

Smoking Cessation:

A briefing for midwifery staff

Also available online at www.ncsct.co.uk

CPD Training & Certificate of Assessment



NCSCT



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Author: Andy McEwen

Editors: Linda Bauld and Yvonne Hermon

Reviewers: Jo Locker, Louise Ross and Hilary Wareing

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Background

Smoking in pregnancy poses significant health risks to the mother and to the baby. For the mother, smoking in pregnancy carries with it all the health risks associated with smoking but with some additional pregnancy-related health risks, including ectopic pregnancy, placenta praevia and pre-eclampsia; pregnant women are also at increased risk of deep vein thrombosis.

The risk of miscarriage, stillbirth, premature birth, low birth weight, fetal growth restriction (FGR) and neo-natal death is increased in babies born to mothers who smoke, and they are twice as likely to die from Sudden Unexplained Death in Infancy (cot death). Children born to mothers who smoke are more likely to have behavioural problems, including attention and hyperactivity problems, learning difficulties and reduced educational performance, and respiratory problems.

The 2010 Infant Feeding Survey revealed that a third of mothers in England (26%) smoked in the 12 months before or during their pregnancy and that one in eight mothers (12%) reported that they continued to smoke throughout their pregnancy. In the UK, rates of smoking in pregnancy differ across groups with mothers aged 20 or under six times more likely than those aged 35 and over to have smoked throughout pregnancy (35% and 6% respectively). Pregnant women are also more likely to smoke if they are less educated, live in rented accommodation and are single or have a partner that smokes.

Smoking status can and does change in pregnancy. Although many women stop smoking by themselves prior to becoming pregnant and others will stop immediately, once pregnancy is confirmed, other pregnant women who smoke and who want to stop smoking will need considerable support to stop successfully. Nicotine contained in cigarettes isn't particularly harmful (it is the tar and carbon monoxide that cause most of the health problems), but it is highly addictive, and smoking is a chronic relapsing condition.

All staff coming into contact with pregnant women have a role to play, mainly through triggering quit attempts (by delivering very brief advice on smoking). This briefing is aimed at helping members of the midwifery team to deliver very brief advice (VBA) on smoking to their patients.

Most local stop smoking services have a specialist pregnancy smoking cessation practitioner who can provide behavioural support and advice on medication to pregnant women who smoke and who want to stop. The National Centre for Smoking Cessation and Training (NCSCT) has developed a specialist online training course for practitioners who are NCSCT Certified: Smoking cessation in pregnancy and the post-partum period. This course provides information on the health effects of smoking in pregnancy, the benefits of cessation and effective methods to help pregnant women to stop smoking; it also focuses on best practice in assisting pregnant women to stop smoking and has links to useful resources.

This briefing is written for the midwifery team to complement the NCSCT Smoking cessation in pregnancy and the post-partum period training module to maximise the opportunity for pregnant women who smoke to get expert support before, during and after their quit attempt.

Introduction

There are three simple steps to intervening with pregnant women who smoke:

