Greater Manchester Integrated Care Partnership

NHS
Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

Greater Manchester Smokefree Pregnancy Guideline and Care Pathway

Updated December 2023
Version 2.3

Part of Greater Manchester Integrated Care Partnership

LMNS
Greater Manchester and Eastern Cheshire
Local Maternity and Neonatal System

Document Control

Ownership

Role	Department	Contact
Jane Coyne, Treating Tobacco Dependency Programme Lead Lead Midwife - Treating Tobacco Dependence, NHS E Prevention Team	NHS Greater Manchester	jane.coyne@nhs.net
Fran Frankland, Smoke Free Pregnancy Specialist	For NHS Greater Manchester	fran@frankland1.com
Hilary Wareing, Director Improving Performance in Practice	Tobacco Control Collaborating Centre	hwareing@ipip.co.uk

Version control

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V1.0i	Amendment to Referral Services: North Manchester Be Well contact details removed	03/04/2021
V1.1a	Amendment to Referral Services: Referral services contact details updated Adjusted pronouns Inserted link to test your breath resources	23/11/2021
V1.1b	Update PPM ref NICE Guidance and update reference and phone numbers	24/02/2022
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V2.3	Ratified by GMEC SCN Maternity Steering Group Endorsed by GM LMNS Maternity and Neonatal System Group Re introduce CO Testing Tool (appendix 3)	15/12/23 01/05/2024

Contents

1 Introduction and Scope

Smoking, including shisha during pregnancy has serious consequences on the health of the child and can lead to an increased risk of miscarriage, premature birth, stillbirth and low birth weight babies which lead to a higher infant mortality rate. (DOH 2007)

There is strong evidence that reducing smoking in pregnancy reduces the likelihood of stillbirth.[i] pregnant people who stop smoking completely will benefit from a decreased risk of miscarriage, stillbirth, ectopic pregnancy, and placental complications, pre-term rupture of membranes, premature birth, low birth weight and a reduction in the risk of sudden infant death syndrome.[ii]

The Greater Manchester (GM) Infant Mortality review identified smoking as the most prominent risk factor associated with infant mortality. A universal approach to smoking cessation in pregnancy will help to deliver smokefree pregnancies and smoke free childhoods.

This evidence-based guideline aims to support clinicians identify pregnant people who smoke and ensure they are offered a maternity led pathway that supports them to quit and prevent relapse within maternity specialist stop smoking services. Along with this combined pharmacotherapy and behavioural interventions for pregnant people significantly increases smoking abstinence (83%) versus usual care or minimal support control groups not using medication.[iii]

2 Service Approach

This guideline supports a pan GM approach to a standardised pathway, as some boroughs have more than one local provider. Due to the way maternity services are provided across GM, a person may choose to give birth outside of the local area in which they would receive primary care and community services.

Helping pregnant people who smoke to quit involves communicating in a sensitive, client-centred manner, particularly as some pregnant people find it difficult to say that they smoke. Such an approach is important to reduce the likelihood that some of them may miss out on the opportunity to get support.

The recommendations in this guidance which refer to NHS Stop Smoking Services also apply to other; non-NHS Services that offer help to quit and operate to the same standard.

3 Roles and Responsibilities

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

- Midwives, Maternity Tobacco Dependency Advisors.
- Obstetricians, sonographers, paediatricians/ neonatologists.
- GPs, practice nurses, health visitors, family nurses.
- Early pregnancy staff, students and maternity healthcare support/care assistants

Healthcare workers should aspire to use every/any appointment or meeting as an opportunity to carbon monoxide (CO) screen pregnant people to establish smoking status. If they smoke, explain how NHS Stop Smoking Services can support them to quit and advise them to stop.[iv]

4 Antenatal Pathway

NICE guidance on Smoking in Pregnancy recognises some pregnant people will find it difficult to say they smoke because 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 (Appendix 1) will support practitioners to follow the pathway for people who smoke during pregnancy.

A CO test is an immediate, non-invasive biochemical screening method for helping to assess whether someone smokes or is at risk of harm due to raised CO levels.

Antenatal Booking Assessment
Prior to performing a CO test the person should be provided with a Test your Breath leaflet (Appendix 2), a CO test should be performed prior to establishing smoking status. All CO test results should be documented in the maternity records.

For the mechanics of performing a CO test refer to Appendix 3.

CO Testing
Prior to a CO test, explain that CO is a poisonous gas, and that CO screening is a simple routine part of antenatal care. Cigarette smoke is the largest cause of raised CO whilst environmental factors such as pollution from car exhaust fumes, faulty gas appliances and second-hand tobacco smoke can also contribute to raised CO readings. The pregnant person should be informed that the raised level can be reversed by avoiding these factors. 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 person's exposure to smoking. Cigarette smoke also contains over 7000 chemicals of which hundreds are toxic and may also cause damage to the fetus.

At the first face-to-face (F2F) contact/booking appointment **ALL** pregnant people will be asked to provide an exhaled CO test. *Note*: it is not appropriate to ask if someone smokes during a prebooking non F2F (Face to Face) appointment.

Regardless of smoking status, the midwife will explain the effects of CO on their own health and that of their unborn baby. *Note:* Take into consideration the last time a tobacco product was used, the number of cigarettes smoked and when on the day of the test.

Following the CO test, regardless of whether the reading is high or low (see above), reiterate to the pregnant person a raised CO reading is linked to potential poor fetal outcomes due to hypoxia and can result in miscarriage, restricted growth, damage to the placenta and fetal loss[v].

