evidence-based stop-smoking services.

In addition, in other countries the provision of incentives to quit has been shown to be effective with this group (research is required to see whether it would work in the UK).

Interventions using a 'stages of change' approach have had mixed success. (In some studies the approach was effective; in others it was no better than the control.) Giving pregnant women feedback on the effects of smoking on the unborn child and on their own health (such as reports of urinary cotinine levels) is not effective.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Smoking: supporting people to stop

3. Behavioural support with pharmacotherapy

5. Outcome measurement

5 Use of NRT and other pharmacological support

Actions for evidence-based stop-smoking services

Discuss the risks and benefits of NRT with pregnant women who smoke, particularly those who do not wish to accept other help from evidence-based stop-smoking services. Use only if smoking cessation without NRT fails. If they express a clear wish to receive NRT, use professional judgement when deciding whether to offer a prescription.

Only prescribe NRT for use once they have stopped smoking (they may set a particular date for this)[1]. Only prescribe 2 weeks of NRT for use from the day they agreed to stop. Only give subsequent prescriptions to women who have demonstrated, on re-assessment, that they are still not smoking.

Advise pregnant women who are using nicotine patches to remove them before going to bed.

Neither varenicline or bupropion should be offered to pregnant or breastfeeding women.

For further information, see evidence-based stop smoking interventions.

Context

There is mixed evidence on the effectiveness of NRT in helping women to stop smoking during pregnancy. The most robust trial to date has found no evidence that it is effective (or that it affects the child's birthweight). In addition, there is insufficient data to form a judgement about whether or not NRT has any impact on the likelihood that a child will need special care or will be stillborn.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Smoking: supporting people to stop

3. Behavioural support with pharmacotherapy

4. Pharmacotherapy

[1] The British National Formulary (2010) advises on use of NRT during pregnancy: 'Intermittent therapy is preferable but avoid liquorice-flavoured nicotine products'.

6 Advice and interventions for partners

Provide clear advice about the danger that other people's tobacco smoke poses to the pregnant woman and to the baby – before and after birth.

Recommend not smoking around the pregnant woman, mother or baby. This includes not smoking in the house or car.

Offer partners who smoke help to stop using a multi-component intervention that comprises three or more elements and multiple contacts. Discuss with them which options to use – and in which order, taking into account:

- their preferences
- contra-indications and the potential for adverse effects from pharmacotherapies such as NRT
- the likelihood that they will follow the course of treatment
- their previous experience of smoking cessation aids.

Do not favour one medication over another. Together, choose the one that seems most likely to succeed taking into account the above.

For more information, see stop smoking interventions and services.

Context

Interventions which are effective with the general population will not necessarily work with the partners of women who are pregnant. For example, simply providing booklets, self-help guidance or media education campaigns is not effective with this group around the time of pregnancy.

7 Training to deliver interventions

Ensure all midwives who deliver intensive stop-smoking interventions (one-to-one or group support – levels 2 and 3) are trained to the same standard as NHS stop-smoking advisers. The minimum standard for these interventions is set by the NHS Centre for Smoking Cessation and Training. They should also be provided with additional, specialised training and offered ongoing support and training updates (see further information about the NHS Centre for Smoking Cessation and Training's forthcoming specialist module).

Ensure all midwives who are not specialist stop-smoking advisers are trained to assess and record people's smoking status and their readiness to quit. They should also know about the health risks of smoking and the benefits of quitting – and understand why it can be difficult to stop. In addition, they should know about the treatments that can help people to quit and how to refer them to local services for treatment. (Acquisition of this knowledge and skill set is part of level 1 training in brief stop-smoking interventions[1]. Please note, midwives are not advised to carry out brief interventions with pregnant women. However, they are advised to use these skills to initiate a referral to evidence-based stop-smoking services.)

Ensure midwives and NHS stop-smoking specialist advisers who work with pregnant women:

- know how to ask them questions in such a way that encourages them to be open about their smoking
- always recommend quitting rather than cutting down
- have received accredited training in the use of CO monitors.

Ensure brief stop-smoking interventions (level 1) and intensive one-to-one and group support to stop smoking (levels 2 and 3) are incorporated into pre- and post-registration midwifery training and midwives' continuing professional development, as appropriate.

