Greater Manchester Integrated Care Partnership

NHS
Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

Greater Manchester Alcohol Exposed Pregnancy Standing Operational Procedure

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Version 2i

LMNS
Greater Manchester and Eastern Cheshire
Local Maternity and Neonatal System

Part of Greater Manchester Integrated Care Partnership

Document Control

Ownership

Role	Department	Contact
Róisín Reynolds, Senior Advisor	GMHSCP	Roisin.reynolds1@nhs.net
Rachael Nielsen, Project Manager	GMHSCP	Rachael.nielsen@nhs.net

Version control

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V2i 11/11/22	Section 5 Postnatal Care: Text changed following discussion with MVP and AEP maternity working group that the wording was too rigid and could encourage HCPs to take a strict line with the families in their care which could result in families either hiding their alcohol consumption and not getting the necessary safety advice, and/or impacting breastfeeding rates. Original text: When supporting breastfeeding mothers, use the opportunity to raise awareness of potential alcohol exposure. Alcohol passes freely into breast milk and regularly drinking more than 2 units of alcohol a day while breastfeeding may affect a baby's development. To prevent any alcohol exposure to the baby alcohol use should be avoided. To reduce the risk of alcohol exposure breast feeding should be avoided for at least 2-3 hours after drinking. New text: When supporting breastfeeding mothers, use the opportunity to raise awareness of potential alcohol exposure. Alcohol passes freely into breast milk although small amounts would be unlikely to see an effect in the baby, regularly drinking large amounts of alcohol while breastfeeding may affect a baby's development. Advise that to minimise alcohol exposure to the baby, consider mitigating the risk by only having small amounts of alcohol on an infrequent basis or avoiding breastfeeding for 2-3 hours after drinking. Further advice can be found in Appendix 7.	
V2i	Updated version uploaded to GMEC SCN Maternity Resources web page and link circulated.	29/11/22

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Contents

1. Introduction and Scope

This evidence-based guideline aims to support Greater Manchester prenatal healthcare staff to prevent alcohol harm in pregnancy by providing all pregnant women[1] with consistent and accurate advice on the risks of alcohol use in pregnancy, embed routine alcohol screening and recording throughout pregnancy, deliver brief alcohol interventions and implement pathways for those who require enhanced support.

This guideline does not replace individual Trust's Substance Misuse Policies and should be used in conjunction with all local ratified polices that support healthy pregnancies.

The Chief Medical Officers' guidance (2016) is "If you are pregnant or planning a pregnancy, the safest approach is to not drink alcohol at all, to keep risks to your baby to a minimum. Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk".

Alcohol is a teratogen and therefore crosses the placenta interfering with fetus development and causing malformations. The fetus cannot filter out the toxins from alcohol, instead, the alcohol circulates in the fetus' blood system which can harm brain cells and damage the nervous system of the developing fetus throughout the entire nine months of pregnancy.

Alcohol use in pregnancy increases the risk of miscarriage, still birth and low birth weight (Royal College of Obstetricians and Gynaecologists 2018).

A study in The Lancet (2017) estimated 41% of pregnant women in UK drank alcohol while pregnant - the 4th highest in the world. A further study in Leeds UK found 78.6% of a cohort of 1303 pregnant women drank alcohol in the first trimester.

The harm caused by pre-natal alcohol exposure is diagnosed by the term Fetal Alcohol Spectrum Disorder (FASD). FASD is a neurodevelopmental condition with lifelong cognitive, emotional and behavioural challenges. In addition to effects on the brain, FASD is a full-body diagnosis that can include more than 400 known conditions.

The first UK FASD Prevalence study published by the University of Salford (September 2021) showed that FASD affects at least 1.8% - 3.6% of children. If this is extrapolated to the whole of Greater Manchester, it suggests that there are between 619-1,238 affected live births annually.

The World Health Organisation (WHO) (2014) recommends that midwives screen for alcohol use on multiple occasions antenatally using a validated tool and deliver Brief Interventions when alcohol consumption is disclosed

[1] This guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant.