Interpreting CO Readings
Referral pathway and required actions following the CO test Appendix 4

If the pregnant person does not smoke but has a CO level of 4 PPM or more, help her to identify the source of CO and reduce it. Other sources include household or other secondhand smoke, heating appliances or traffic emissions.[vi]

Other factors to consider include the time since they last smoked, the number of cigarettes smoked on the test day. CO levels quickly disappear from expired breath; as a result, low levels of smoking may go undetected. *Note:* CO has a short half-life, this means that CO levels will reduce by half after around 3-4 hours.

For pregnant people who have **not** been exposed to smoking but have a CO of 4PPM or above, it is imperative that professionals understand the increased risk of CO poisoning.

Symptoms of CO Poisoning
Symptoms related to CO poisoning– tension type headache, dizziness, sickness, tiredness and confusion, stomach pains, shortness of breath/breathing difficulty, 'flu' like symptoms (unlike flu, CO does not cause a high temperature).

Being aware that symptoms may be less severe when you are away from the source of CO - ideally CO as soon as possible on entering the clinical area.

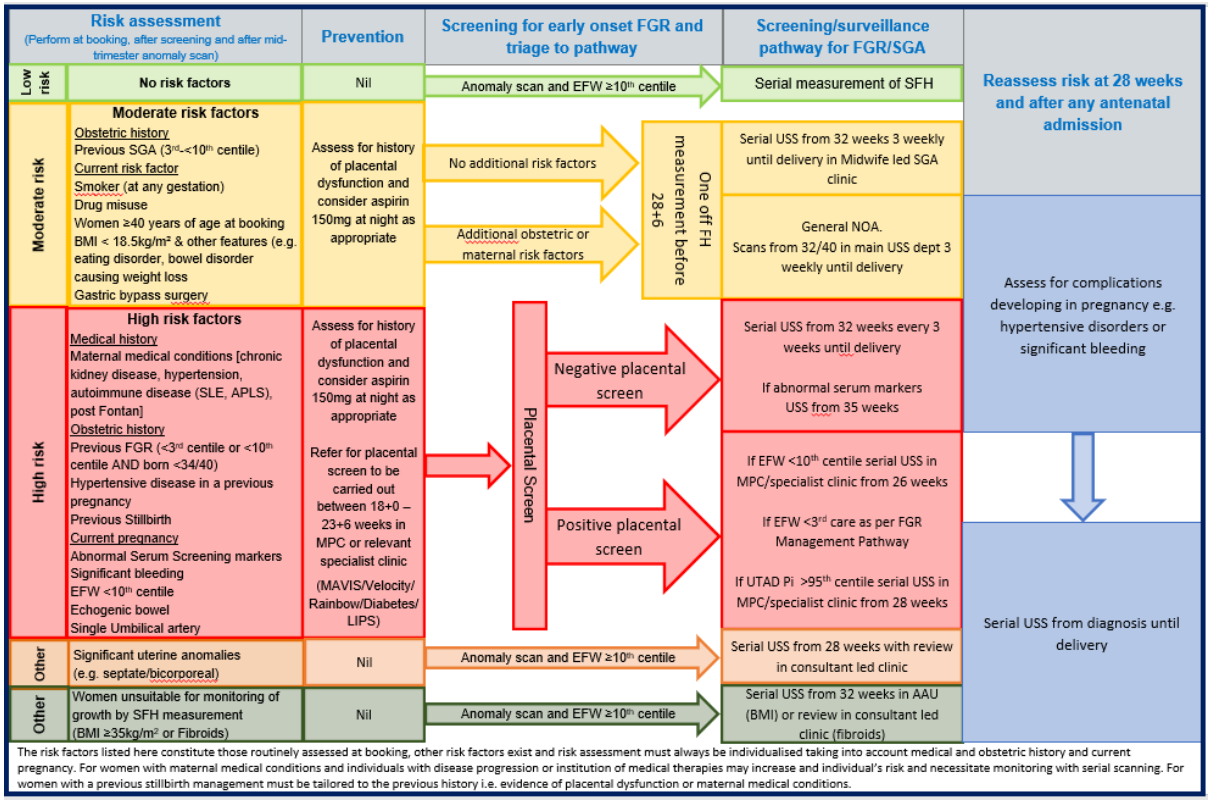
For non-smokers with exceptionally high CO rates i.e. ≥10PPM and/or symptoms of CO poisoning. It should be strongly recommended that they seek medical attention at local A & E.

As identified in SBLv3, pregnant women in the moderate-risk category require serial ultrasound scans every 4 weeks from 32 weeks gestation. *Reference table below*.

At any point through the pregnancy continuum, when a pregnant person is identified as a smoker they go onto the moderate risk FGR scan pathway as per SBLv3. *Reference table below*.

It is the named midwife or maternity health care provider's responsibility to change the pregnant person's pathway to moderate risk, if/when their status returns to smoker.

Smoking status needs to be confirmed and documented at **all** antenatal contacts, for risk assessment to be performed. It is then the responsibility of the clinician who has carried out the risk assessment to ensure the pregnant person is on the correct risk pathway (ref table below SBL v3).



Ref: https://www.england.nhs.uk/long-read/saving-babies-lives-version-3/#element-1-reducing-smoking-in-pregnancy

If the pregnant person has a consistent raised CO reading (4PPM or above) the midwife may consider referring to a consultant clinic for review for serial growth scans.

Referral Criteria

Referral criteria – refer all pregnant people through an 'Opt-Out' (i.e., the midwife should not ask if they want to be referred, it is inferred consent), and informed that a referral is going to be made for any of the criteria below to local maternity specialist stop smoking services (Appendix 4) who:

- Smoke tobacco/shisha/cannabis
- Have a raised CO ≥ 4 PPM
- Recent uptake of vaping (quit since conception- due to the risk of relapse).
- Early quitters (quit since conception- due to the risk of relapse).

