NICE National Institute for Health and Care Excellence

Public Health England

NICE guideline

# Stop smoking interventions and services

NICE guideline

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## Your responsibility

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

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

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

# Contents

This guideline replaces PH1 and PH10.

This guideline is the basis of QS43 and QS82.

## Overview

This guideline covers stop smoking interventions and services delivered in primary care and community settings for everyone over the age of 12. It aims to ensure that everyone who smokes is advised and encouraged to stop and given the support they need. It emphasises the importance of targeting vulnerable groups who find smoking cessation hard or who smoke a lot.

### *Who is it for*

- Commissioners and providers of stop smoking interventions or services, including those in the voluntary and community sectors who have a role or responsibility for this
- Health, social care and other frontline staff with links to stop smoking services who engage with people who smoke
- Health and wellbeing boards
- Members of the public who want to stop smoking or who want to help others to stop

# Recommendations

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

For recommendations for women who are pregnant or planning a pregnancy, and mothers of infants and young children, and their families see NICE's guideline on smoking: stopping in pregnancy and after childbirth.

For people with cardiovascular or respiratory disease who smoke, see also recommendations 1, 7 and 9 in NICE's guideline on smoking: acute, maternity and mental health services.

## *1.1 Commissioning and providing stop smoking interventions and services to meet local needs*

These recommendations are for commissioners and managers of stop smoking services.

1.1.1 Use sustainability and transformation plans, health and wellbeing strategies, and any other relevant local strategies and plans to ensure evidence-based stop smoking interventions and services are available for everyone who smokes (see recommendation 1.3.1). **[2018]**

1.1.2 Use Public Health England's public health profiles to estimate smoking prevalence among the local population. **[2018]**

1.1.3 Prioritise specific groups who are at high risk of tobacco-related harm. These may include:

- people with mental health problems, including mental health disorders (for example, see NICE's guidelines on depression in adults and smoking: acute, maternity and mental health services)
- people who misuse substances (for example, see NICE's guideline on coexisting severe mental illness and substance misuse: community health and social care services)
- people with health conditions caused or made worse by smoking (for example, see NICE's guidelines on cardiovascular disease: identifying and supporting people most at

risk of dying early, type 1 diabetes in adults, asthma and chronic obstructive pulmonary disease)

- people with a smoking-related illness (see NICE's guideline on lung cancer)
- populations with a high prevalence of smoking-related morbidity or a particularly high susceptibility to harm
- communities or groups with particularly high smoking prevalence (such as manual workers, travellers, and lesbian, gay, bisexual and trans people)
- people in custodial settings
- people living in disadvantaged circumstances
- pregnant women who smoke (see NICE's guideline on smoking: stopping in pregnancy and after childbirth). **[2018]**

See how the committee made recommendations 1.1.1 to 1.1.3.

## *1.2 Monitoring stop smoking services*

These recommendations are for commissioners and managers of stop smoking services.

1.2.1 Set targets for stop smoking services, including the number of people using the service and the proportion who successfully quit smoking. Performance targets should include:

- treating at least 5% of the estimated local population who smoke each year
- achieving a successful quit rate of at least 35% at 4 weeks, based on everyone who starts treatment and defining success as not having smoked (confirmed by carbon monoxide monitoring of exhaled breath) in the fourth week after the quit date. **[2018]**

1.2.2 Check self-reported abstinence using carbon monoxide monitoring, with success defined as less than 10 parts per million (ppm) at 4 weeks after the quit date. This does not imply that treatment should stop at 4 weeks. **[2018]**

1.2.3 Monitor performance data for stop smoking services routinely and independently. Make these results publicly available. **[2018]**

1.2.4 Audit exceptional results (for example, 4-week quit rates lower than 35% or above 70%) to determine the reasons for unusual performance as well as to identify best practice and ensure it is being followed. [2018]

See how the committee made recommendations 1.2.1 to 1.2.4.

## *1.3 Evidence-based stop smoking interventions*

These recommendations are for commissioners and providers of stop smoking support.