Public Health England's Maternity high impact area: Reducing the incidence of harms caused by alcohol in pregnancy stipulates that reducing the incidences of harms caused by alcohol before, during and after pregnancy is a public health priority, and is vital to ensuring that all children are given the best possible start in life.

NICE Antenatal Care Guideline NG201 (2021) advises that alcohol consumption should be discussed during antenatal care and midwives should follow the UK Chief Medical Officers' low-risk drinking guidelines.

NICE Guidance CG110 (2010) covers care for pregnant woman with complex social factors including alcohol misuse.

NICE Quality Standard - QS204 (2022) set out clear quality standards that all "Pregnant women are given advice throughout pregnancy not to drink alcohol" and that "Pregnant women are asked about their alcohol use throughout their pregnancy and this is recorded".

British Congenital Cardiac Association; Fetal Cardiology Standards Revised April 2012

2. Roles and responsibilities

This guideline is for all users who provide health and support services for pregnant women:

- Midwives, maternity support workers.
- Obstetricians, sonographers, paediatricians/neonatologists.
- GPs, practice nurses, health visitors, family nurses.

Pregnant women do not choose to intentionally harm their babies and rely on midwives and other health care professionals to provide them with current evidence-based information in order that they can make informed decisions about their care and their baby. Focussing on the process of giving this information, is the key to achieving meaningful interactions about alcohol use.

3. Antenatal Pathway

Pre-booking contact

Early pregnancy health and wellbeing information should be provided **before** the booking appointment where possible.

Due to the teratogenic effect of alcohol to the fetus, information about the risks of alcohol use in pregnancy should be given at the earliest opportunity and include the UK Chief Medical Officers' low-risk drinking guidelines:

- there is no known safe level of alcohol consumption during pregnancy
- drinking alcohol during the pregnancy can lead to long-term harm to the baby
- the safest approach is to avoid alcohol altogether to minimise risks to the baby

It is recommended that an appropriately trained health care practitioner (HCP) conducts a '1st contact' appointment either over the telephone or in person at the earliest opportunity following pregnancy confirmation. During this appointment the HCP should adopt a non-judgemental and supportive approach and give the women clear advice on avoiding alcohol throughout the pregnancy explaining the benefits of this, including preventing fetal alcohol spectrum disorder (FASD) and reducing the risks of miscarriage, low birth weight, preterm birth and the baby being small for gestational age.

Enquiring about alcohol use patterns **prior** to pregnancy can be a good predictor of alcohol use in pregnancy. Asking open questions places the woman at the heart of the conversation and is more likely to open a collaborative discussion. For example, *could you talk me through a typical night out?*

This discussion should be supported using an approved alcohol screening tool such as The Alcohol Use Disorders Identification Test–consumption subset (AUDIT-C). AUDIT-C is a validated 3-question alcohol screen that it can be used as a measure of any level of alcohol use and inform subsequent personalised care and support.

In line with guidance the AUDIT- C should be completed for all women without prejudice on at least 3 intervals during the pregnancy (first contact, booking and 36 weeks) with the outcome score documented in the electronic maternal health records. If alcohol use has been reported, the amount and frequency must also be documented.

If the woman reports that alcohol use took place **prior** to confirmation of their pregnancy but that they have since abstained, it is vital that a careful alcohol history is documented. Support should be offered to mitigate stress through reinforcing that stopping their alcohol use is the safest option during pregnancy and emphasising the importance of protective factors such as continued alcohol abstinence and good diet for the remainder of the pregnancy.

Women may not initially disclose their alcohol intake or feel able to describe their alcohol intake. They may not have a clear idea of how much they are drinking and the unit calculator in appendix 2 can be used to support this discussion.

See below for advice on when on-going alcohol use is identified.

Women and their partners can be directed to the #Drymester website where they can access further information and non-judgemental advice on maintaining a healthy alcohol-free pregnancy.

Booking Contact

In line with NICE Antenatal Guidelines and NICE FASD Quality Standards: alcohol use should also be discussed at the booking appointment, alongside nutrition and diet, physical activity, smoking cessation and recreational drug use.