Explain it is normal practice to refer pregnant people to their local maternity specialist stop smoking service as soon as possible.

The referral, ideally, should be an immediate telephone call to gain an appointment or referral within 1 working day.

If they decline the referral (but still send referral to the MTDS and indicate they have declined therefore by default they will be placed on the RPI register), accept the answer in an impartial manner; leave the offer of support and future referral open. Also highlight the flexible support that the Specialist Stop Smoking Service offers pregnant people; for example, appointments with a MTDA for behavioural support and treatment with pharmacotherapy (NRT Nicotine Replacement Therapy) and/or vape device (Appendix 7 and 8).

Where appropriate, for each of the stages above, record CO in PPM, smoking status, whether a referral is accepted or declined, and any feedback given. This should be recorded in the maternity records.

Advice should be to stop smoking completely rather than 'cutting down'. It is not recommended that pregnant smokers reduce the number of cigarettes smoked per day as this may create the false impression of risk reduction[vii]. Any level of smoking increases the risks associated with harm and pregnancy loss.

Discuss the benefits and importance of 'Smokefree Homes' and cars.

In recognition of the home environment, it is recommended that the midwife should inform them of the importance of smokefree homes and how to access to local stop smoking services for family members, significant others, carers, partners and co-habitors. Always offer referral advice.

Subsequent Antenatal appointments

For **ALL** subsequent antenatal appointments CO testing should be undertaken, their smoking status asked and documented. This provides an opportunity for further VBA (Very Brief Advice) to be given and re-referral to maternity Stop Smoking Services.

The Specialist Stop Smoking Service will give feedback to the named midwife, or maternity health care provider, on any non-engagement with their service. This will encourage the midwife to re-address/CO test at the next antenatal contact.

Those who were found to be smokers at the booking appointment who have not engaged with Stop Smoking Services by the time of their dating scan, will be identified as needing RPI (Risk Perception Intervention). This intervention will be undertaken by specially trained midwives within antenatal clinic following the person's booking scan and they will then offer a re-referral to the Maternity Specialist Stop Smoking Services.

In the third trimester (approx. 36 weeks) ALL pregnant people should have CO testing, their smoking status asked and documented. Midwives are encouraged to discuss repeat referral to Stop Smoking Services, support abstinence planning for admission to hospital and the birth to support the smokefree hospital site agenda. This an opportunity for an enhanced discussion that may support a quit attempt prior to birth.

5 Use and care of your CO Monitor

Please see monitor user manual for instructions.
https://www.bedfont.com/documents/resources/smokerlyzer/manuals/Smokerlyzer-Manual-UK.pdf

For accurate results the CO monitor should be used and stored at room temperature.

No products containing alcohol should be used as it affects the functioning and effectiveness of the monitors.

Single use mouthpieces should be removed and disposed of (refer to manual). D-Pieces can be used up to 30 days and then replaced, cleaning should be usual infection control measures (NHS Policy).

After each use clean the monitor with alcohol free detergent wipes in line with NHS Infection Control Policy.

If the person has an obvious respiratory infection, do not perform the monitoring.

6 Referral to Stop Smoking Services

The referring maternity practitioner will need to refer by locally agreed referral methods (Appendix 4), addressing any factors which prevent the person from using maternity Specialist Stop Smoking Services. This could be a lack of confidence, lack of knowledge around services, fear of failure and concerns about being stigmatised.

Ideal referral, gold standard, is a telephone referral at point of contact enabling the pregnant person to leave their booking appointment with an appointment with the service within 5 working days.

The Maternity Specialist Stop Smoking Services are to document the care given and any NRT administration in the maternity records alongside the smokefree pregnancy platform. This promotes a team approach and increases the person's confidence and engagement in the service.

They will have weekly appointments until the 4-week quit is achieved, then offer monthly support until birth and beyond up to three months postpartum, ensuring the quit is CO validated.

They will give feed back to the referrer if the person does not engage at any point with the service as per the Saving Babies Lives Care Bundle.

Stop smoking advice and referral should also be made at any given opportunity.

7 Risk Perception Intervention

All pregnant people who were smoking at the time of booking should be identified at their booking scan and those who remain smoking or have not engaged with the Maternity Specialist Stop Smoking service should receive a Risk Perception Intervention (RPI) at Dating or Nuchal Translucency Scan.

- Prior to their booking scan the pregnant people who have declined or not engaged with Specialist Stop Smoking services should be identified and antenatal clinic notified of the need for RPI and when they will be attending for their scan.
- The specially trained midwife will undertake the RPI.
- Following the Intervention those who accept will be re-referred to the stop smoking service

Information

- The person is informed about the risks to themselves and the fetus (including morbidity and mortality).
- Discussion of risk of harm to the fetus from exposure to CO.
- Information regarding management of pregnancy and delivery.
- Clear documentation of discussions/information given to the person.

N.B. For those people who do not receive RPI e.g., late bookers who are not scanned, specially trained staff can utilise elements of the RPI conversation to personalise a conversation for those not engaging and encourage referral to stop smoking services. RPI that are not performed should be highlighted through incident reporting methods.

8 Nicotine Replacement Therapy

Please see local agreements for NRT provision.

Vaping and NRT refer to Appendix 7 and 8.

9 In-patient care

Pregnant people who have smoked throughout their pregnancy are likely to experience symptoms of nicotine withdrawal during their hospital stay, it is essential that the pregnant people are identified as smokers as part of entry into the maternity system e.g. Maternity triage, Antenatal ward, during labour and following the delivery of their baby, particularly pregnant people who have a prolonged postnatal admission (e.g. following a premature birth or a caesarean section).

All areas to review abstinence plan and ensure availability of nicotine replacement therapy (NRT) in all in-patient areas to support with withdrawal symptoms.