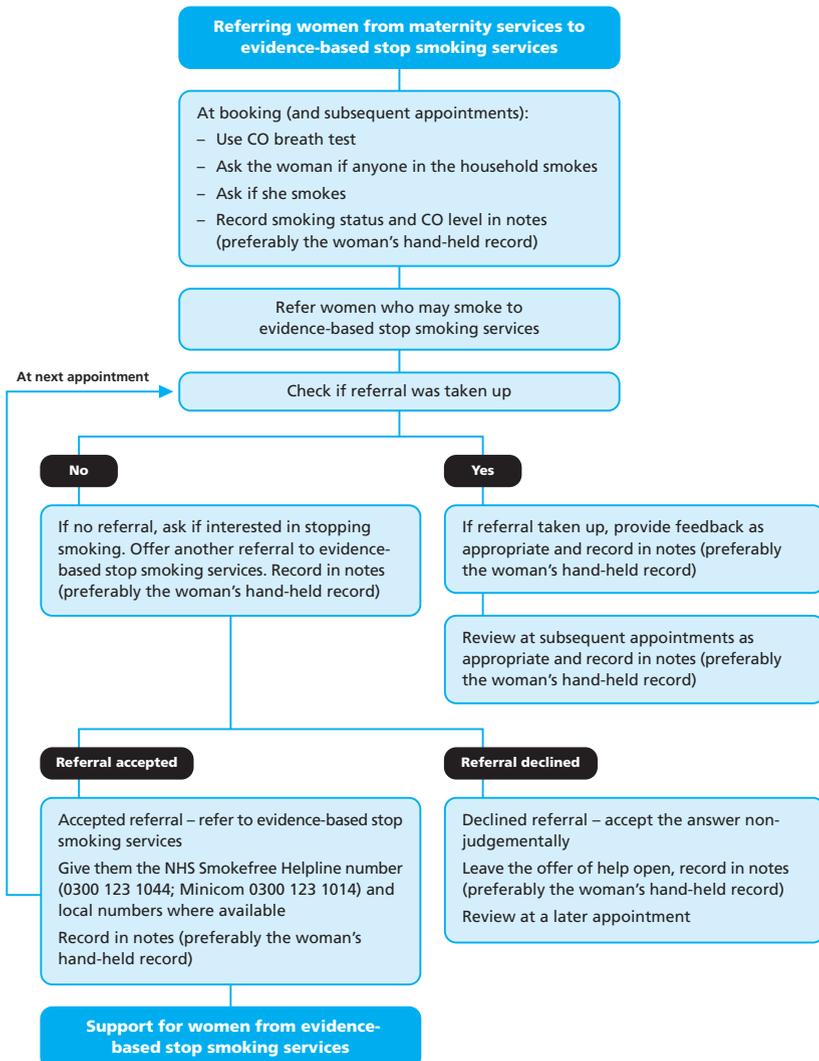


The CO screening can take place before establishing smoking status to assess CO exposure and then be followed up by asking about smoking.

This is known as Very Brief Advice and a generic training module (focussing on all smokers and not just pregnant women) is available on the NCSCT website: www.ncsct.co.uk/VBA

The rest of this briefing expands on how midwifery staff can deliver this simple but effective intervention.

National Institute for Health and Care Excellence (NICE) referral pathway for pregnant women who smoke



Intervention opportunities

Any contact with a pregnant woman offers an opportunity for the delivery of Very Brief Advice, including antenatal appointments.

- Pre-conceptual consultations
- First Pregnancy

Up to 10 weeks	Booking Appointment by Community Midwife (home or clinic)
10–13 weeks	Dating ultrasound scan (hospital)
15 weeks	Blood test by Community Midwife
20–21 weeks	Anomaly scan (not-standard) by ultrasonographers (hospital)
25 weeks	Community Midwife appointment (home or clinic)
28 weeks	Community Midwife appointment (home or clinic)
32 weeks	Community Midwife appointment (home or clinic)
36 weeks	Community Midwife appointment (home or clinic)
38 weeks	Community Midwife appointment (home or clinic)
Term	Community Midwife appointment (home or clinic)
Term +7 days	Community Midwife appointment (home or clinic)
New Birth visit	Health Visitor (home)

All pregnant women follow this schedule unless they become classified as ‘high risk’ when they may be admitted into hospital for antenatal care or investigation, or transferred to obstetrician-led care.

Section 1: **Ask**

Midwives are especially well placed to deliver Very Brief Advice (VBA) to pregnant women.

When taking the full medical history at the booking appointment **past and present smoking status** should be included; with smoking status being a mandatory field in the electronic and/or written notes.

Past and present smoking status relates to tobacco smoking. If a woman reports that she is using an electronic cigarette (e-cigarette), confirm that she is no longer using tobacco alongside the e-cigarette. If she is not using tobacco, her current smoking status should be recorded as a non-smoker. See page 21 for more information on e-cigarettes.

It is important to ask women about their smoking status **at every opportunity** (but at least once within each trimester) and to record any advice given. **This ensures that stopping smoking is deemed important throughout the pregnancy not just at the initial visit.** Pregnant women who stop smoking prior to conception, or after the pregnancy is confirmed, may well relapse and so it is important that the topic is raised repeatedly, even with those who are recorded as ex-smokers or non-smokers.

Cannabis is the most widely used recreational drug amongst pregnant women, with an estimated 5% of mothers in England reporting its use before and during their pregnancy. Pregnant women who report not smoking but who continue to smoke cannabis will be putting their baby at risk because of elevated CO levels and may record higher CO readings than that of a non-smoker, and should be recorded as a smoker.