The HCP should adopt a non-judgemental, compassionate and personalised approach to this discussion. This is an opportunity to revisit the Chief Medical Officers' guidelines and the advice given at first contact on the benefits of avoiding alcohol throughout the pregnancy. This is also an opportunity to dispel any misconceptions somebody may hold in relation to perceived 'safe' alcohol use in pregnancy, for example, Guinness being a good source of iron. Guinness contains around **0.3mg of iron per pint**, which isn't significant enough to be of any health benefit and women need 14.8mg a day.

The AUDIT- C screen should be completed at this appointment with the outcome score and any action taken documented on the Maternal Information System (MIS).

Where on-going alcohol use is identified, an alcohol brief intervention (ABI) can be used to support an open discussion. This approach is strongly recommended in the World Health Organisation (2014) guidelines on brief interventions. These interventions are most effective at evoking behaviour change when the HCP asks permission to discuss first.

For example:

- I have a concern about your alcohol use. I don't know if you are concerned about it too, but would it be ok if I tell you what I think, or is there anything that you would like to ask about or tell me first?
- Can I tell you what I know about that?
- There is something I need to tell you here, is that ok?

More information on ABIs can be found in appendix 4.

See section 4 for guidance on how to respond when someone may be considered to be alcohol dependent.

36 Weeks Contact

The goal is to continue to have the conversation and it is therefore important to ensure at this appointment that the HCP continues to provide consistent and clear advice on avoiding alcohol throughout the pregnancy and revisits the associated benefits with the woman. If the woman discloses that there has been any alcohol use during the pregnancy the quantity, frequency and pattern of drinking should be documented in their maternity records.

The AUDIT- C screen should be completed at this appointment with the outcome score and any action taken documented in the MIS.

It is important that the woman is aware that stopping alcohol exposure at any stage of the pregnancy will prevent further long-term impacts. It is never too late.

Please note: Alcohol use can be discussed at any point during pregnancy in addition to these minimum recommendations, if consumption is disclosed the same screening/documentation/referral pathways should be used.

4. Supporting pregnant women with complex needs

Some women will find it hard to stop using alcohol when pregnant for a number of reasons. If you suspect or know the woman you are supporting is alcohol dependent, they must be advised that it is unsafe for them to stop drinking suddenly and an urgent referral must be made to the local specialist alcohol service with enhanced support put in place to increase the likelihood of engagement.

It's important to be aware that pregnant women who experience difficulties associated with alcohol and / or other substance(s) may be anxious about the attitudes of healthcare staff and the potential role of social services. Health practitioners have a key role to play in breaking the stigma associated with substance use. Focus on the person and their needs and provide supportive and coordinated care during pregnancy.

In line with NICE Guidance CG110; particular attention should be paid to:

- integrating care from different services
- ensuring that the attitudes of staff do not prevent women from using services
- addressing women's fears about the involvement of children's services and potential removal of their child, by providing information tailored to their needs
- addressing women's feelings of guilt about their misuse of substances and the potential effects on their baby

When harmful drinking and/or dependency is suspected / known the HCP should follow guidance within the Trusts substance use policy. This will include regular 1:1 supervision with the named midwife for safeguarding & liaison with the named obstetrician.

Significant pre-natal alcohol exposure should be highlighted via a neonatal alert prior to delivery for oversight from a neonatal doctor to ensure a neonatal plan is in place for any necessary observations of the baby following birth.

5. Postnatal Care

If it is known that a pregnancy was alcohol exposed, it is important that the parent(s) is sensitively provided with information on the possible impact this may have had on the baby and encouraged to discuss any concerns with their GP. Early diagnosis of FASD significantly improves outcomes for the individual affected.

The details of pre-natal alcohol use should be comprehensively documented alongside other relevant information in the handover to Health Visiting colleagues in line with existing Trust pathways and procedures. For example, birth notifications and safeguarding communications.