Make pregnant people aware of the hospital smokefree policy antenatally and help them to make plans to be smokefree and access NRT either readily available on the unit or provided by their advisor from the Maternity Specialist Stop Smoking Services. If there is no provision of NRT within the unit for pregnant women who are smoking at time of admission, contact your local Maternity Stop Smoking Service and seek advice about access to NRT.

As part of admission to hospital it is a requirement that they are to have a CO test on admission, if an emergency use your clinical judgement as to the timing of the CO test. Ascertain smoking status and document. This will enable assessment within 30 minutes of admission, to commence abstinence plan and pharmacotherapy (NRT) if required.

Those who have chosen to vape during their pregnancy should be continued to be supported to do so within Trust guidelines.

10 Postnatal Care

The postnatal ward plays an intrinsic part in the possible period of abstinence. Encouragement should be given to those pregnant people who have remained abstinent during their hospital stay, continued availability of NRT is crucial to further facilitating the abstinence attempt.

For those who remain smoking, utilise the ‘Making Every Contact Count’ and offer ‘Very Brief Advice’ whilst on the ward. Take any opportunity to repeat a CO test if it is felt this would enhance conversations to support a quit attempt. If possible, CO test on discharge and refer if appropriate for advice about access to community-based support services.

It is important that the smoking status is communicated between maternity and neonatal care teams. This will allow neonatal colleagues to also offer appropriate Very Brief Advice whilst the baby is an inpatient and have a useful discussion around smokefree homes upon discharge.

Discuss the risks of second-hand smoke to the baby and provide information on the higher incidence of sudden infant death syndrome. Advise that bed sharing is especially dangerous if they and/or their partner are smokers (no matter where they smoke). Document in the postnatal notes and child health record (red book).

Support pregnant people who have successfully stopped during pregnancy to remain smokefree postnatally by continuing to access their Specialist Stop Smoking Service.

Reinforce the benefits of staying smoke free and having a smokefree home.

When supporting breastfeeding, use the opportunity to raise awareness of the physiology of breastfeeding when smoking, i.e., 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 pregnant people to remain non-smokers.

11 Monitoring and Evaluation

Team responsible for monitoring: Team leaders, Matron, Specialist Midwives for those responsible in delivering the Smokefree Pregnancy pathway.

Frequency of monitoring: Monthly review of key standards, quarterly report.

Process for reviewing results and ensuring improvements in performance: Monthly key standard data to be reported and disseminated to clinical leads, including relevant data required by CNST. Key standards to be included in Saving Babies quarterly report. Key standards 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.

12 Example of auditable points and data collection

SFP KPIs

KPI	KPI
KPI 1 % of referrals actioned by stop smoking services within 1 working day	95%
KPI 2 % of referrals leading to a completed appointment within 5 working days of referral	60%
KPI 3 % of referrals leading to a completed appointment	85%
KPI 4 % of referrals leading to a completed at least 1 appointment and signed up to the incentive scheme	95%
KPI 5 % of referrals leading to a quit being started (set a quit date)	70%
KPI 6 % of referrals which achieved a 4-week quit (set a quit date and maintained for four weeks)	60%
New KPI 6A % of those setting a quit date – how many were quit at four weeks	75%
KPI 7 % of referrals which had a successful four week quit validated by CO test	95%
KPI 8 % of referrals which achieved a 12-week quit (set a quit date and maintained for twelve weeks)	40%
New KPI 8A % of those setting a quit date – how many were quit at twelve weeks	60%
KPI 9 % of referrals which had a successful twelve week quit validated by CO test	95%
KPI 10 % of referrals for RPI leading to a completed appointment	(Monitor only)