Example of how to explore whether someone is a smoker

Accurately recording smoking status is part of the medical history and simply involves asking: ***“Do you smoke or have you smoked in the past?”*** and then filling in ‘yes’, ‘no’ or ‘ex-smoker’ in the appropriate fields.

“What age were you when you first started smoking?”

“How many cigarettes a day do you usually smoke? Is that always the same or do you sometimes smoke more or less?”

“Has your smoking changed since you discovered that you are pregnant?”

These questions allow you to convey the message that you are not being judgemental about smoking in pregnancy and that you simply want to gather the information.

The stigma around smoking in pregnancy means that some women find it difficult to disclose that they smoke and this can prevent them receiving appropriate advice and support.

Conducting carbon monoxide (CO) screening in pregnancy

CO is a poisonous gas contained in cigarette smoke; it affects the body's ability to transport oxygen around the body which reduces the oxygen available to the baby. CO crosses the placenta and enters the bloodstream of the baby: it increases the risk of miscarriage and slows the baby's growth and development.

CO screening is an immediate and simple method for helping to assess whether or not someone smokes and is a routine part of antenatal care. It is also a useful way of raising the subject of smoking.

A raised CO level of 4 parts per million (**4ppm**) or above is a sign that further investigation and support is required.

Explaining that CO levels rapidly return to normal, for both the mother and the baby, if there is **not even a single puff** on a cigarette, can encourage pregnant women to stop smoking.

Public Health England have produced guidance on CO screening during antenatal care which can be found here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/372112/CO_antenatal_checks_algorithm_StdQweb.pdf

Example of explaining CO and CO screening

“Carbon Monoxide is a poisonous gas and is very harmful to your baby. It is present in exhaust fumes, faulty gas appliances and cigarette smoke. It passes via your bloodstream to your baby and deprives your baby of oxygen and nutrients. It also slows the baby’s growth and development. Fortunately, CO levels return to normal very quickly once someone stops smoking.”

“As part of routine antenatal checks we measure the CO level in your bloodstream. It’s a simple breath test and we can give you the results immediately. This machine will measure the amount of carbon monoxide in your lungs in parts per million.”

For CO screening to be conducted properly, pregnant women must hold their breath for a minimum of 15 seconds before blowing into the CO monitor; this allows time for the CO in the blood to pass into the air in the lungs.

Example of explaining how CO screening is conducted

“What I am going to ask you to do in a minute is to take a big deep breath, hold your breath and then exhale into this machine. You will need to hold your breath for about 15 seconds. After you have taken your breath I will hand the machine to you, the machine will count down and I will then tell you when to exhale into it.”

And then whilst conducting the screening say: ***“I’d like you to take a nice big breath ... well done ... keep holding your breath, only 10 seconds left now ... OK, take hold of the machine ... place your lips around the tube and 5, 4, 3, 2, 1 ... blow now.”***

If the screening wasn’t completed adequately (i.e. the client did not hold their breath for the required time or did not place their lips around the tube properly) then the pregnant woman will have to be politely advised that the test needs to be repeated (after a couple of minutes to ensure they have their breath back).

Check smoking status and repeat CO screening as part of routine antenatal care, and review care based on outcomes.

Section 2: **Advise**

Interpreting carbon monoxide (CO) screening in pregnancy

The recommended cut-off for detecting smoking in pregnant women is 4 parts per million (4ppm).

Although CO screening is a good measure of recent tobacco smoke intake, it will not usually detect smoking from over 48 hours ago, or even the day before. This is because **CO is eliminated from the body rapidly**. CO readings will typically be lower in the morning than the afternoon because CO levels build up over the course of the day as the woman continues to smoke.

If a CO reading is **under 4ppm** you should inform the woman that this is a normal reading, (CO is produced by the body anyway and so rarely reaches 0ppm), that this is good news for her and her baby and that you will repeat the screening at every visit so that she can know that her and her baby are safe from high levels of carbon monoxide.

Example of what to say to someone with a low CO reading

“This reading is classed as that of a non-smoker; within the normal range for a pregnant non-smoker of between 1 and 4ppm and your baby is already benefiting from this.”