When supporting breastfeeding mothers, use the opportunity to raise awareness of potential alcohol exposure. Alcohol passes freely into breast milk although small amounts would be unlikely to see an effect in the baby, regularly drinking large amounts of alcohol while breastfeeding may affect a baby's development. Advise that to minimise alcohol exposure to the baby, consider mitigating the risk by only having small amounts of alcohol on an infrequent basis or avoiding breastfeeding for 2-3 hours after drinking. Further advice can be found in Appendix 7.

If the mother you are supporting plans to return to drinking **any** alcohol when they return home with their baby, highlight that alcohol may make them less aware of their baby's needs. Advise that if they do drink alcohol to ensure their baby is cared for by an adult who has not had any alcohol.

If the mother has disclosed that they regularly drank heavily prior to pregnancy but abstained during pregnancy, it is important to have sensitive discussions with them and (if appropriate) other people living in the home regarding the hidden harms associated with parental alcohol use. This information should be considered in line with local safeguarding polices and procedures, and documented and shared with other processionals as appropriate.

Children of parents who use alcohol and non-prescribed drugs are more likely to be at an increased risk of adverse life experiences and poor outcomes. Recent evidence suggests that psychosocial interventions that not only target the primary symptoms, but also consider the person's situation from a societal and familial perspective (such as motivational interviewing and parent skills training) may be effective in reducing parental substance use at both short-term (6-month) and long-term (12-month) follow-up (McGovern et al, 2021. Cochrane Review).

Advise the mother against anyone in the home sharing a bed or sofa with their baby especially if they have drunk any alcohol, highlighting that doing this has a strong association with sudden infant death syndrome (SIDS). Document this in the postnatal notes and child health record (red book). See appendix 6 for further information.

6. Contraception

Information about contraception should be offered in both the prenatal and antenatal period to support informed decision-making and facilitate provision of contraception by maternity staff in line with Trust policy.

Clinicians should refer to the relevant current FSRH guidelines including the UK Medical Eligibility Criteria for Contraceptive Use (UKMEC), when making a clinical judgement on safe and appropriate methods of contraception for women after pregnancy.

Women should be informed of the effectiveness of different contraceptives including the superior effectiveness of long-acting reversible contraception (LARC). Effective contraception such as LARC is key to preventing alcohol exposed pregnancies.

Each GM Maternity provider should aim to have maternity staff trained and competent to fit LARC to all medically eligible women who request it prior to discharge from maternity services. Details on the process for training and obtaining a certificate of competence can be found in appendix 5

7. Monitoring and Evaluation

- Team responsible for monitoring: Team leaders, Matron, Specialist Midwives for those responsible in delivering
- the Alcohol Exposed Pregnancy pathway.
- Frequency of monitoring: Monthly review of performance data, quarterly report.
- Process for reviewing results and ensuring improvements in performance: Monthly performance data to be captured by Trust Business Intelligence (BI) and disseminated to clinical leads. Compliance against statements 1 and 2 of NICE Quality Standard - QS204 (2022) to be included in Saving Babies quarterly report. Compliance also to be reported at Saving Babies Lives meetings held monthly who will review and monitor any outstanding actions. Quarterly report to obstetric directorate meeting for review and monitoring of outstanding actions (via directorate manager).
- Adverse incidents relating to this Guideline should be reported via the Trust Incident Reporting System.
- The requirement to audit this guideline will be included in Trust Quality Improvement programmes.

8. Workforce Training

All prenatal care providers, including physicians, obstetricians, midwives and nurses, must be trained in FASD prevention and must have the capacity to inform and advise pregnant women and their partners about the risks of alcohol use in pregnancy at each antenatal appointment. This skill development of the wider maternity system ensures consistent messaging and support for women throughout their pregnancy.

