National Institute for Health and Care Excellence

Guideline version (Final)

Smoking cessation interventions and services

[E] Evidence reviews for advice

NICE guideline NG92

Evidence reviews

March 2018

FINAL

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

NICE accredited

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Review question

Is very brief advice from a community, health or social care professional effective and cost effective?

Is brief advice from a community, health or social care professional effective and cost effective?

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. The methods used for study identification are Methodology section (see Appendix A) and reviewing methods specific to this review question are described in the review protocol in Appendix B.

Declarations of interest were recorded according to NICE's 2014 conflicts of interest policy.

Public health evidence

Included studies

Very brief advice

No published evidence was identified that used the classification of very brief advice or described similar interventions that provided support or referral in under 30 seconds.

Brief advice

Two Cochrane reviews provided evidence for this review question. The reviews focused on current smokers, some of whom were motivated to quit. Both reviews excluded trials that exclusively included pregnant women. Characteristics of the included reviews are presented in Table 1 and further details are in Appendix D2.

Excluded studies

See Appendix E for excluded studies.

Summary of studies included in the evidence review

Table 1: Characteristics of included studies

Author, year, title	Quality	Populations	Interventions	Comparison	Outcomes
Rice et al. 2013. Nursing interventions for smoking cessation.	++	35 studies of smokers (adults > 18 years of age) The most common setting was secondary care	Advice delivered in a single 10-minute consultation with 1 follow-up visit	Usual care	Quit rates
Stead et al. 2013. Physician advice for smoking cessation.	++	17 studies of smokers (adults and young people) The most common setting	Advice delivered in a single 20-minute consultation with 1 follow-up	Usual care	Quit rates

Author, year, title	Quality	Populations	Interventions	Comparison	Outcomes
		was primary care.	visit		

Stead et al. (2013 [++]) focused on the effectiveness of brief advice delivered by physicians or by physicians supported by other healthcare workers to their patients. This review found that brief advice (defined as advice with or without a leaflet) during a single consultation lasting less than 20 minutes plus up to one follow-up visit] increased quit rates compared with no advice [or usual care] - (17 trials, RR 1.66, [CI 1.42 to 1.94]).

Rice et al. (2013 [++]) focused on brief advice delivered by nurses. This review found that brief advice (single 10 minute session with 1 follow-up visit) increased quit rates but this was not significant compared with no advice or usual care (7 trials, RR 1.27, [0.99 to 1.62]).

Included studies

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 covered in the overall health economic modelling by one study, which delivered brief advice exclusively and in combination with pharmacotherapy. Both options were cost effective and potentially cost saving to both NHS and local authorities against a 'do nothing alternative'. However, brief advice and pharmacotherapy in combination was cost-saving and more effective compared with brief advice alone. The committee noted that very brief advice would always be offered at the initial discussion, at each opportunity after that and when prescriptions are offered so, there is no additional cost associated with doing this.

Evidence statements

No published evidence was identified that described the effectiveness of very brief advice that was less than 30 seconds.

Applicability: No published evidence was identified

There is strong evidence from a single review showing that brief interventions (single consultation lasting less than 20 minutes plus up to one follow-up visit delivered by physicians) increase quit rates when compared with a control intervention and this was statistically significant (17 trials, RR 1.66, [95%CI 1.42 to 1.94]).

Applicability: There are no obvious limits to the applicability of this evidence as the majority of the studies were conducted in UK settings though the indirectness of the intervention (longer that 10 minutes) would lessen confidence in the findings.

There is strong evidence from a single review showing that brief interventions (single consultation lasting 10 minutes or less with a single follow-up visit delivered by nurses) do not increase quit rates when compared with a control intervention (7 trials, RR 1.27, [95%CI 0.99 to 1.62]).

Applicability: There are some limits to the applicability of this evidence as the majority of the studies were conducted in non-UK settings. The different context of healthcare service organisation in these countries may affect the delivery of specific interventions.