1.3.1 Ensure the following evidence-based interventions are available for adults who smoke:

- behavioural support (individual and group)
- bupropion[1]
- nicotine replacement therapy (NRT) – short and long acting
- varenicline[2]
- very brief advice. [2018]

1.3.2 Consider text messaging as an adjunct to behavioural support. [2018]

1.3.3 Offer varenicline as an option for adults who want to stop smoking, normally only as part of a programme of behavioural support, in line with NICE's technology appraisal guidance on varenicline. [2018]

1.3.4 For adults, prescribe or provide varenicline, bupropion or NRT before they stop smoking. [2018]

1.3.5 Agree a quit date set within the first 2 weeks of bupropion treatment and within the first 1 to 2 weeks of varenicline treatment. Reassess the person shortly before the prescription ends. [2018]

1.3.6 Agree a quit date if NRT is prescribed. Ensure that the person has NRT ready to start the day before the quit date. [2018]

1.3.7 Consider NRT[3] for young people over 12 who are smoking and dependent on nicotine. If this is prescribed, offer it with behavioural support. [2018]

1.3.8 Ensure behavioural support is provided by trained stop smoking staff (see the National Centre for Smoking Cessation and Training [NCSCT] training standard). [2018]

1.3.9 Ensure very brief advice is delivered according to the NCSCT training module on very brief advice. [2018]

See how the committee made recommendations 1.3.1 to 1.3.9.

## *1.4 Engaging with people who smoke*

These recommendations are for health and social care workers in primary and community settings.

1.4.1 At every opportunity, ask people if they smoke and advise them to stop smoking in a way that is sensitive to their preferences and needs. [2018]

1.4.2 Encourage people being referred for elective surgery to stop smoking before their surgery. Refer them to local stop smoking support. [2018]

1.4.3 Discuss any stop smoking aids the person has used before, including personally purchased nicotine-containing products (see recommendations 1.4.4 and 1.5.1). [2018]

1.4.4 Offer advice on using nicotine-containing products on general sale, including NRT and nicotine-containing e-cigarettes. [2018]

See also recommendations 1, 7 and 9 in NICE's guideline on smoking: acute, maternity and mental health services.

See how the committee made recommendations 1.4.1 to 1.4.4.

## *1.5 Advice on e-cigarettes*

These recommendations are for health and social care workers in primary and community settings.

1.5.1 For people who smoke and who are using, or are interested in using, a nicotine-containing e-cigarette on general sale to quit smoking, explain that:

- although these products are not licensed medicines, they are regulated by the Tobacco and Related Products Regulations 2016
- many people have found them helpful to quit smoking cigarettes
- people using e-cigarettes should stop smoking tobacco completely, because any smoking is harmful
- the evidence[4] suggests that e-cigarettes are substantially less harmful to health than smoking but are not risk free
- the evidence in this area is still developing, including evidence on the long-term health impact. **[2018]**

See how the committee made recommendation 1.5.1.

## *1.6 If a person who smokes wants to quit*

These recommendations are for health and social care workers in primary and community settings.

1.6.1 Refer people who want to stop smoking to local stop smoking support. **[2018]**

1.6.2 Discuss how to stop smoking with people who want to quit (the NCSCT programmes explain how to do this). **[2018]**

1.6.3 Set out the pharmacotherapy and behavioural options as listed in recommendation 1.3.1, taking into consideration previous use of stop smoking aids, and the adverse effects and contraindications of the different pharmacotherapies. **[2018]**

1.6.4 Explain that a combination of varenicline and behavioural support or a combination of short-acting and long-acting NRT are likely to be most effective. **[2018]**

1.6.5 If people opt out of a referral to local stop smoking support, refer them to a professional who can offer pharmacotherapy and very brief advice. **[2018]**

1.6.6 Agree the approach to stopping smoking that best suits the person's preferences. Review this approach at future visits. **[2018]**

See how the committee made recommendations 1.6.1 to 1.6.6.

## *1.7 If a person who smokes is not ready to quit*

These recommendations are for health and social care workers in primary and community settings.

1.7.1 If people are not ready to stop smoking:

- make sure they understand that stopping smoking reduces the risks of developing smoking-related illnesses or worsening conditions affected by smoking
- ask them to think about adopting a harm reduction approach (see NICE's guideline on smoking: harm reduction)
- encourage them to seek help to quit smoking completely in the future
- record the fact that they smoke and at every opportunity ask them about it again in a way that is sensitive to their preferences and needs. **[2018]**

See how the committee made recommendation 1.7.1.