If the woman admits to being a smoker but blows a low reading of below 4ppm then tell her: ***“Any cigarettes you have from now on will cause the level of carbon monoxide to rise quickly and your baby will then be at risk.”***

Note that e-cigarette use alone will not result in a raised CO reading. If a woman reports that she is using an e-cigarette but not smoking, and still has a high CO reading, then this suggests she is likely to be continuing to use tobacco alongside the e-cigarette.

If the CO reading is **4ppm or above** you will need to explore whether the woman is a smoker.

Example of how to find out if the woman is a smoker

“Exposure to tobacco smoke is the most common cause of carbon monoxide being found during the breath test. Do you or anyone else in your household smoke?”

If the pregnant woman **is a smoker** you will need to explain that the normal range for a pregnant non-smoker is between 1 and 4ppm and that her reading is x times higher than that. Explain that this level of carbon monoxide is harmful to her baby and her baby's health is at risk.

If the pregnant woman **says that she has stopped smoking or does not smoke** but the CO reading is higher than 4ppm, then there are other possible reasons for this high reading and you should explain to her that either:

1. she may have been exposed to carbon monoxide fumes from a **faulty gas boiler, cooker, car exhaust or from paint stripper** (it might be worth you checking these things out as exposure to carbon monoxide is dangerous); the Gas Safety Advice Line number 0800 300 363 should be given to her at this point.
2. that she may be **lactose intolerant** (most people know if they are) and the high reading is a consequence of her consuming dairy products which can produce gases in your breath.

It is, of course, possible that the woman is a current smoker but is reluctant to admit this; and so any further questions should be phrased sensitively to encourage a frank discussion.

Assessing motivation to stop smoking

Once you have established whether a pregnant woman smokes, either through asking them or after carbon monoxide screening, the next step is to see whether they are interested in stopping smoking.

We know that pregnant women can be highly motivated to make changes in pregnancy (e.g. reducing alcohol consumption, avoiding certain foods and giving up smoking) because of their desire to have a healthy baby.

Simply informing pregnant women that there is a local service that is effective and that other pregnant women have found useful, can help motivate them to make an attempt at stopping smoking.

Example of explaining the best way of stopping smoking and the support offered by the local stop smoking services

“We know that the best way of stopping smoking is with the help of a trained stop smoking practitioner. We have a local stop smoking service that many pregnant women have found very useful – it is part of routine care that we put you in touch with them.”

If the pregnant woman agrees then you can be encouraging about her decision and refer her to the local stop smoking service for specialist advice and support.

Some women will say that they have cut down on their smoking and it is worth asking them why they have done this; most will say that it is because they are worried about the harm smoking might have on their baby. This offers an opportunity to inform them that cutting down doesn't offer any significant health advantages and that help is available for them to quit (see page 24 for more detail).

Example of what to say if the pregnant woman does not feel able to stop now or is reluctant to receive help

“It is your choice and if you’d like to talk it through with someone then the stop smoking service will be able to do this with you. Why don’t I give them your number and they can give you a call for a chat?”

You can also ask whether the pregnant woman’s partner smokes, if their partner is motivated to stop smoking and whether they would also like support to do so. If their partner or other family members smoke, and do not want to quit, they will need on-going support to help them manage this.

The support of family and friends, particularly partners who share the home, is crucial in any attempt to stop smoking but is especially so for pregnant women. Research shows that the support from family and friends is important in determining whether a pregnant woman will be successful in stopping smoking; and that pregnant women are more likely to notice their partner’s social support during a quit attempt than non-pregnant women are.

If partners or significant others can also make a quit attempt then the pregnant woman stands a better chance of quitting herself. If both are successful then the home will also be free from tobacco smoke for the new born baby.

Documenting smoking cessation interventions

It is important for all healthcare professionals to keep a written record of the stop smoking advice given to each woman throughout her pregnancy. **Systematic recording** is an important motivation for healthcare workers in supporting women to stop, it shows we work as a team to achieve the best possible outcomes in pregnancy and it helps keep all staff 'on message'.

Pregnant women have the right to decline a referral for help to stop smoking; this should be recorded in their notes as well as them being informed that they can ask for help at any point in the future. **All records on smoking should be consistent** in the woman's hand-held and hospital notes, and on computerised records (if available), to allow everybody involved in antenatal care to monitor progress and to track their success.