This training should take place as part of the introduction to a new role and then occur every three years as mandatory training. Those maternity providers implementing an AEP pathway for the first time should prioritise this training as part of the implementation process. The training should be delivered inline with Best Practice Guidance

As a minimum this training should include:

- AEP and FASD awareness
- CMO guidelines
- Motivational Interviewing techniques

- How to deliver Brief Alcohol Interventions (BAI)
- Long-Acting Reversible Contraception (LARC)
- Local referral pathways
- #Drymester resources

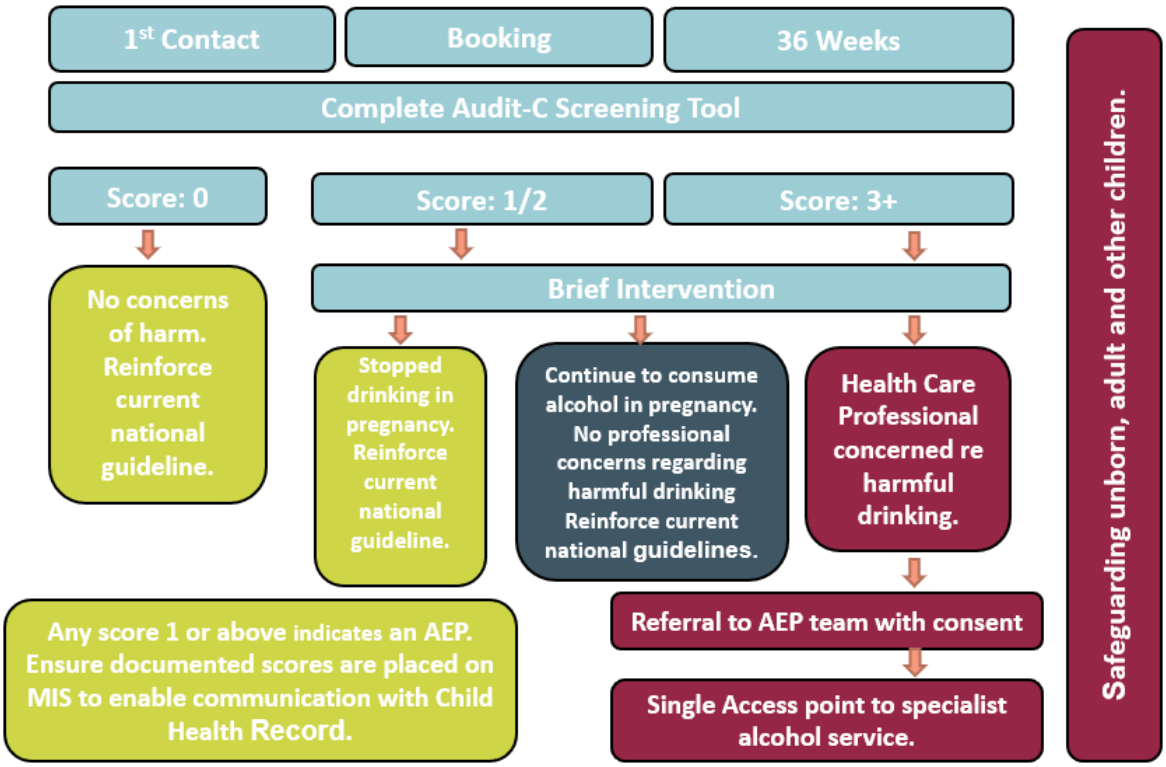
9. Example of auditable points and data collection

- % antenatal appointments in which pregnant women are advised not to drink alcohol during pregnancy
- % pregnant women screened for alcohol consumption using AUDIT- C at first contact
- % pregnant women screened for alcohol consumption using AUDIT- C who score +3 at first contact
- % pregnant women who scored AUDIT- C +3 at first contact with a reduced Audit C score at booking / second contact
- % pregnant women screened for alcohol consumption using AUDIT- C at 36 weeks
- # pregnant women referred to specialist alcohol treatment services
- % pregnant women fitted with LARC prior to discharge
- % midwifery staff trained in AEP/FASD awareness and brief advice
- # midwives trained to fit LARC

10. Abbreviations

ABI	Alcohol Brief Intervention
AEP	Alcohol Exposed Pregnancy
ANC	Antenatal Clinic
AUDIT- C	Alcohol Use Disorders Identification Test Consumption
BI	Business Intelligence
CMW	Community Midwife
FASD	Fetal Alcohol Spectrum Disorder
GP	General Practitioner
HV	Health Visitor
HCP	Health Care Practitioner
LARC	Long-Acting Reversible Contraception
MIS	Maternity Information System
NHS	National Health Service
NICE	National Institute of Clinical Excellence