Maternity KPIs

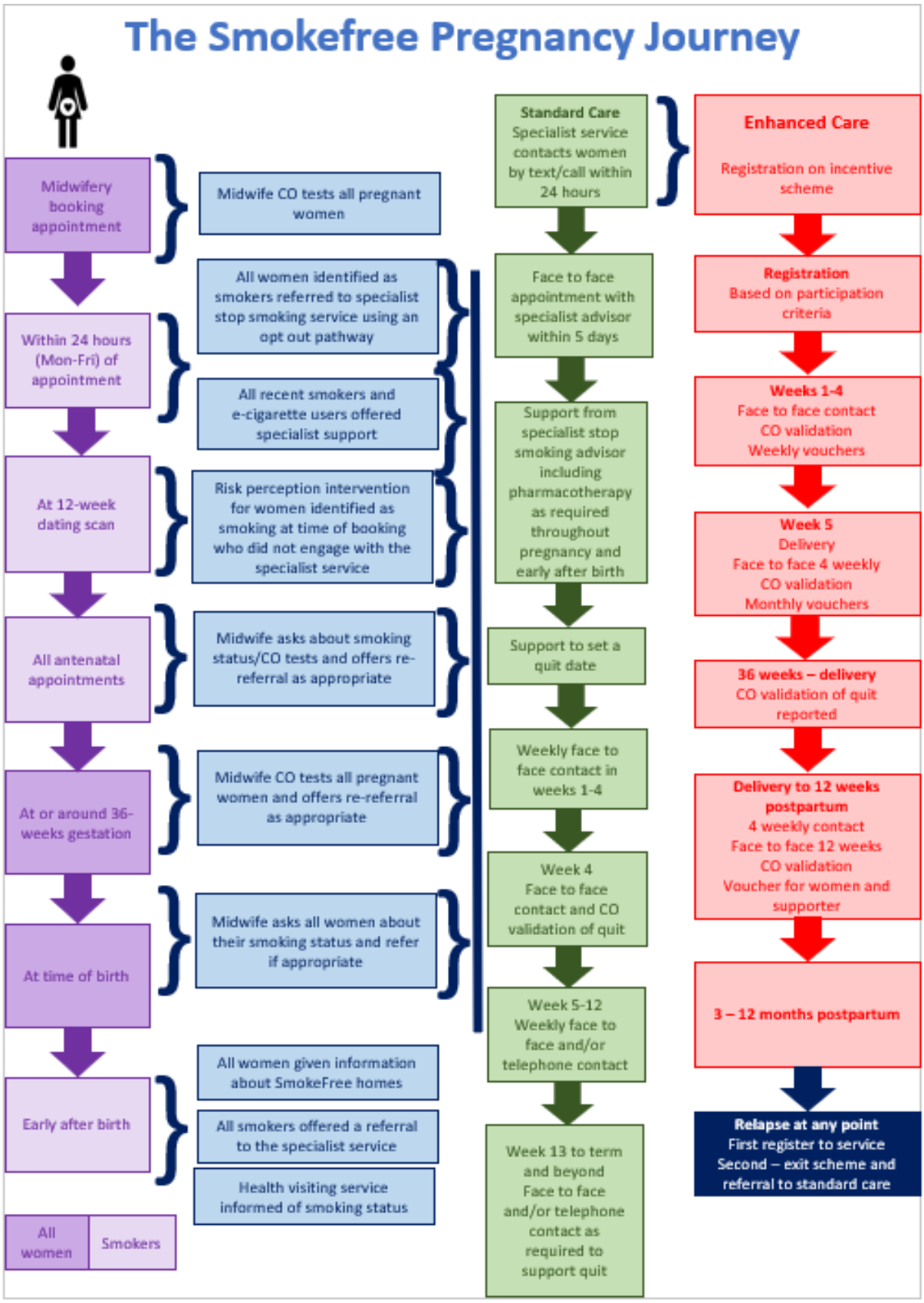
Percentage of women where CO measurement and smoking status is recorded at booking	95%
Percentage of women where CO measurement and smoking status is recorded at 36 weeks	95%
Percentage of women identified as smokers referred to Stop Smoking Service	90%
Percentage of women identified as smokers referred to Stop Smoking Service within one working day	90%

Percentage of eligible women offered RPI	75%
Percentage of those offered RPI who refused referral to SSS	50%

13 Abbreviations

ANC	Antenatal Clinic
CMW	Community Midwife
CNST	Clinical Negligence Scheme for Trusts
CO	Carbon Monoxide
GP	General Practitioner
HV	Health Visitor
MECC	Making Every Contact Count
MTDA	Maternity Tobacco Dependency Advisor
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NRT	Nicotine Replacement Therapy
RPI	Risk Perception Intervention
SATOB	Smoking at the Time of Booking
SATOD	Smoking at Time of Delivery
VBA	Very Brief Advice

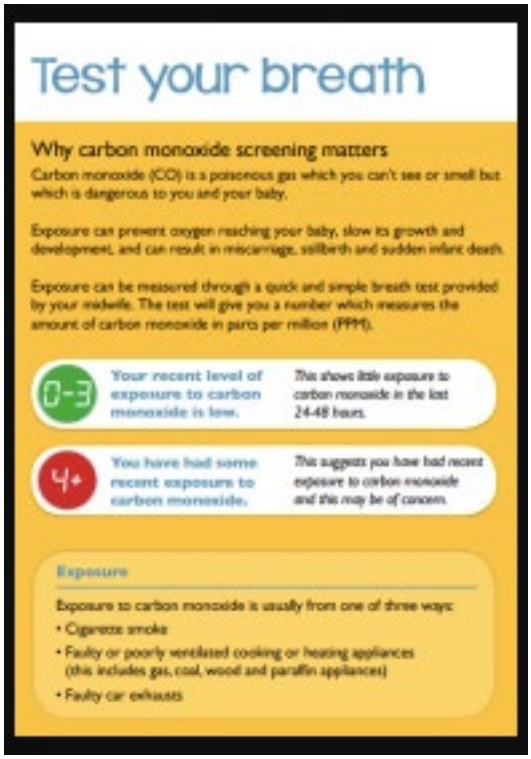
Appendix 1: The Smokefree Pregnancy Journey



Appendix 2: CO Testing Leaflet

Link to new information sheet and downloadable copies available at:

https://smokefreeaction.org.uk/smokefree-nhs/smoking-in-pregnancy-challenge-group/smoking-in-pregnancy-challenge-group-resources/carbon-monoxide-screening/



Test your breath

Why carbon monoxide screening matters

Carbon monoxide (CO) is a poisonous gas which you can't see or smell but which is dangerous to you and your baby.

Exposure can prevent oxygen reaching your baby, slow its growth and development, and can result in miscarriage, stillbirth and sudden infant death.

Exposure can be measured through a quick and simple breath test provided by your midwife. The test will give you a number which measures the amount of carbon monoxide in parts per million (PPM).

0-3 Your recent level of exposure to carbon monoxide is low. This shows little exposure to carbon monoxide in the last 24-48 hours.

4+ You have had some recent exposure to carbon monoxide. This suggests you have had recent exposure to carbon monoxide and this may be of concern.