Any personal information collected from the pregnant woman by a stop smoking practitioner is subject to the usual confidentiality and data protection regulations and safeguards and pregnant women should be reassured of this.

Section 3: **Act**

Role of Stop Smoking Services

Local stop smoking services vary in the way they are set up across the country. Many services have a specialist midwife or stop smoking practitioner who works supporting pregnant women to quit smoking. **It is important that healthcare professionals know what support is available locally or nationally and know what that support involves.**

Stop smoking service practitioners will provide a combination of behavioural support and information on stop smoking medications, and will be able to help pregnant women make an informed choice about using nicotine replacement therapy to help them stop smoking.

As a healthcare professional, you can make pregnant women aware of the 'smoking in pregnancy' information available on the NHS Smokefree website (www.nhs.uk/start4life/stop-smoking), and give the NHS Smokefree Helpline number (0300 123 1044; Minicom 0300 123 1014) and local helpline numbers if appropriate.

The evidenced-based behavioural support programme provided by local stop smoking services offer pregnant women their best chance of quitting before, during and after a pregnancy.

A look at the website of your local stop smoking service will give you some idea of what is offered. You can find out your local stop smoking provider by visiting NHS Smokefree: www.nhs.uk/smokefree/help-and-advice/local-support-services-helplines

Supporting pregnant women to remain abstinent from smoking

We know that many smokers lack the confidence to succeed and may lose heart if stopping smoking is more difficult than they anticipated. **Pregnant women can find stopping smoking incredibly difficult and the relapse rate in pregnancy is high.** Boosting their motivation to quit and their confidence in quitting successfully is a crucial ingredient of the behavioural support programme offered by the stop smoking service.

Community midwives, who see the pregnant woman regularly, can be a valuable extra source of support to complement the intervention provided by the stop smoking in pregnancy specialist practitioner and can help pregnant women maintain their resolve to stay off cigarettes.

It is important to congratulate pregnant women on their achievement thus far, to record recent non-smoking status in their notes and to encourage them to remain a non-smoker. **Also, continue to conduct carbon monoxide (CO) screening.** These readings will provide powerful evidence of the benefits to themselves and the baby of not smoking, and motivation to remain abstinent.

If a woman reports that she has stopped tobacco smoking completely but is using an e-cigarette, she should still be congratulated and encouraged to stay away from all tobacco use, even if that involves continuing to use an e-cigarette to avoid relapsing to smoking.

There isn't nearly as much evidence for e-cigarettes being a useful aid to quitting smoking as there is with established stop smoking medications. However, they appear to be very popular with smokers and new evidence is emerging all the time indicating that e-cigarettes can help with quitting and with cutting down. **What we definitely know is that e-cigarettes are significantly safer than smoking tobacco.** A briefing summarising the evidence on e-cigarettes and making clinical recommendations is available here: www.ncsct.co.uk/publication_ecigarette_briefing.php

Pregnant women should be asked how confident they are that they can stay stopped and if they need any additional support.

Example of how to enquire about how pregnant women are finding their quit attempts

“Have you thought what you will do in place if you feel tempted to smoke? Are you using any stop smoking medications?”

As postnatal relapse is common, ask: ***“Have you thought about what you might do to remain a non-smoker after your baby is born?”***

Use the discussion to emphasise the advantages for the new baby of a smokefree home.

Provide information on how the NHS Smokefree Helpline can continue to offer them help, for example through their telephone support programme. Encourage pregnant women to continue with their quit attempts at every opportunity; let them know that as each day goes by without a cigarette they are significantly increasing their chances of never smoking again.

Pregnant women who express little or no interest in stopping smoking

Pregnant women have the right to decide to not stop smoking and so discussing smoking with those who say they do not want to stop needs to be done in a sensitive manner. Pregnant women should be reassured that they are not being judged, but that you are keen to ensure the best possible outcome for their pregnancy.

Example of how to explain why you are discussing smoking status

“As a healthcare professional I frequently see women for whom things have gone wrong because they smoked. People come for antenatal care because they want a safe pregnancy. My role is to do everything I can to make sure you have a healthy pregnancy and safe delivery. Stopping smoking is one of the main things you can do to reduce your risks of problems in the pregnancy and during delivery.”

“I’m not going to be putting pressure on you. However, I will talk with you again about this at future antenatal appointments because there are health benefits to your baby whenever you stop and help is available throughout your pregnancy.”