Appendix 1: Example of an AEP Pregnancy Journey



Appendix 2: AUDIT - C

Questions (1st contact/booking/36wks) *During pregnancy/since we last discussed intake*	Score System 0	1	2	3	4	Score
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 – 2	3-4	5 – 6	7 - 9	10+	
How often have you had 6 or more units on a single occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL	

Appendix 3: Drymester

https://www.drymester.org.

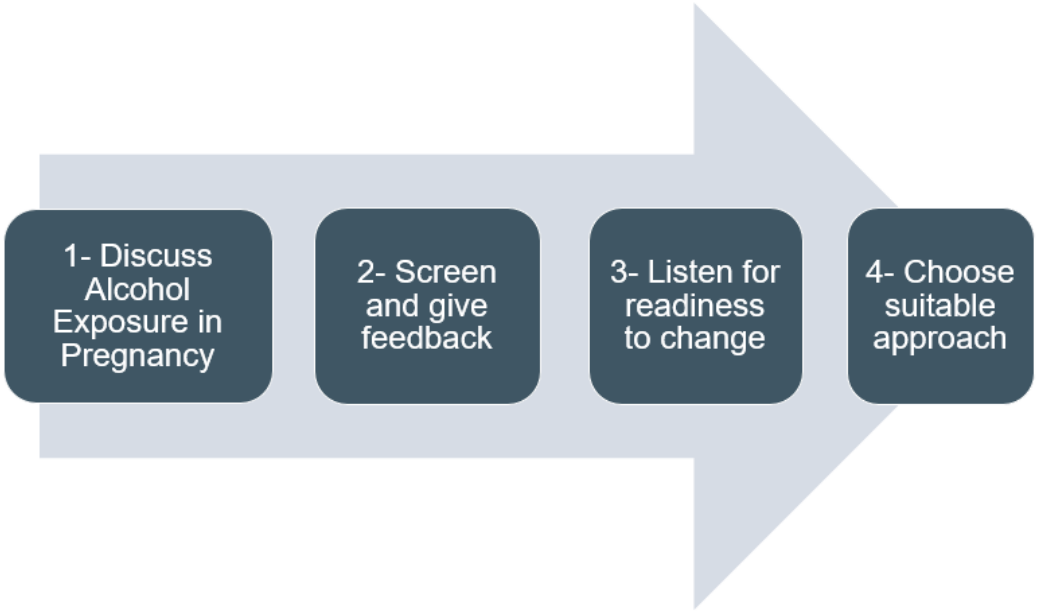
Appendix 4: ABI

A brief intervention is a conversation with a goal to support women to abstain from alcohol throughout their pregnancy. In that five minute conversation a midwife can make a change in the path that woman takes by providing evidence-based information.
An ABI should be:

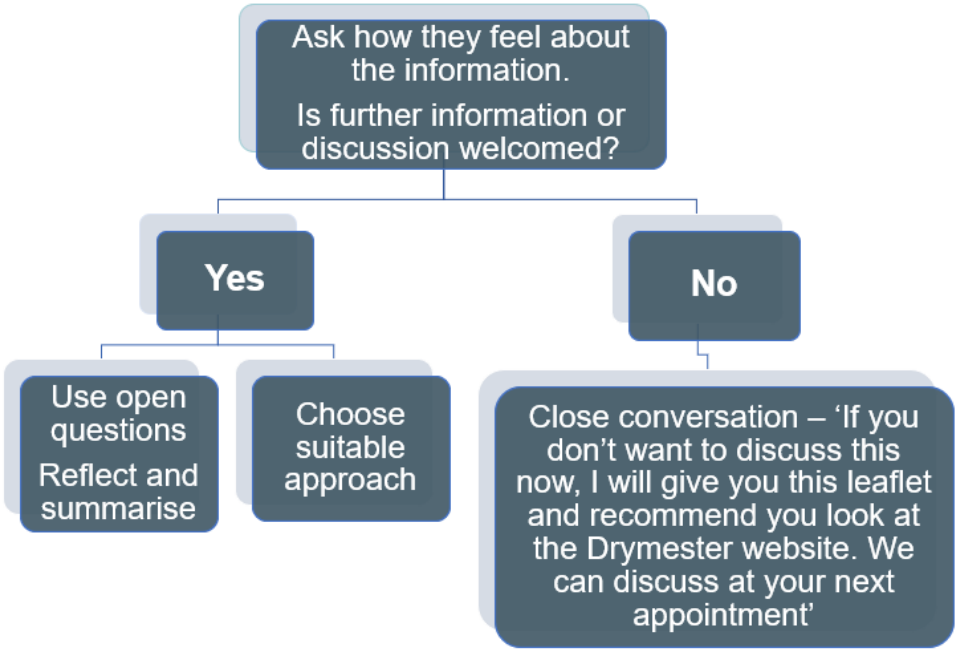
- Short
- Evidence-based
- Structured
- Non-confrontational
- Seeks to motivate and support the woman to think about and/or plan behaviour change

A brief intervention is not just handing out a leaflet.

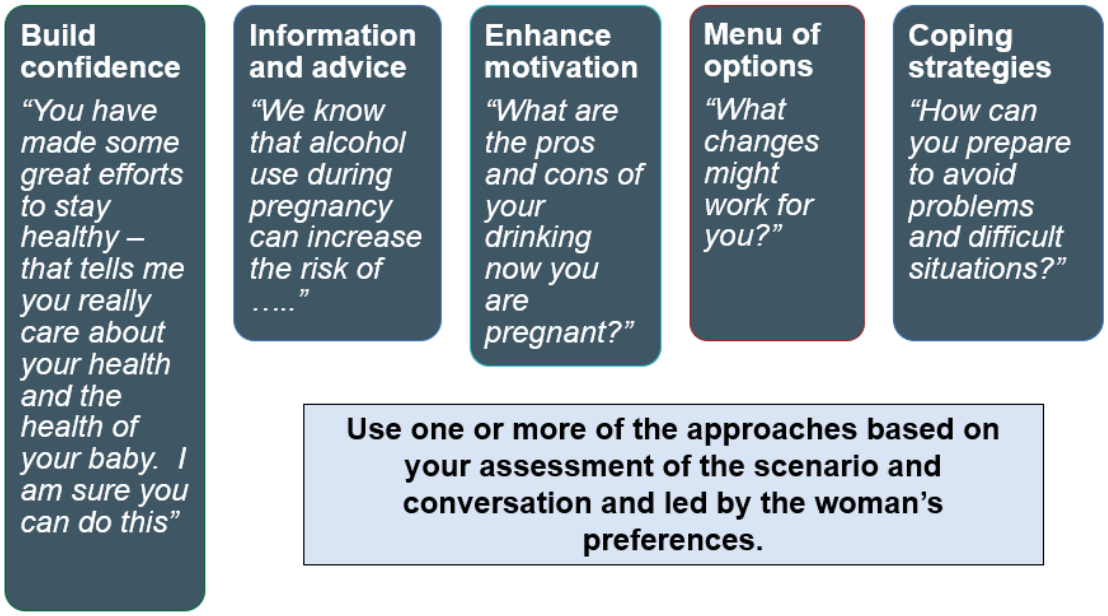
Stages of an ABI



Listen for readiness to change



Suitable Approach



Appendix 5: LARC

Training:

https://www.fsrh.org/education-and-training/e-learning-for-sexual-and-reproductive-healthcare-esrh/

Appendix 6: Safe Sleeping

Appendix 7: Breastfeeding

All correspondence to:
The Breastfeeding Network
PO Box 11126, Paisley PA2 8YB
Admin Tel: 0844 412 0995
e-mail: druginformation@breastfeedingnetwork.org.uk
www.breastfeedingnetwork.org.uk

the Breastfeeding network
Drugs in Breastmilk Information

Alcohol and Breastfeeding

The information provided is taken from various reference sources. It is provided as a guideline. No responsibility can be taken by the author or the Breastfeeding Network for the way in which the information is used. Clinical decisions remain the responsibility of medical and breastfeeding practitioners. The data presented here is intended to provide some immediate information but cannot replace input from professionals.