## *1.8 Telephone quitlines*

1.8.1 Ensure publicly sponsored telephone quitlines offer a rapid, positive and authoritative response. If possible, callers whose first language is not English should have access to information and support in their chosen language. **[2008]**

1.8.2 All staff should receive smoking cessation training (at least in brief interventions to help people stop smoking). **[2008]**

1.8.3 Staff who offer counselling should be trained to the NCSCT Standard (individual behavioural counselling) and preferably hold an appropriate counselling qualification. Training should comply with the Standard for training in smoking cessation treatments or its updates. **[2008, amended 2018]**

## *1.9 Education and training*

### Local stop smoking services

1.9.1 Ensure training and continuing professional development is available for all those providing stop smoking advice and support. [2008]

1.9.2 Ensure training complies with the NCSCT training standard or its updates. [2008, amended 2018]

### Healthcare workers and others who advise people how to quit smoking

1.9.3 Train all frontline healthcare staff to offer very brief advice on how to stop smoking in accordance with recommendations 1.6.2 and 1.6.5. Also train them to make referrals, if necessary and possible, to local stop smoking services. [2008, amended 2018]

1.9.4 Ensure training on how to support people to stop smoking is part of the core curriculum for healthcare undergraduates and postgraduates. [2008]

1.9.5 Provide additional, specialised training for those working with specific groups, for example people with mental health problems and pregnant women who smoke. [2008]

1.9.6 Encourage and train healthcare professionals to ask people about smoking and to advise them of the dangers of exposure to secondhand smoke. [2008]

For recommendations for secondary care providers see NICE's guideline on smoking: acute, maternity and mental health services.

## *1.10 Campaigns to promote awareness of local stop smoking services*

1.10.1 Coordinate communications strategies to support the delivery of stop smoking services, telephone quitlines, school-based interventions, tobacco control policy changes and any other activities designed to help people to stop smoking. [2008]

1.10.2 Develop and deliver communications strategies in partnership with the NHS, regional and local government and non-governmental organisations. The strategies should:

- Use the best available evidence of effectiveness, such as Cochrane reviews.
- Be developed and evaluated using audience research.
- Use 'why to' and 'how to' quit messages that are non-judgemental, empathetic and respectful, for example testimonials from people who smoke or used to smoke.
- Involve community pharmacies in local campaigns and maintain links with other professional groups such as dentists, fire services and voluntary groups.
- Ensure campaigns are sufficiently extensive and sustained to have a reasonable chance of success.
- Consider targeting and tailoring campaigns towards low income and some minority ethnic groups to address inequalities. **[2008, amended 2018]**

For recommendations on campaigns for secondary care providers see recommendation 12 in NICE's guideline on smoking: acute, maternity and mental health services.

## *1.11 Closed institutions*

1.11.1 Develop a policy, using guidance provided by the Department of Health and Social Care, to ensure effective stop smoking interventions are provided and promoted in prisons, military establishments and long-stay health centres, such as mental healthcare units. **[2008]**

See also NICE's guidelines on smoking: workplace interventions, smoking: acute, maternity and mental health services and recommendations 9 and 10 in NICE's guideline on smoking: harm reduction.

## *1.12 Employers*

1.12.1 Negotiate a smokefree workplace policy with employees or their representatives. This should:

- State whether or not smoking breaks may be taken during working hours and, if so, where, how often and for how long.
- Direct people who wish to stop smoking to local stop smoking support.
- Implement NICE's guideline on smoking: workplace interventions. **[2008, amended 2018]**

For recommendations for employees of secondary care providers see NICE's guideline on smoking: acute, maternity and mental health services.

## *Terms used in this guideline*

### Behavioural support

Individual behavioural support involves scheduled face-to-face meetings between someone who smokes and a counsellor trained in smoking cessation. Typically, it involves weekly sessions over a period of at least 4 weeks after the quit date and is normally combined with pharmacotherapy.

Group behavioural support involves scheduled meetings in which people who smoke receive information, advice and encouragement and some form of behavioural intervention (for example, cognitive behavioural therapy). This therapy is offered weekly for at least the first 4 weeks of a quit attempt (that is, for 4 weeks after the quit date). It is normally combined with pharmacotherapy.

### Nicotine-containing products

Products that contain nicotine but do not contain tobacco and so deliver nicotine without the harmful toxins found in tobacco. Some have been licensed for smoking cessation by the Medicines and Healthcare products Regulatory Agency (MHRA; see nicotine replacement therapy below). Currently there are no licensed nicotine-containing e-cigarettes on the market. E-cigarettes on general sale are regulated under the Tobacco and Related Product Regulations by the MHRA. For further details see the MHRA website.

### Nicotine-containing products on general sale

This includes over the counter NRT and nicotine-containing e-cigarettes.