All healthcare professionals should make a note of what discussions have taken place, what advice was given and whether a referral was accepted; this should be recorded in the pregnant woman’s hand-held record (or follow local protocols on recording this information). If a referral isn’t accepted, provide the NHS Smokefree Helpline number (0300 123 1044; Minicom 0300 123 101) as an avenue of future support.

The issue of stopping smoking should be raised with pregnant women at every opportunity. Pregnant women may change their mind about stopping smoking as their pregnancy progresses and this discussion lets them know that help is available. A quit attempt can be started at any point during the pregnancy and as soon as the women expresses an interest in doing so.

Smokers frequently deny or minimise the health risks of smoking to themselves and their baby and may avoid having a discussion on stopping smoking unless you raise it. You can always ask whether there is anything that worries the woman about smoking whilst pregnant. If appropriate you could link this question to any poor outcomes experienced during previous pregnancies.

Always respect a woman's decision but be clear on the advice that you are giving and document what has been said.

Smoking reduction in pregnancy

Many pregnant women, aware of the health risks of smoking during pregnancy, **try to reduce their consumption of tobacco** in an attempt to reduce the risks to their baby. It is fairly common for women who smoke to tell their midwife at their booking appointment that they have 'cut down' their smoking. You can recognise that this shows some awareness of the health consequences of smoking and that these women are already doing something to try and reduce the risk to their baby.

A reduced number of cigarettes does not, however, equate to significantly reduced health risks and stopping smoking completely is the only way of ensuring that the unborn baby is not at risk from smoking.

E-cigarettes have been found to lead to a genuine reduction in tobacco consumption in people using them to cut down the amount that they smoke. Interestingly, there is evidence that the use of e-cigarettes to deal with temporary abstinence (those times when people are unable to smoke tobacco) or to cut down the amount of tobacco that they are smoking can lead to smokers attempting to quit, even for those who never intended to quit smoking when they started using e-cigarettes.

Example of how to explain the concept of compensatory smoking

“Your brain and body are used to regular doses of nicotine. When you cut down the number of cigarettes that you smoke your brain and body still ‘demand’ these regular doses. So what tends to happen, without you realising it, is that you will get similar doses of nicotine from fewer cigarettes by smoking these cigarettes more ‘efficiently’ (taking more puffs, inhaling deeper and longer, smoking more of the cigarette). Similar doses of nicotine equals similar doses of tar and carbon monoxide which means little or no benefit from cutting down on your smoking.”

Action to be taken:

- Describe what help is available and boost their motivation to make a quit attempt by building on the fact that they have already tried to do something about their smoking and are obviously concerned about the effect it may have on their baby.
- Reinforce the importance of abrupt cessation as a goal as this can help pregnant women focus their attention on the effort required.
- Use carbon monoxide (CO) measurements to monitor cigarette intake and provide feedback on the health effects of continued smoking for them and the unborn child (although if their CO levels are very low this could be counter-productive).
- Document any conversations with the pregnant woman, and advice given by you, and communicate this to relevant colleagues.

Antenatal admission of a pregnant woman who smokes

Antenatal problems may emerge during pregnancy and women may be unaware of the link between the problem and their smoking, or the immediate health benefits to them and their pregnancy of stopping smoking.

Women who smoke are more likely to be admitted for antenatal care than non-smokers, especially for intrauterine growth restriction (IUGR). Although these women are frequently on bed rest, **some women suffer from acute nicotine withdrawal symptoms and request to leave the ward to smoke.** If behavioural support and nicotine replacement therapy (NRT) was used to deal with nicotine withdrawal, it would help improve compliance with treatment.

An admissions protocol for pregnant smokers should be developed, by the hospital midwifery team with the support of the local stop smoking service, to include:

- A system that ensures that the smoking status of pregnant women is recorded as part of the hospital admission procedure
- The delivery of very brief advice on smoking to all pregnant women admitted for antenatal care.
- Encouragement of cessation during any antenatal admission; using the opportunity to link smoking to the presenting medical problem. NICE recommends Stop before the Op for planned caesarean section
- The referral of pregnant women who smoke for inpatient stop smoking support or to the local stop smoking service
- Access to NRT to help manage withdrawal symptoms, made available via the hospital pharmacy
- Provision of the details of the NHS Smokefree Helpline 0300 123 1044; Minicom 0300 123 101

The progress of pregnant women who stop smoking should be monitored. They should be encouraged to stay stopped and to use NRT if necessary, for withdrawal relief and to prevent lapse, once they are discharged.