Ensure all healthcare and other professionals who work with the target group are trained in the same skills – and to the same standard – as those required of midwives who are not specialist smoking cessation advisers. This includes: GPs, practice nurses, health visitors, obstetricians, paediatricians, sonographers, midwives (including young people's lead midwives), family nurses and those working in fertility clinics, dental facilities and community pharmacies. It also includes those working in youth and teenage pregnancy services, children's centres, social services and voluntary and community organisations.

Ensure all the healthcare and other professionals listed in the previous paragraph:

- know what support local evidence-based stop-smoking services offer and how to refer the women being targeted
- understand the impact that smoking can have on a woman and her unborn child
- understand the dangers of exposing a pregnant woman and her unborn child – and other children – to secondhand smoke.

Ensure all training in relation to smoking and pregnancy addresses the:

- barriers that some professionals may feel they face when trying to tackle smoking with a pregnant woman (for example, they may feel that broaching the subject might damage their relationship)

- important role that partners and 'significant others' can play in helping a woman who smokes and is pregnant (or who has recently given birth) to quit. This includes the need to get them to consider quitting if they themselves smoke.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Smoking: supporting people to stop

1. Identifying people who smoke

2. Referral to smoking cessation services

8 Services to meet the needs of disadvantaged women

Evidence-based stop-smoking services should:

- Ensure services are delivered in an impartial, client-centred manner. They should be sensitive to the difficult circumstances many women who smoke find themselves in. They should also take into account other sociodemographic factors such as age and ethnicity and ensure provision is culturally relevant. This includes making it clear how women who are non-English speakers can access and use interpreting services[1].
- Involve these women in the planning and development of services.
- Ensure services are flexible and coordinated. They should take place in locations – and at times – that make them easily accessible and should be tailored to meet individual needs.
- Collaborate with the family nurse partnership pilot and other outreach schemes to identify additional opportunities for providing intensive and ongoing support. (Note: family nurses make frequent home visits.)
- Work in partnership with agencies that support women who have complex social and emotional needs. This includes substance misuse services, youth and teenage pregnancy support and mental health services.

9 See what NICE says on ensuring adults have the best experience of NHS services

See Patient experience in adult NHS services

[1] For the national standard for level 1 see standard for training in smoking cessation treatments or future updates from the NHS Centre for Smoking Cessation and Training.

[1] This is an edited extract from a recommendation that appears in cardiovascular disease: identifying and

supporting people most at risk of dying early.

Glossary

Brief interventions

(interventions that help people stop smoking, involving opportunistic advice, discussion, negotiation or encouragement and, where necessary, referral to more intensive treatment; they are delivered by a range of professionals, typically in less than 10 minutes)

CO

carbon monoxide

Community workers

(practitioners working outside the health sector who have a remit for smoking cessation)

Group behaviour therapy

(programmes that involve weekly meetings for the first 4 weeks of a quit attempt, during which people who smoke receive information, advice and encouragement and some form of behavioural intervention (for example, cognitive behavioural therapy) delivered over at least two sessions)

Individual behavioural counselling

(a face-to-face encounter between someone who smokes and a counsellor trained in smoking cessation)

NRT

(nicotine replacement therapy products are licensed for use as a smoking cessation aid and for harm reduction, as outlined in the British national formulary; they include transdermal patches, gum, inhalation cartridges, sublingual tablets and a nasal spray)

Pharmacotherapies

(nicotine replacement therapy, varenicline or bupropion as an aid to help people to quit smoking)

PSHE

personal, social, health and economic

Self-help materials

(any manual or structured programme, in written or electronic format, that can be used by individuals in a quit attempt without the help of health professionals, counsellors or group support)

SMEs

small and medium-sized enterprises

stop smoking services

(services commissioned to deliver the interventions recommended in this guidance)

stop smoking support

(includes interventions and support to stop smoking regardless of how services are commissioned or set up)

Telephone counselling and quitlines

(proactive or reactive advice, encouragement and support over the telephone to anyone who smokes who wants to quit, or who has recently quit)

text messaging

(the text messages should be tailored to the person and aim to advise on quitting by giving information about the consequences of smoking and what to expect when trying to quit, encouraging and boosting self-efficacy, motivating and giving reminders of how to deal with difficult situations)

very brief advice

(asking about current and past smoking behaviour, providing information on the consequences of smoking and stopping smoking, and advising on options for support and pharmacotherapy, in line with the NCSCT's training standard on very brief advice)

Sources

Smoking: stopping in pregnancy and after childbirth (2010) NICE guideline PH26

Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and

their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.