## Nicotine replacement therapy

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

## Text messaging

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

## Stop smoking services

Services commissioned to deliver the interventions recommended in this guideline.

## Stop smoking support

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

## Very brief advice

Asking about current and past smoking behaviour, providing information on the consequences of smoking and stopping smoking, and advising on options for support and pharmacotherapy, in line with the NCSCT's training standard on very brief advice. This is consistent with the definition of brief intervention used in NICE's 2006 guideline (PH1).

For other public health and social care terms see the Think Local, Act Personal Care and Support Jargon Buster.

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[1] See information on bupropion hydrochloride in the British national formulary.

[2] See information on varenicline in the British national formulary.

[3] The UK marketing authorisation for nicotine replacement therapy products varies for use in children and young people under 18. Refer to the summary of product characteristics for prescribing information on individual nicotine replacement therapy preparations.

[4] See reports by Public Health England (E-cigarettes and heated tobacco products: evidence review), the British Medical Association (E-cigarettes: balancing risks and opportunities) and the Royal College of Physicians (Nicotine without smoke: tobacco harm reduction).

## Putting this guideline into practice

NICE has produced tools and resources to help you put this guideline into practice.

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes recommended for clinical practice that can be done quickly – like changes in prescribing practice – should be shared quickly. This is because healthcare professionals should use guidelines to guide their work – as is required by professional regulating bodies such as the General Medical and Nursing and Midwifery Councils.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.

4. **Think about what data you need to measure improvement** and plan how you will collect them. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

# Context

Smoking is the main cause of preventable illness and premature death in England. In 2015/16, an estimated 474,000 NHS hospital admissions in England were linked to smoking-related conditions. An estimated 16% (79,000) of all deaths in 2015 were attributed to smoking (Statistics on smoking Health and Social Care Information Centre).

Treating smoking-related illness is estimated to cost the NHS £2.5 billion a year (Statistics on smoking) and the wider cost to society is around £12.7 billion a year (The local costs of smoking in England – 2017 Action on Smoking and Health).

The number of people using stop smoking services has declined (Statistics on NHS stop smoking services in England – April 2016 to March 2017 Health and Social Care Information Centre). Reasons for this are not clear. The number of prescriptions of stop smoking medications has also fallen by over 50% since 2011 (Statistics on smoking in England – 2017).

This guideline updates and replaces NICE's guideline on smoking: brief interventions and referrals and recommendations 1, 2, 3, 4, 6 and 10 of NICE's guideline on stop smoking services.

This guideline incorporates recommendation 7, and recommendations 11 to 16 of NICE's guideline on stop smoking services. Recommendation 5 of that guideline was replaced by NICE's guideline on smoking: harm reduction, and recommendations 8 and 9 were updated by NICE's guideline on smoking: stopping in pregnancy and after childbirth.

## *Commissioning*

Local authorities are responsible for commissioning tobacco control and stop smoking services. They are guided by the Public Health Outcomes Framework, as well as their local joint strategic needs assessment, sustainability and transformation plans, and joint health and wellbeing strategy.

This guideline will help local authorities and the NHS to meet smoking-related outcomes within the 'health improvement' domain in the Public Health Outcomes Framework 2016 to 2019 (Department of Health and Social Care).

## *More information*

You can also see this guideline in the NICE Pathway on stopping smoking.

To find out what NICE has said on topics related to this guideline, see our web page on smoking and tobacco.

See also the evidence reviews and information about how the guideline was developed, including details of the committee.

# Rationale and impact

## *Overview*

The committee were tasked with partially updating recommendations from 2 NICE guidelines about smoking cessation. The aim was to develop a single NICE guideline about smoking cessation that would reflect changes in current practice and commissioning. Some recommendations from the 2006 and 2008 guidelines were not reviewed by the committee as part of this update and these original recommendations have been retained. However, some recommendations have been edited to ensure that they meet current editorial standards, and reflect the current policy and practice context. Because this update is for smoking cessation only, we have not included guidance on smokeless tobacco cessation. Users should consult NICE's guideline on smokeless tobacco: South Asian communities. Other recommendations were reviewed, taking into account any new evidence and expert opinion.

Given the large body of research about smoking cessation, we developed a pragmatic approach to identifying evidence. Evidence was identified through a series of steps. Briefly, these steps involved reviewing high quality systematic reviews conducted by Cochrane, followed by non-Cochrane systematic reviews and then individual studies. The committee used the results of this to update some recommendations, and to identify gaps where further evidence was needed to inform decisions. Gaps identified by the committee included evidence about the use of digital media as an adjunct to other interventions.