Recommendations

E1 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]

E2 Encourage people being referred for elective surgery to stop smoking before their surgery. Refer them to local stop smoking support. [2018]

E3 Discuss any stop smoking aids the person has used before, including personally purchased nicotine-containing products (see recommendations E4 and C1). [2018]

E4 Offer advice on using nicotine-containing products on general sale, including NRT and nicotine-containing e-cigarettes. [2018]

If a person who smokes wants to quit

E5 Refer people who want to stop smoking to local stop smoking support. [2018]

E6 Discuss how to stop smoking with people who want to quit (the NCSCT programmes explain how to do this). [2018]

E7 Set out the pharmacotherapy and behavioural options as listed in recommendation B1 taking into consideration previous use of stop smoking aids, and the adverse effects and contraindications of the different pharmacotherapies. [2018]

E8 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]

E9 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]

E10 Agree the approach to stopping smoking that best suits the person's preferences. Review this approach at future visits. [2018]

If a person who smokes is not ready to quit

E11 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]

Rationale and impact

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 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).

If the person who smokes wants to quit

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 effective and highly cost-effective in helping people to stop smoking. Managers should ensure professionals that staff are available in primary or community settings to offer pharmacotherapy and very brief advice when 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.

If a person who smokes is not ready to quit

The committee noted that changing smoking behaviour might not be a priority for some people because of other more pressing needs and goals, for example relieving stress or complying with peer pressure. 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, 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.

If the person who smokes wants to quit

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

If a person who smokes is not ready to quit

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.

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

The committee noted the lack of published evidence for very brief advice of less than 30 seconds. No expert testimony was sought as the committee agreed that best practice dictates that very brief advice would always be given when a prescription is offered. As advice is also given if pharmacotherapy is declined, the committee also noted that the recommendation to discuss treatment options with smokers would cover the elements of very brief advice.

The committee noted that for the most part the evidence of effectiveness in increasing quit rates for brief advice was supported by their experiences in clinical and public health practice.

Benefits and harms

Very brief advice was considered useful by the committee as a means of checking smoking status and signposting to more support such as specialist stop smoking service as required. This is consistent with existing recommendations in stop smoking services to ask about smoking status and readiness to quit at every opportunity, The committee noted that there is

a need for all clinical and public health professionals to accept that enquiring about smoking status and signposting to more support is a normal, routine part of their daily practice. This indicates that there is a pre-requisite for these professionals to be knowledgeable about local publicly funded stop smoking services in order to be able to provide the correct advice.

The risk with asking about smoking status at every opportunity is that smokers may feel bombarded with advice and this may have an effect on the subsequent interactions with the individual. The committee noted that there was potentially greater harm associated with not giving appropriate advice. These include missing opportunities to reinforce the 'stop smoking' message and also the opportunity to tailor the advice to the individual. There is also the potential that if advice is not provided then the person may seek advice from alternative sources that may not be able to signpost to local stop smoking services.

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 covered in the overall health economic modelling, which indicated that all interventions were cost effective and potentially cost saving to both NHS and local authorities.

Other factors the committee took into account

The committee considered the impact of different professionals delivering the interventions and not that quit the odds ratio for quitting was larger for brief advice delivered by GPs then for brief advice delivered by nurses. The committee were not minded to base the recommendations on who would deliver the intervention but instead recommended be delivered by people with appropriate training.

The committee agreed that brief advice, as used in the context of this guideline, corresponded with the National Centre for Smoking Cessation and Training (NCSCT) very brief advice. This was considered by the committee as the best source for evidence-based advice to give to smokers. The NCSCT very brief advice module includes the concepts of

- Ask, (Assessing current and past smoking behaviour)
- Advise (Providing information on consequences of smoking and smoking cessation) and
- Act (Providing options for later/additional support and advising on stop smoking medications)

The NCSCT has identified the competencies (knowledge and skills) needed to effectively help smokers to stop smoking and also conducts research into the behavioural support given to smokers in the UK. To this end, the NCSCT has developed training, assessment and certification programmes based upon these competencies and also provides resources for commissioners, managers and practitioners.