ASH/NCSCT webinar – Supporting pregnant smokers: Implications of new NICE guidance and the NHS Long Term Plan (March 2022)

Q&A RESPONSES

Webinar Recording

Can "In House" be an external service we refer all smokers to?

The aim of an inhouse service is that the service is owned and run by maternity services, this enables maternity to fully 'own' the pathway. The women prefer this as it is one seamless service with all staff using the same maternity information system, with the same uniform and feels safe and trusted. Plus, continuity of carer is 'gold standard' and may local authority stop smoking services are not commissioned to offer support beyond 12-weeks, whereas maternity delivered services can offer support until 3-months post-birth.

Is CO monitoring back up and running now, after COVID?

Yes, full implementation of SBLCBv2 Element 1 is now included in the year 4 CNST Scheme. In order to comply with MIS CNST, the CO monitoring should take place +/- 3 days around the booking appointment, at 36 weeks, and throughout pregnancy. With regards to booking appointments these are expected to be business as usual.

There is no alternative pathway that will be accepted, therefore if trusts are not fully implementing CO monitoring they will fail Safety Action 6.

The SBL metric (Element 1, Process indicator 2) which monitors the percentage of women with a CO reading at booking, finds CO readings made within +/-3 days of the booking date. The CO reading does not need to occur on the same date as the booking, so if a woman’s face to face appointment takes place up to 3 days after her booking date it would be counted as ‘CO monitoring at booking’, but if the reading is made/recorded in MSD201/2 more than 3 days later, it wouldn't.

OHID, iPiP and e-LfH have developed a short 10-minute e-learning session to support midwives and health visitors in refreshing their skills and ensuring they can undertake a COVID safe intervention.

Both NHSE and OHID recommend that when resuming CO monitoring in any setting staff should adhere to their monitor manufacturer’s latest guidance on the safe use of products, including the regular cleaning of monitors, replacement of consumables and use of relevant Personal Protection Equipment (PPE) in relation to COVID-19 guidance.

The NCSCT also issued guidance on resumption of face-to-face consultation including advice on safe CO testing in January 2021.

Midwives are finding that opt out referral is causing friction with women. Have you got any practical advice on how to approach this?

In reality, there should be no friction, because Very Brief Advice (VBA) should be fairly neutral/factual and if a woman declines/opts out, her wishes should be respected. Nevertheless, the best way to reduce the chance of friction when talking to pregnant women
about their smoking is to focus on the risks of harm from carbon monoxide poisoning, and following the evidence-based process set out in the NCSCT Standard Treatment Programme for pregnant women. This includes specific examples of how to ask women how they feel about raised carbon monoxide levels; the risk to their unborn baby; where that may stem from; if smoking is a factor; making sure immediate referral to a tobacco addiction specialist happens who can support them in their feelings about quitting; how they can get more effective support to quit; and how to deal with women who say they aren’t ready to quit.

The NCSCT STP also offers suggestions of key questions to ask to create a dialogue with pregnant smokers e.g., “is there anything that worries you about your smoking [now you are pregnant]”. Always offer a response that shows understanding/empathy on how difficult it can be to quit; you are more likely to engage and maintain in conversation if you do this. As well as asking: “is it ok if I give you some information about why we worry about women who continue to smoke in pregnancy?” A key question that is unlikely to get a negative response and they are more likely to listen to you, as you’ve asked permission. However, it is vital to follow up with information and encouragement to take up referral for specialist support and free treatments that are available including advice on the use of e-cigarettes.

Opt-out referral might result in an increased number of referrals for pregnant women who may not be 100% ready to quit. Helping to increase motivation and confidence of pregnant women who are not ready to quit is a key part of the support provided by midwives.

Training on delivering very brief advice (VBA) and making referrals to stop smoking support will help staff feel much more confident about having challenging conversations with women.

Further guidance and links to training on delivering VBA to pregnant women is available via the Smoking in Pregnancy Challenge Group website.

Previously guidance was - if someone hasn’t quit smoking after few weeks to stop treatment (NRT). Has this changed and would it be acceptable to continue with NRT if there has been a significant reduction in smoking intake, evidenced by a drop in CO reading, but abstinence has not been achieved, but there is motivation to quit?

The key here is to assess tobacco dependency (time to first cigarette/number or amount of tobacco smoked) – always ask smokers if they have cut down and use the number of cigs smoked as part of their assessment. CO test, assess motivation to quit, and address barriers. Offering medication alongside intensive support is vital (this needs to be a good 45-minute session) to address barriers/facilitators/coping strategies/treatment choice and correct NRT usage etc. Weekly support sessions should be provided including CO testing and discussing progress.

If smokers are deemed motivated to quit by setting a quit date but continue to smoke, then the dual use of smoked tobacco and NRT is not going to reduce toxins and therefore harm. In this instance, I would always make sure that e-cigarettes have been discussed as an option, as NRT is not as effective to help titrate need for nicotine to reduce withdrawal symptoms. If a woman remains abstinent (including the odd lapse - NOT RELAPSE), then the guidance is saying to continue issuing NRT for as long as necessary. I would say in my experience, quite often women discontinue patches earlier than 12 weeks, but should always be encouraged to use the quicker acting NRT such as gum/lozenge/inhalator/mouth spray as often as necessary.

Cutting down is not an effective strategy to reduce risk. Nicotine from tobacco keeps the dopamine receptors active and therefore the addiction cycle continues. The risk is smoking frequency could increase, and often once relapse has happened smokers revert to smoking as much as if not more than before their quit attempt. We also need to be careful as
evidence shows there is no safe level of smoking, and by saying it is ok to continue smoking even alongside NRT, it could be seen as advice that it is safe to smoke even a little.

**What training regarding intensive stop smoking interventions would you recommend?**

For any maternity care providers or health care professional who are offered a full intensive intervention, they all should receive the same specialist level of training. The NCSCT offers a **FREE online Training and Assessment Programme** including core competencies (knowledge & skills) for stop smoking practitioners. Once NCSCT Certified Stop Smoking Practitioners, have taken the training and passed the assessment, they can then access the **specialist stop smoking and pregnancy module**. Alongside this they offer a 2-day face to face or virtual behavioural support training programme (will need funding).

Additionally, there is a free NCSCT ‘**Very brief advice for pregnant smokers**’ online training module, which is useful for those maternity care providers offering advice and referral. This course is not as in-depth as the full training programme, but still gives useful examples of how to address challenging questions and myths that you will encounter when addressing smoking.

**How much should the financial incentives be? Do you need to carry through to the postnatal period?**

The value and frequency of incentive varies between schemes. Incentive schemes have been shown to be effective in supporting pregnant women to quit smoking with vouchers ranging from £8 – £200 in value. This suggests that the value of the incentive may be less significant than the prospect of receiving an incentive, and significantly getting women into specialist services to receive the full programme of support to quit.

When considering an incentive scheme and deciding on the value of vouchers, in addition to the existing evidence base, you should consider:

- The local costs of living;
- Conducting local insights with women;
- Frequency of incentives;
- The overall numbers of women the scheme aims to recruit and available resource.

Relapse to smoking is extremely common up to one year following birth so schemes which extend support into the postnatal period are likely to be effective for reducing relapse rates.

See also:

- Smoking in Pregnancy Challenge Group briefing on incentive schemes
- Smoking in Pregnancy Challenge Group Webinar - Incentive schemes (March 2019)