The committee considered the body of evidence (published or expert testimony) presented for each review question, and then drafted recommendations based on this evidence and the experiences of the topic experts. More detailed information on how the evidence or testimony was considered by the committee is available in the systematic reviews done to support this guideline. If original recommendations from NICE's guidelines on smoking: brief interventions and referrals and stop smoking services were deleted, the committee discussed these in light of the new recommendations to ensure that no recommendations were deleted without a satisfactory update or reason for deletion.

This committee only discussed evidence linked to recommendations being updated, the original evidence reviews and deliberations of the 2006 and 2008 guideline committees were not reviewed as part of this update process.

See the PH1 and PH10 evidence for recommendations that have been incorporated from previous guidelines.

### Economic modelling

A stepped approach was taken to the effectiveness evidence. The effectiveness evidence from 30 different interventions was modelled. Intervention costs ranged from £19 to £763 per person. Intervention effectiveness in terms of people who quit ranged from 9 to 47% and they were all highly cost effective at a threshold of £20,000 per quality-adjusted life year. Additionally, a 2-way scenario analysis that varied the quit rate associated with an intervention and the cost of the intervention showed that even when the lowest quit rate identified in the effectiveness studies (9%) is combined with the most expensive intervention cost (£763 per person), the intervention is still cost effective. Because patient preference is essential for successful intervention, the committee considered any cost-effective intervention to be an option for use.

### How the recommendations might affect practice

Smoking is the main cause of preventable illnesses and deaths in England. The estimated annual cost to the economy is more than £11 billion. Of this annual cost, £2.5 billion fell to the NHS (Statistics on smoking, England – 2016 Health and Social Care Information Centre), £5.3 billion to employers, and £4.1 billion to wider society. This last figure is based on the death or absence of people who would otherwise be working and contributing to the economy. Smoking-related ill-health also increases costs for the adult social care system, which are not included here but which are likely to be substantial. For example, the World Health Organization estimates that smoking may be responsible for up to 14% of all cases of Alzheimer's disease, the most common form of dementia.

But if all health and social care workers could identify which of the people they see are smoking and give them information and support to help them quit, these figures could change. In some cases it might lead to people getting help to quit at an earlier stage, preventing smoking-related health problems entirely or stopping them getting worse.

Targeting groups who smoke heavily or who find it most difficult to stop will make the most difference, because they are most at risk of becoming ill or dying. Focusing time and resources where they will make the most difference will also reduce costs for the NHS.

## *Commissioning and providing stop smoking interventions and services to meet local needs*

The discussion below explains how the committee made recommendations 1.1.1 to 1.1.3.

### Why the committee updated the recommendations

Government policy changes since the publication of NICE's 2008 guideline on stop smoking services mean that the NHS and local authorities now produce sustainability and transformation plans to jointly meet local health needs. Their priorities for providing care, set out in health and wellbeing strategies, are founded on these plans. The committee agreed that commissioners and managers should use Public Health England's public health profiles, such as the Local Tobacco Control Profiles to find recent data on tobacco use and tobacco-related harm because knowing an area's needs is key. Local government and health services can use these data to plan how to tackle tobacco use and ensure that stop smoking interventions are available for everyone who smokes. Having reliable data will help local authorities allocate funds to local stop smoking services.

Public Health England's public health profiles together with sustainability and transformation plans, and health and wellbeing strategies will provide data on specific groups who are at high risk of tobacco-related harm in the area. Based on topic experts' experience, the committee agreed that some people in these groups are likely to smoke heavily or find it harder to quit than the general population of people who smoke. They are also more likely to have other physical health problems. Stopping smoking can reduce smoking-related complications.

### How the recommendations might affect practice

Like NICE's 2008 guideline on stop smoking services, this guideline recommends the provision of stop smoking services and support, so there is no change in the funding implications. The value of support for stop smoking remains strong and the level of funding for this activity should not be reduced. By targeting groups at high risk of harm from smoking, stop smoking services can make a bigger difference and use resources more effectively.

Full details of the evidence and the committee's discussion are in evidence review A.

## *Monitoring stop smoking services*

The discussion below explains how the committee made recommendations 1.2.1 to 1.2.4.

### Why the committee updated the recommendations

The committee agreed that stop smoking services that meet the targets are more likely to be funded, even when there are competing demands on local budgets. These targets, which were set because of expert opinion, were recommended in the original 2008 guideline on stop smoking services. The committee agreed that, based on their experience, there was no need to change them.