Section 4: **The Post-Partum Period**

Smoking at Time of Delivery (SATOD)

Data collection on the smoking status of pregnant women at the time of delivery allows for smoking prevalence at a local and national level to be calculated.

Carbon monoxide (CO) screening could be used to assess smoking status, although many women may have gone for a number of hours without a cigarette at this point, resulting in a low CO reading. Of course you could simply ask whether they are smoking (see page 9).

Collecting this mandatory data also offers another opportunity to raise the topic of smoking and secondhand smoke; and can influence the support given to women immediately after the baby is born, including referral to a local stop smoking service.

Smoking at Time of Delivery (SATOD) data covers information on the prevalence of smoking at the time of delivery (child birth). Hospital trusts in England are required to submit figures each quarter from the following:

- Number of maternities
- Number of women known to have been smoking at time of delivery
- Number of women known not to have been smoking at time of delivery

Example of how midwifery staff could explain using CO screening to collect SATOD data

“We routinely ask all women to blow into a monitor so that we can record the amount of carbon monoxide in their lungs. The main source of carbon monoxide is from smoking. Are you currently smoking or have you recently given up?”

Inpatient care following the delivery of the child

Women who have smoked throughout their pregnancy are likely to experience symptoms of nicotine withdrawal following the delivery of their baby. This will be particularly pronounced in women who have a prolonged postnatal admission (e.g. following a premature birth or a caesarean section). New mothers may ask maternity staff to look after their baby while they go outside to smoke. Many trusts now have smokefree site policies that do not allow this.

It is important that protocols for discussing smoking, referral of smokers and recoding smoking related information are established. This will help the discussion of smoking to become part of routine practice. If pregnant women are aware of hospital policies they can plan accordingly for their admission and might even be prompted to stop smoking, even if temporarily.

The use of NRT in the delivery suite and postnatal wards may be helpful for women in dealing with their enforced temporary abstinence from smoking.

Action to take:

- Work closely with the local stop smoking service to ensure that all healthcare professionals are confident discussing smoking with pregnant women and delivering very brief advice (VBA) on smoking
- Ensure that a protocol for inpatient smokers is developed by the hospital midwifery team with the support of the local stop smoking service, including:
 - Make women aware of the hospital smokefree policy and maternity ward policies regarding leaving the ward to smoke. Ensure that these policies reinforce to patients the risks of secondhand smoke and of holding their newborn child after smoking
 - Deliver VBA on smoking (Ask – Advise – Act)
 - Refer women who smoke for inpatient stop smoking support or to the local stop smoking service
 - Ensure there is access to NRT via the hospital pharmacy whether women are quitting smoking or need help with managing temporary abstinence
 - Provide details of the NHS Smokefree Helpline 0300 123 1044; Minicom 0300 123 1014
- Ensure that there are clear and simple referral procedures to stop smoking services in place.
- Agree what, and where, information relating to smoking is recorded (e.g. hand-held notes, electronic patient records, postnatal discharge summary, Personal Child Health Record 'Red book')

About the National Centre for Smoking Cessation and Training

The National Centre for Smoking Cessation and Training (NCSCT) is a social enterprise committed to support the delivery of effective evidence-based tobacco control programmes and smoking cessation interventions provided by local stop smoking services.

The NCSCT works with and for the field to deliver training and assessment programmes, support services for local and national providers and conducts research into behavioural support for smoking cessation.

Our training programmes are based on research into what competences (skills and knowledge) are required by stop smoking practitioners and has proven to be effective.

The NCSCT is supported by Public Health England and provides an online training and assessment programme for stop smoking practitioners, plus post-certification courses in smoking cessation and pregnancy, and in smoking cessation and mental health.

The NCSCT also offers open access online courses to all health and social care professionals on VBA on smoking and VBA on secondhand smoke, plus a course dealing with smoking cessation medications.

This briefing gives expert, concise guidance on how to deliver Very Brief Advice (VBA) to pregnant women who smoke and how to carry out routine carbon monoxide (CO) screening with all pregnant women.