Exposure

Exposure to carbon monoxide is usually from one of three ways:

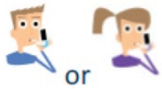
- Cigarette smoke
- Faulty or poorly ventilated cooking or heating appliances (this includes gas, coal, wood and paraffin appliances)
- Faulty car exhausts

Appendix 3: Taking a CO Breath Test

The form can be downloaded here CO Testing Tool

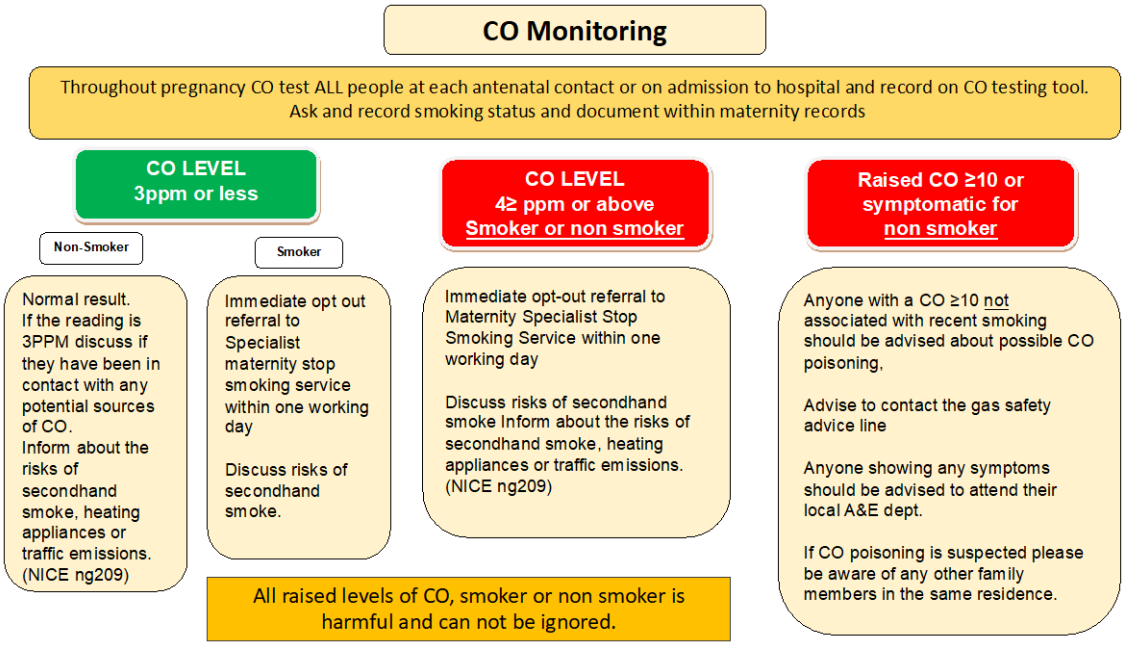
Please ensure you are familiar with the devices specific to your locality; this is an example….

Taking a breath test

1. Attach a breath sampling D-piece™ and new SteriBreath™ mouthpiece
2. Turn on the monitor by pressing the power button once
3. Press 'breath test' symbol on screen,  or
4. To cancel the breath test, press
5. Inhale and hold breath for the pre-set 15 second countdown
6. A beep will sound during the last three seconds of the countdown.
7. Blow slowly into mouthpiece, aiming to empty lungs completely

8. The ppm and equivalent %COHb and/or %FCOHb levels will rise and hold onscreen.
9. On the piCO™ and piCO^{baby}™, when the test is finished will appear at the bottom of the screen
10. On the Micro^{+}™, when the test is finished will appear at the bottom of the screen
11. If a high reading has been recorded, you can mute the sound by pressing
12. To repeat breath test, press once to return to the home screen and repeat steps 3-8
13. To save the reading (Micro^{+}™ only) press and select the relevant patient profile
14. Remove the D-piece™ between tests to purge sensor with fresh air
15. To switch off, press and hold the power button for 3 seconds, unit will also power off after 2 minutes of inactivity to save power.

Appendix 4: Acting on results of a breath test.



Symptoms of Carbon Monoxide (CO) poisoning are not always obvious, particularly with low level exposure. However, exposure can cause symptoms similar to food poisoning or flu, and can also include

- ☐ **Tension-type headache**
- ☐ **Dizziness**
- ☐ **Feeling and being sick**
- ☐ **Tiredness and confusion**
- ☐ **Shortness of breath**
- ☐ **Difficulty breathing**
- ☐ **Stomach pain**

Appendix 5: GM Stop Smoking in Pregnancy Support Services

Bolton	
Delivered by specialist midwife/MTDA team, Ingleside Birth and Community Centre, Oakwood Park, Swinton Park Road, Salford, M6 7WR	
Referral methods	Tel: 07827992883
	E-referral: specialistservice@boltonft.nhs.uk

MFT	
Delivered by specialist midwife/advisor team, Trafford General Hospital, Moorside Road, Davyhulme, Manchester, M41 5SL	
Referral methods	Tel: 07971115482
	E-referral: mft.maternity.stopsmoking@nhs.net

Rochdale	
Delivered by specialist midwife/MTDA team, Rochdale Infirmary, Whitehall Street, Rochdale, OL12 0NB	
Referral method	Tel: 07966 240892
	E-referral: ncamaternitystopsmokingservices@nhs.net

Oldham	
Smoking cessation delivered by specialist midwife/MTDA team, Royal Oldham Hospital, Rochdale Rd, Oldham OL1 2JH	
Referral methods	Tel: 07966 240892
	E-referral: ncamaternitystopsmokingservices@nhs.net

Tameside	
Delivered by specialist midwife/MTDA team, Tameside General Hospital, Fountain Street, Aston-under-Lyne, OL6 9RW	
Referral method	Tel: 07425096374 or 0161 922 5989
	E-referral: tga-tr.Tameside.Maternity.StopSmoking@nhs.net

Stockport	
Delivered by specialist midwife/MTDA team, Stepping Hill Hospital, Poplar Grove, Stockport, SK2 7JE	
Referral methods	Tel: 0161 419 4734 or 07876351391
	E-referral: maternity.stopsmoking@stockport.nhs.uk

Wigan	
Maternity Smokefree Pregnancy Team, c/o Midwives office, Longshoot Health Centre, Scholes, Wigan, WN1 3NH	
Referral methods	Tel: **07786 501322**
	E-referral: MaternitySmokeFree.PregnancyTeam@wwl.nhs.uk

Appendix 6: Supply or administration of a GSL medicine without a prescription Authorisation form

Principles:

This authorisation form is for the supply or administration of GSL medicines without a prescription. The following standards must be met:

- General Sales List (GSL) medicines only
- Used in line with GSL Marketing Authorisation, including the directions for use and taking into account the intended group of patients.
- The benefits of supply or administration of the medicine must outweigh the risks to the patient group.