Quit rates are important because they provide planners with a figure that represents the benefit of a person stopping smoking. Topic experts advising on using carbon monoxide monitoring as a marker for quitting suggested that there was no reason to change the cut-off of 10 ppm recommended in the 2008 guideline. But because there is no universally agreed threshold the committee made a research recommendation on this (research recommendation 2).

Independent monitoring of quit rates and making the results public should ease concern about stop smoking services enhancing their performance results to ensure continued funding.

### How the recommendations might affect practice

The recommendations will support current best practice and encourage investment in evidence-based services.

Full details of the evidence and the committee's discussion are in evidence review A.

## *Evidence-based stop smoking interventions*

The discussion below explains how the committee made recommendations 1.3.1 to 1.3.9.

### Why the committee updated the recommendations

Evidence showed that all the stop smoking interventions recommended for adults are effective. But to get the most benefit, staff delivering behavioural interventions must be trained to the NCSCT training standard. There was some evidence that NRT helped young people over 12 who smoke, and topic experts on the committee emphasised that young people are more likely to stop smoking when they also get behavioural support.

Topic experts explained that, in their experience, quit rates increase when text messaging is added to behavioural support. Evidence for text messaging alone was not reviewed so the committee did not make a recommendation for this. The text messages should be tailored to the person, give information about the health effects of smoking, provide encouragement, boost self-efficacy, motivate and give reminders of how deal with difficult situations.

### How the recommendations might affect practice

All the interventions are clinically effective, cost effective and cost saving to both the NHS and local authorities. Most organisations will not need to change current practice, and support to stop smoking services should remain a priority. Behavioural support in the UK is currently only provided

by stop smoking services. If GPs were commissioned to provide this intervention they would be likely to contract this out to the local stop smoking services. Staff working in GP settings currently offer pharmacotherapy plus very brief advice.

Individual behavioural support involves more staff than group behavioural support. But group behavioural support can lead to delays in support for people wanting to quit because they usually need a minimum number of people before they can start. Text messaging is routinely provided in stop smoking services as an opt-out adjunct to behavioural support and because it is cheap it does not need significant investment.

Full details of the evidence and the committee's discussion are in evidence review B.

## *Engaging with people who smoke*

The discussion below explains how the committee made recommendations 1.4.1 to 1.4.4.

### Why the committee updated the recommendations

Evidence showed that advice and referral is effective and highly cost effective in helping people to stop smoking. So health and social care workers in primary and community settings should speak to people about their smoking status at every contact. This is particularly important for people from more disadvantaged groups because evidence shows that they have much higher smoking rates and lower than average quit rates. They are also more likely to have respiratory, heart or other chronic conditions caused by, or worsened by, smoking.

Although some staff worry that people who smoke may feel they are being given too much advice, the committee considered that missing the chance to give appropriate advice carried a greater risk of harm. Also, the person may seek advice from other sources that may not be able to guide them to local stop smoking support. Topic experts persuaded the committee that people are more likely to think about stopping when asked in a way that is sensitive to their preferences and needs.

Evidence showed that smoking delays recovery after surgery, so people should stop smoking before having elective surgery. Because this is so important, the committee recommended that people planning surgery be referred for stop smoking support (an opt-out approach) rather than being offered a referral (an opt-in approach).

### How the recommendations might affect practice

Asking about smoking status, giving advice and referring to local stop smoking support should be part of routine care. Staff should gain the knowledge and skills to give this care though their basic training and further training provided by their employers.

Full details of the evidence and the committee's discussion are in evidence review E.

## *Advice on e-cigarettes*

The discussion below explains how the committee and NICE made recommendation 1.5.1.

### Why the committee updated the recommendations

People who smoke often ask healthcare practitioners about using nicotine-containing e-cigarettes, which are increasingly being used for quitting. Because of the misconceptions and confusion about the safety of e-cigarettes, the committee agreed that advice should be given to allow an informed discussion on using them to stop smoking.

The long-term harms caused by smoking, even in the short term, are well established and are the reason people who smoke are advised to quit. The committee were aware of reports produced by Public Health England (E-cigarettes and heated tobacco products: evidence review) and the Royal College of Physicians (Nicotine without smoke: tobacco harm reduction) stating that the constituents of cigarette smoke that harm health are either absent in e-cigarette vapour or, if present, are mostly at much lower levels.

