National Institute for Health and Care Excellence

Guideline version (Final)

Smoking cessation interventions and services

[A] Evidence reviews for stop smoking services

NICE guideline NG92

Evidence reviews

March 2018

November 2021: NICE guideline NG92 (March 2018) has been updated and replaced by NG209. The recommendations labelled [2018] or [2018, amended 2021] in the updated guideline were based on these evidence reviews.
See www.nice.org.uk/guidance/NG209 for all the current recommendations and evidence reviews.

FINAL

These evidence reviews were developed by Public Health Internal Guideline Development team

Disclaimer

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users 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 compliance with those duties.

NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive. All NICE guidance is subject to regular review and may be updated or withdrawn.

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Included studies

No published evidence was looked for or reviewed for this review so the committee agreed to use expert testimony (see Appendix F4 & F5).

Evidence statements

No published evidence was looked for or reviewed. The expert testimony covered the following themes

- Some local authorities have decommissioned stop smoking services entirely and others are limiting services to provide for certain groups e.g. pregnant women. (Expert testimony 4)
- Reduction in the number of staff employed in a number of services has resulted in less, and lower quality, behavioural support received by smokers (Expert testimony 4)
- The English stop-smoking services (SSS) have been extremely cost-effective and could be more effective if they were all commissioned to follow evidence-based guidance from the National Centre for Smoking Cessation and Training (NCSCT), and the National Institute for Health and Care Excellence (NICE). (Expert testimony 5)
- The Stop-Smoking+ model as template that can be used to develop local service delivery plans to maximise the success at stopping smoking that can be obtained with reduced budgets. (Expert testimony 5)

Applicability: This evidence is directly applicable as it is based on existing practice in the UK.

Recommendations

A1 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).

A2 Use Public Health England's public health profiles to estimate smoking prevalence among the local population. [2018]

A3 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]A4 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]

A5 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]

A6 Monitor performance data for stop smoking services routinely and independently. Make these results publicly available. [2018]Make these results publicly available. [2018]

A7 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]

Rationale and impact

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.

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

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 be 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.

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

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

The committee agreed that quit rate was the most important outcome as it was a reliable proxy for all the benefits accrued after a smoker quits. This includes the reduction in risk to tobacco-related illnesses and the morbidity and mortality associated with these. For people with tobacco-related illness there is an increased benefit in terms of greater risk reduction, lessening of symptoms, fewer hospital admissions etc.

For people with other medical conditions, stopping smoking can reduce the risk of complications associated with those conditions, increase treatment options (for example in HIV), and reduce delays in recovery after surgery

From a population health aspect the committee noted that one of the largest risk factors for starting smoking is having a parent who smokes so any increase in quit rates in one generation will have a carry-on benefit in terms of further reducing the number of people who

take up smoking in the next generation. There is an additional benefit from reduced exposure to second-hand smoke.

The quality of the evidence

No evidence was reviewed for this topic. The committee agreed to consider expert testimony as an appropriate method to update this set of recommendations. The expert testimony presented to the committee supported the retention of these recommendations and the committee were not aware of any reason to remove or weaken these recommendations.

Benefits and harms

The committee agreed with the exert testimony that local stop smoking services have been effective in helping individuals to quit smoking.

Cost effectiveness and resource use

No review of cost effectiveness evidence was undertaken. Instead, a bespoke model was developed which explored the threshold at which interventions are cost effective and assessed the cost effectiveness of a range of interventions identified in the effectiveness reviews.

This topic area was not covered in the overall health economic modelling. However, scenario analyses indicated that even interventions that increased the quit rate by 1% would be cost-effective if the costs were less than £225 per person.

Other factors the committee took into account

Social inequalities in tobacco use make a significant contribution to inequalities in health. Interventions that are effective in reducing social inequalities in tobacco use are therefore central to the government's public health strategy and to the broader goal of promoting health equity.

It is important to ensure that publicly funded stop smoking services are easily accessible by people from these groups and that they are encouraged to use them. The committee noted the cultural acceptability of behaviour change interventions such as those delivered by stop smoking services varies from group to group. There was agreement on the need to emphasize the need for stop smoking services to work closely with different client groups over time and to use needs assessments to gather local and cultural information to ensure interventions are tailored appropriately.

It was also noted that changing smoking behaviour might not be a priority for the individuals being targeted. People do not necessarily make their own long-term health a priority and may want to focus on other, more immediate needs and goals (for example, relieving stress, or complying with peer pressure).

Motivated individuals actively seeking to make changes in their behaviour require a different approach from those who are unmotivated. The latter may need more information about the benefits of change, as well a realistic plan of action. The committee considered that for these individuals it might be necessary to make use of each contact to see if the individual is ready to take up the offer for support to quit smoking.

The topic experts suggested that a local stop smoking service should be seen as part of a comprehensive system-wide plan to achieve targets for reducing smoking prevalence.

However guidance on reducing smoking prevalence is available in related NICE guidance such as ‘Smoking: reducing and preventing tobacco use (NICE QS82) and related national government documents. It was also recognised that reducing smoking prevalence would require other interventions such as legislation which is outside the remit of NICE guidance. The committee were mindful of the competing demands on local budgets but have referred to the health economic modelling which demonstrates significant return on investment for stop smoking services. While the committee is not in a position to recommend that a specialist stop smoking service is mandatory, the committee have recommended the evidence based interventions that should be made available in what way local stop smoking services have been commissioned and organised. The committee noted the time point for establishing the outcome of a quit attempt is currently 4 weeks whereas longer durations of 3 months or 1 year could be used for checking the status of the quit attempt as a proxy for long term effectiveness. The committee noted there is potential for people to fall between services and so retained the recommendation on monitoring and audit to ensure this risk can be minimised.

Community pharmacies serve local communities and have the potential to reach and treat large numbers of people who use tobacco. They are able to meet the needs of minority ethnic and disadvantaged groups and those who may have difficulty accessing other community services.

The committee discussed the different targets for CO monitoring and noted that while these were originally based on consensus, the committee were not aware of new evidence on CO monitoring and drafted a research recommendation to guide future updates. The committee agreed to retain the recommendations from PH10 in their entirety as they saw no evidence to amend these beyond updating the terminology used.