Section 1:

Title:	**Supply or administration of Nicotine Replacement Therapy**			
Group of practitioners who will supply/administer:	Specialist Midwives with remit for smoking cessation and specialist smoking cessation maternity assistants			
Department:	Community Midwifery	Hospital / MCS / LCO:		
Clinical Lead Name:		Designation:		
Product details				
What medicine(s) is/are to be supplied? Confirm that this is a GSL. State pack size and brand (if applicable)	Nicotine replacement therapy (GSL) See Appendix 7			
What are the directions for use?	See Appendix 7			
Is the intended use (dosing, patient population) in line with the GSL licence and product information? Note: Off-label use and clinical trial medicines will not be accepted.	tbc			
Population details				
Who are the group of patients?	All women who are pregnant or recently given birth under the care of…… (Obstetrics)			
Age range of patients?	Adult:	16-60	Paediatric:	
State the expected patient benefits	To support women in their 'Quit' attempt to stop smoking whilst pregnant or post-natal up to 12 months post-partum.			

Administration	
Who will administer the medicine? (for patient administration at home or for administration by a healthcare practitioner)	Qualified midwives Specialist maternity assistant smoking cessation advisors
If a non-registered healthcare practitioner is administering the medicine, are they acting on the instructions of a registered healthcare professional, e.g. registered nurse or acting independently?	Acting on the instructions of a registered midwife
Where will administration of the medicine(s) be documented?	Smoking cessation documentation which will be filed within maternal medical records
Storage	
Where is the product obtained/purchased from? (e.g. via Pharmacy, NHS supplies or other)	NHS supplies?
Where will the medicine be stored?	Locked storage within clinic setting
Who is the key holder with access to medicines where they will be stored?	Clinic co-ordinator
Supply	
Will the medicine be supplied to a patient? (if no, skip to next section)	Yes
Who will supply the medicine?	Qualified specialist midwife and specialist smoking cessation maternity assistant
Where is the medicine being supplied from? (e.g. from clinic stock, delivered to a patient's home. NB: unless a specific exemption from the Medicines Act applies GSLs must be supplied from an MFT premise)	Clinic stock
Training	
What basic training does this group of practitioners have? (e.g. BTEC, scientific degree, etc.)	Registered midwife status (Diploma/Degree) Specialist smoking cessation maternity assistants: babyClear training, NCSCT online training
What training for practitioners supplying this medicine is proposed? Describe how this will be delivered.	NSTC training package (online) babyClear 2 day smoking cessation advisor training (face to face) Face to face and online

What competence assessment will be undertaken? (attach copies if available)	Certificate of completion of NCSTC and babyClear training		
Other supporting information			
What procedures will be in place (attach copies if available)?	All women referred to the Maternity Smoking Cessation service who are offered and accept NRT will have this recorded on a proforma within Maternity handheld notes and local smoking cessation documentation. Babyclear programme		
Any supporting information (attach)			
Form completed by: (include name and designation)			
• I understand that the administration or supply of this GSL medicine by this group of practitioners is appropriate for the range of staff and the patient cohort. The expected benefit of administration or supply outweighs the risks to the patient group. • I will communicate this information to clinical leads and line managers in the relevant areas. • I understand that if there is any change to the procedure that has been submitted or any of the above details than this must be discussed with the Deputy Director of Pharmacy			
Medical Director:	Signature	Print Name	Date
Director of Nursing:	Signature	Print Name	Date

Section 2:

The above request has been reviewed by the PGD Subgroup on: _____ and they APPROVE the supply/administration of the medicine stated by the practitioners stated.

Signed, on behalf of the PGD Subgroup:

Deputy Director of Pharmacy and Head of Medicines Management:	Signature	Print Name	Date

Appendix 7: NRT

Name of medication	Dose of medication	Indications for use	Side effects, cautions and Contraindications
Nicotine Patch (Nicorette®)	Skin Patch <10 cigarettes per day (CPD): 15mg 16 hr patch for 8 weeks followed by 10mg 16 hr patch for 4 weeks >10 CPD: 25mg 16hr patch for 8 weeks followed by 15mg 16hr patch for 2 weeks then 10mg 16hr patch for 2 weeks	Stop smoking treatment If patches are used they should, if possible, be removed at night when the fetus would not normally be exposed to nicotine. Easy to use/excellent safety/tolerability profile.	Cautions, further information Most warnings for nicotine replacement therapy also apply to continued cigarette smoking, but the risk of continued smoking outweighs any risks of using nicotine preparations. Specific cautions for individual preparations are usually related to the local effect of nicotine. Side-effects Bloating; blurred vision; constipation; coughing; diarrhoea; dry mouth; dyspepsia; dysphagia; epistaxis; flatulence; gastritis; gastro-intestinal disturbances (may be caused by swallowed nicotine); hiccup; increased salivation; irritation of the throat; mild local reactions at the beginning of treatment are common because of the irritant effect of nicotine; minor skin irritation; mouth ulcers; nasal irritation; nausea; oesophagitis; paraesthesia; sneezing; vomiting; watery eyes
Nicotine oral spray (Nicorette®) Quick Mist spray)	Mouth spray 1mg/spray Spray once or twice on urge to smoke (usually every 30mins – 1hour) Max 2 sprays per dosing episode Max 4 sprays per hour Max 64 sprays/day	Stop smoking Treatment	As above under Nicotine Patch
Nicotine Gum (Niquitin®, Nicorette®, Nicotinell®)	Chewing Gum >20 CPD: 4mg when required <20CPD: 2mg when required Niquitin®: Max 15 pieces per day Nicorette®: Max 15 pieces per day Nicotinell®: Max 25 pieces per day.	Stop smoking Treatment	As above under Nicotine Patch plus Jaw Ache, Difficult with dentures