However, the committee also concluded that because e-cigarettes have only been widely available for a short period, the evidence on the long-term impact of their short-term use as well as the long-term health impact of their long-term use was still developing.

The committee were concerned that people who smoke should not be discouraged from switching to e-cigarettes, and as a result continue to smoke, because the evidence is still developing. Although there is a little evidence on the effectiveness and safety of these as medicinal products, the committee expected that these products are likely to be less harmful than smoking. Although they did not review the evidence detailed in the reports, they noted the recent reviews by Public Health England and others that stated that e-cigarettes are substantially less harmful than smoking. NICE was also aware of the reports produced by other national organisations as well as Public Health England. NICE agreed during post-committee discussions with Public Health England

that the guideline should reflect the guidance produced by others when advising people who want to stop smoking about e-cigarettes.

### How the recommendations might affect practice

Many staff are not aware of what advice to give on e-cigarettes so staff will need information and training. Managers of services providing stop smoking support may need to ensure staff are aware of the latest information, but the costs should be minimal.

Full details of the evidence and the committee's discussion are in evidence review C.

## *If a person who smokes wants to quit*

The discussion below explains how the committee made recommendations 1.6.1 to 1.6.6.

### Why the committee updated the recommendations

People who want to stop smoking should be referred to stop smoking support in their area because evidence and expert opinion showed that support provided by these services is clinically effective and highly cost effective in helping people to stop smoking. Managers should ensure that staff are available in primary or community settings to offer pharmacotherapy and very brief advice if there are no local stop smoking services or the person does not want to be referred.

Many people try to quit smoking using a variety of methods. Topic experts believe that allowing a person to choose the method that they prefer, provided it is not a pharmacotherapy that is unsuitable for them, is likely to increase success. But the committee recommended that before agreeing the approach to take with the smoker, stop smoking services, GPs and other prescribers should explain that a combination of pharmacotherapy and behavioural support may be the best option.

### How the recommendations might affect practice

Most organisations will not need to change practice and the recommendations will support best practice.

Full details of the evidence and the committee's discussion are in evidence review E.

## *If a person who smokes is not ready to quit*

The discussion below explains how the committee made recommendation 1.7.1.

### Why the committee updated the recommendations

The committee noted that changing smoking behaviour might not be a priority for some people because of other more pressing personal needs and goals. Unlike people who are motivated to change, people who are not motivated to stop smoking may need more information about the benefits of quitting. Using each contact to find out if they are ready to take up the offer for support could make it more likely that they will quit smoking.

### How the recommendations might affect practice

Asking about smoking status and giving advice should be part of routine care. The recommendations will reinforce current best practice and organisations should not need to change practice.

Full details of the evidence and the committee's discussion are in evidence review E.

## *Recommendations that have not been updated*

Evidence for recommendations from the previous guideline that have not been updated (sections 1.8 to 1.12) can be found on the evidence tab for this guideline.

## Recommendations for research

The guideline committee has made the following recommendations for research.

### *1 Digital media*

How effective and cost effective are stop smoking interventions delivered using web-based packages or apps?

#### Why this is important

There is limited evidence on the effectiveness and cost effectiveness of digital media as an adjunct to specialist help. Web-based packages and apps are cheap, easy to access and freely available. So it is important to find out whether they work in the short or longer term.

### *2 Carbon monoxide monitoring*

What is the validity of different thresholds of carbon monoxide in exhaled breath as markers of quitting, based on diagnostic review and modelling?

#### Why this is important

Recommended thresholds for showing that a person has stopped smoking vary depending on factors such as the measurement method, the target population, when the guidance was developed and manufacturer recommendations. Being around other smokers or in areas with heavily polluted air can influence the accuracy of the results. It is important to have valid markers of abstinence to monitor the success of interventions.

## Update information

**March 2018:** This guideline is an update of NICE guidelines on smoking: brief interventions and referrals (PH1 published March 2006) and stop smoking services (PH10 published February 2008) and replaces them.

Updated or new recommendations have been made about brief advice (given typically in less than 10 minutes), very brief advice (given as the opportunity arises in less than 30 seconds), behavioural support (for example, delivered to a person or a group) and pharmacotherapies (nicotine replacement therapy, including licensed e-cigarettes and bupropion).

Recommendations are marked as **[2018]** if the recommendation is new or the evidence has been reviewed.

NICE has deleted all the recommendations from the 2006 guideline and some recommendations from the 2008 guideline, because either the evidence has been reviewed and the recommendations have been updated, or NICE has updated other relevant guidance and has replaced the original recommendations.