Breastfeeding mothers can have occasional, small amounts of alcohol but should not drink regularly or heavily (e.g. binge drinking) without considering how to limit the baby's exposure.
If you drink any alcohol DO NOT bed share with your baby or fall asleep in the sofa/chair.
If you do binge drink, your baby should be cared for by an adult who has not had any alcohol.
It is not necessary to express breastmilk to clear it of alcohol.

- Never share a bed or sofa with your baby if you have drunk any alcohol. Doing this has an increased association with sudden infant death syndrome (SIDS).
- Alcohol passes freely into breastmilk reaching approximately maternal levels BUT maternal blood levels have to reach 300mg/100ml before mild sedation is reached in the baby (this compares with a level of 80mg/100ml needed to fail the police breath test in England, Wales and N. Ireland; 50mg/100ml Scotland.
- To reduce exposure of the baby to alcohol, avoid breastfeeding for 2-3 hours after drinking.
- Peak levels in the milk appear after 30-90 minutes but this does not mean that social drinking of small amounts of alcohol mean that you cannot breastfeed.
- Excess levels of alcohol in milk may lead to drowsiness, deep sleep, weakness and decreased growth in the infant. Reduction of let-down is reported when the mother drinks heavily. Alcohol may reduce the baby's sucking time at the breast but not the volume of milk consumed.
- It is not necessary to express breastmilk to clear it of alcohol; as the mother's blood levels fall, the level of alcohol in the breastmilk will decrease.
- Binge drinking (more than 6 units of alcohol in one period), may make you less aware of your baby's needs. If you have drunk enough alcohol to make you feel disorientated or cause vomiting you should not be caring for your baby without supervision from a sober adult. You should ideally express for comfort and to maintain your supply – although this may be the last thing on your mind!
- Chronic consumption of alcohol is more likely to cause harm than occasional social drinking.

NB It is vital that mothers who have been drinking alcohol should never let themselves be in a situation where they might fall asleep with the baby; on a bed, chair or settee (this would also apply to other carers who have been drinking alcohol). The place of sleep is a bigger risk than the fact that the mother has been drinking unless her consumption has been very high.

Drinking alcohol reduces the ability of the mother to be aware of her baby's needs, whether she is breastfeeding or not. It is safest to ask someone else to care for the baby.

To talk to a mum who knows about breastfeeding call the National Breastfeeding Helpline 0300 100 0212

Calls to 0300 numbers cost no more than calls to UK numbers starting 01 and 02 and will be part of any inclusive minutes that apply to your provider and call package.

The Breastfeeding Network is a Company Limited by Guarantee Registered in Scotland Company No. 330639
Registered office Whitelaw Wells, 9 Ainslie Place, Edinburgh, EH3 6AT
The Breastfeeding Network is a Registered Scottish Charity No SC027007

Other websites

NHS Breastfeeding and drinking alcohol. - Your pregnancy and baby guide
www.nhs.uk/conditions/pregnancy-and-baby/breastfeeding-alcohol/

Guidelines from the NHS

- Anything you eat or drink while you're breastfeeding can find its way into your breast milk, and that includes alcohol.
- If you regularly drink as much as 14 units per week, it's best to spread your drinking evenly over 3 or more days.
- If you wish to cut down the amount you drink, a good way to help achieve this is to have several drink-free days each week.
- Fourteen units is equivalent to: 6 pints of average-strength beer, 10 small glasses of low-strength wine

Use Alcohol Change's alcohol calculator to check your units: https://alcoholchange.org.uk/alcohol-facts/interactive-tools/unit-calculator

Source: https://www.breastfeedingnetwork.org.uk/alcohol/