Name of medication	Dose of medication	Indications for use	Side effects, cautions and Contraindications
Nicotine Nasal Spray (Nicorette®)	Nasal Spray 500mcg/spray One spray into each nostril on urge to smoke up to twice per hour for 16hrs per day. Max 64 sprays per day reduce dose gradually after 8 weeks. Recommended maximum treatment course: 3 months	Stop smoking Treatment	As Nicorette Patch plus Nasal irritation but settles within few days
Nicotine Inhalator (Nicorette®)	Oral inhalator 15mg Max 6 cartridges per day	Stop smoking Treatment	As Nicorette patch plus Coughing, Throat irritation
Nicotine Micro tab (Nicorette®)	Oral 2 mg tabs At least 12 weeks Maximum treatment duration 6 months. 4 mg (2 tabs per hour when required) > 20 CPD 2mg (1 tab per hour when required) < 20 CPD Max 80 mg 40 tabs per day Reduce dose gradually after 12 weeks.	Stop smoking Treatment	As Nicorette patch plus Stinging mouth, Localised irritation
Nicotine Lozenge (Niquitin® 1.5mg, 2mg, 4mg Nicotinell® 1mg, 2mg, Nicorette® 2mg)	Oral 1.5mg At least 6-12 weeks (depending on brand) then reduce dose gradually. Maximum treatment duration usually 6 months (depending on brand – consult product literature) Use lower strengths for < 20 CPD and higher strengths for >20 CPD 1 lozenge every 1-2 hours or on urge to smoke 1 mg – Max 30 per day Higher strengths – Max 15 per day	Stop smoking Treatment	As Nicorette patch plus stinging mouth, localised irritation

Appendix 8: Vaping

Vaping is designed to appear and feel like real cigarettes but allow users to inhale through vapour without the concentrated toxic compounds found in tobacco smoke. Most have three components including a battery, atomiser, and replacement cartridge, which suspends nicotine in propylene glycol, water, and flavourings. Liquid in the cartridge is heated and evaporates when users draw on the device. Varying levels of nicotine (if used) are then delivered through a vapour, and some products light up at the tip at this point to resemble a lit cigarette.

There has been an overall shift towards the inaccurate perception of vaping being as harmful as cigarettes over the last year in contrast to the current expert estimate that using Based on the latest evidence vaping, is significantly less harmful than smoking and are an effective aid for quitting. However, it is important to use UK vaping liquids that have been regulated by the MHRA and never homemade or illicit vaping substances.[viii]

Recent studies support the Cochrane Review findings that vaping can help pregnant people to quit smoking and reduce their cigarette consumption. There is also evidence that vaping can encourage quitting or cigarette consumption reduction even among those not intending to quit or rejecting other support. More research is needed in this area.

However, for now, the initial advice to pregnant people should be that the National Institute for Clinical Excellence (NICE) guidelines recommends that if a person uses a product containing nicotine to help them quit smoking, it is best to use one that is licensed instead of It is better for the person to consider using NRT that have been tested and are known to be safe to use during pregnancy.

If a person is solely using a vape, this is *not* considered as smoking for recording purposes and the person should be recorded as being a non-smoker.

There is a risk of fire from the electrical elements of vaping and a risk of poisoning from ingestion of vaping liquids. These risks appear to be comparable to similar electrical goods and potentially poisonous household substances. Please see local policies regarding batteries being recharged on Trust premises. All staff should be aware of the fire hazard associated with the use and recharging of vaping devices are not to be used in an oxygen rich environment.

Further information

Link to Health Education England training on CO testing e-LfH Hub

Link to Test Your Breath Leaflet Test-your-breath-new-version.pdf (can be downloaded in different languages)

Link to pregnancy Challenge group resources on vaping 2019-Challenge-Group-ecigs-briefing-FINAL.pdf (smokefreeaction.org.uk)

References

Department of Health (2007) Review of the health inequalities infant mortality PSA target. London: Department of Health.

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[ii] Royal College of Physicians. Passive smoking and children. A report by the Tobacco Advisory Group. London: RCP, 2010.

[iii] https://pubmed.ncbi.nlm.nih.gov/33523610/

[iv] Page 18, point 4.54 Ockenden report https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

[v] 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.

[vi] https://www.nice.org.uk/guidance/ng209/chapter/Recommendations-on-treating-tobacco-dependence-in-pregnant-women#identifying-pregnant-women-who-smoke-and-referring-them-for-stop-smoking-support

[vii] Paul Aveyard et al (2014) BMJ 2014;348: g2787.

[viii] https://smokefreeaction.org.uk/smokefree-nhs/smoking-in-pregnancy-challenge-group/smoking-in-pregnancy-challenge-group-resources/e-cigarettes-in-pregnancy/#:~:text=Using%20e%2Dcigarettes%20before%2C%20during%20and%20after%20pregnancy&text=Smoking%20or%20exposure%20to%20secondhand,Infant%20Death%20Syndrome%20(SIDS).