Where recommendations end **[2008]** the evidence has not been reviewed since the original guideline.

Where recommendations end **[2008, amended 2018]**, the evidence has not been reviewed but changes have been made to the recommendation. These may be:

- changes to the meaning of the recommendation (for example, because of equalities duties or a change in the availability of medicines, or incorporated guidance has been updated)
- editorial changes to the original wording to clarify the action to be taken.

### *Amended recommendation wording (change to meaning)*

| Recommendation in 2008 guideline | Recommendation in current guideline | Reason for change |
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| Recommendation 3 bullet 3<br>• Staff who offer counselling should be trained to at least level two (individual behavioural counselling) and preferably, they should hold an appropriate counselling qualification. Training should comply with the 'Standard for training in smoking cessation treatments' or its updates. | 1.8.3 Staff who offer counselling should be trained to the NCSCT Standard (individual behavioural counselling) and preferably hold an appropriate counselling qualification. Training should comply with the Standard for training in smoking cessation treatments or its updates. | Amended to take account of change in training standards. |
| Recommendation 11<br>• Ensure training complies with the 'Standard for training in smoking cessation treatments' or its updates. | 1.9.2 Ensure training complies with the NCSCT training standard or its updates. | Amended to take account of change in training standards. |
| Recommendation 12<br>• Train all frontline healthcare staff to offer brief advice on smoking cessation in accordance with NICE guidance ('Brief interventions and referral for smoking cessation in primary care and other settings'). Also train them to make referrals, where necessary and possible, to NHS Stop Smoking Services and other publicly funded smoking cessation services. | 1.9.3 Train all frontline healthcare staff to offer very brief advice on how to stop smoking in accordance with recommendations 1.6.2 and 1.6.5. Also train them to make referrals, if necessary and possible, to local stop smoking services. | Amended to reflect that local authorities are responsible for commissioning stop smoking services and to include very brief advice as an option. |

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| Recommendation 14, bullet 2<br>• Develop and deliver communications strategies in partnership with the NHS, regional and local government and non-governmental organisations. The strategies should:<br>– use the best available evidence of effectiveness, such as reviews by the Cochrane Collaboration and the Global Dialogue for Effective Stop Smoking Campaigns<br>– be developed and evaluated using audience research<br>– use 'why to' and 'how to' quit messages that are non-judgemental, empathetic and respectful. For example, testimonials from people who smoke or used to smoke can work well<br>– involve community pharmacies in local campaigns and maintain links with other professional groups such as dentists, fire services and voluntary groups<br>– ensure campaigns are sufficiently extensive and sustained to have a reasonable chance of success<br>– consider targeting and tailoring campaigns towards low income | 1.10.2 Develop and deliver communications strategies in partnership with the NHS, regional and local government and non-governmental organisations. The strategies should:<br>• Use the best available evidence of effectiveness, such as Cochrane reviews.<br>• Be developed and evaluated using audience research.<br>• Use 'why to' and 'how to' quit messages that are non-judgemental, empathetic and respectful, for example testimonials from people who smoke or used to smoke.<br>• Involve community pharmacies in local campaigns and maintain links with other professional groups such as dentists, fire services and voluntary groups.<br>• Ensure campaigns are sufficiently extensive and sustained to have a reasonable chance of success.<br>• Consider targeting and tailoring campaigns towards low income and some | Amended to take into account changes in the external sources referred to and that smoking prevalence may be higher in some minority ethnic groups. |

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| and minority ethnic groups to address inequalities. | minority ethnic groups to address inequalities. | |
| Recommendation 16<br>Negotiate a smokefree workplace policy with employees or their representatives. This should:<br>• state whether or not smoking breaks may be taken during working hours and, if so, where, how often and for how long<br>• direct people who wish to stop smoking to services that offer appropriate support, for example, the NHS Stop Smoking Services<br>• implement the NICE public health guidance, 'Workplace interventions to promote smoking cessation'. | 1.12.1 Negotiate a smokefree workplace policy with employees or their representatives. This should:<br>• State whether or not smoking breaks may be taken during working hours and, if so, where, how often and for how long.<br>• Direct people who wish to stop smoking to local stop smoking support.<br>• Implement NICE's guideline on smoking: workplace interventions. | Amended to reflect that local authorities are responsible for commissioning stop smoking services and to take account of a change in the title of NICE guidance. |

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## *Accreditation*