NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

PUBLIC HEALTH GUIDANCE

DRAFT SCOPE

1 Guidance title

Smoking cessation in secondary care: acute and obstetric services

1.1 Short title

Smoking cessation: acute and obstetric services

2 Background

a) The National Institute for Health and Clinical Excellence (NICE) has been asked by the Department of Health (DH) to develop public health guidance on smoking cessation in secondary care. The referral has been divided into two separate pieces of complementary guidance.

b) This guidance will address smokefree policies and smoking cessation in hospitals and other acute or obstetric care settings. It will cover emergency care, planned specialist medical care or surgery, and obstetric care provided in hospitals, maternity units and outpatient clinics. It will also cover secondary care services provided in the community. The other guidance (‘Smoking cessation in secondary care: mental health services’) will address smokefree policies and smoking cessation in mental healthcare settings. It will cover assessment, care and treatment for people with severe mental illness in hospitals, outpatient clinics and the community, as well as intensive services in psychiatric units and secure hospitals (http://guidance.nice.org.uk/PHG/Wave23/36).

c) This guidance will support a number of related policy documents including:

- 'Fair society, healthy lives' (Marmot Review 2010)
- ‘Healthy lives, healthy people: a tobacco control plan for England’ (DH 2011a)
- ‘Healthy lives, healthy people: our strategy for public health in England’ (DH 2010)
- 'Improving outcomes: a strategy for cancer' (DH 2011b)
- ‘Securing good health for the whole population’ (Wanless 2004)
- ‘The operating framework for the NHS in England 2011/12’ (DH 2011c).

d) This guidance will provide recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness. It is aimed at professionals and managers with any aspect of secondary care or public health as part of their remit. It is particularly aimed at commissioners and providers of evidence-based stop-smoking services. It is also aimed at doctors, nurses, social workers and estates managers working in secondary care. In addition, it will be of interest to all secondary care staff, patients, carers and service users and other members of the public who smoke.

e) The guidance will complement other NICE guidance on stopping smoking. For further details, see section 6.

This guidance will be developed using the NICE public health programme process. (For details see www.nice.org.uk/aboutnice/howwework/developingnicepublichealthguidance/developing_nice_public_health_guidance.jsp).

3 The need for guidance

a) Tobacco smoking is the main cause of preventable morbidity and premature death in England. Smoking causes a wide range of diseases, including cancers, cardiovascular diseases, respiratory diseases and osteoporosis. It also causes complications of pregnancy and low birthweight. In England in 2009, it was estimated that 81,400 deaths among adults aged 35 and over were caused by smoking. The same study estimated that more than 462,000 hospital admissions in this age group were attributable to smoking, accounting for 5% of all admissions (NHS Information Centre 2010). Smoking is also a known risk factor in complications after surgery: it is associated with lower survival rates, delayed wound healing, increased infections, prolonged hospital stay and repeated admissions (Delgado-Rodriguez et al. 2003).

b) Breathing secondhand smoke can have both immediate and long-term health consequences. In the short term, it can exacerbate respiratory symptoms and trigger asthma attacks. In the longer term, there is an increased risk of smoking-related diseases (Royal College of Physicians 2005; Scientific Committee on Tobacco and Health 2004). Scientific evidence suggests that there is no risk-free level of exposure to secondhand smoke (US Surgeon General 2006). People with medical conditions (such as respiratory illnesses), pregnant women and children are particularly vulnerable to exposure to secondhand smoke. Children's vulnerability to tobacco smoke has been well documented. A recent UK report estimated that passive smoking caused 22,600 new cases of wheeze and asthma, 121,400 new cases of middle ear infection and 40 cases of sudden infant death. These consequences were strongly associated with maternal smoking (Royal College of Physicians 2010).

c) Treating smoking-related illnesses was estimated to cost the NHS £2.7 billion in 2006. NHS hospital admissions for smoking-related illnesses accounted for £1 billion of this cost (Callum et al. 2010). The overall financial burden to society has been estimated at £13.74 billion a year. This includes both NHS costs and loss of productivity due to illness and early death (Nash and Featherstone 2010).

d) Although smoking rates have declined sharply in the last 30 years, more than one in five adults in England (21%) smoked cigarettes in 2008. The average consumption was just over 13 cigarettes a day. Smoking prevalence remains higher in certain groups. People in routine and manual occupations are about twice as likely to smoke as those in managerial or professional occupations (29% compared with 14%) (NHS Information Centre 2010).

e) High rates of smoking persist among teenage women during pregnancy. In 2005, teenage women were five times more likely than those aged 35 and over to have smoked throughout pregnancy (45% compared with 9%). Overall, nearly a third (32%) of mothers in England smoked before pregnancy; nearly half of these women (49%) gave up at some stage before the birth. Although most of those who had quit before or during pregnancy were still not smoking shortly after the birth, three in ten mothers (30%) were smoking again less than a year later (British Market Research Bureau 2007).

f) About two-thirds (67%) of people who smoke say that they would like to quit and around seven in ten (71%) say that they want to quit in the near future. Of those who want to give up, the vast majority (83%) cite at least one health reason (Lader 2009). NHS Stop Smoking Services provide care and treatment for people wanting to quit. People who use these services are about four times more

likely to be still not smoking a year later than those receiving no treatment (15% compared with 4%) (Bauld et al. 2009; Ferguson et al. 2005). There is review-level evidence that delivering smoking cessation interventions to inpatients in hospital is effective. (Rigotti et al. 2007; Rice and Stead 2009).

g) Under the smokefree legislation that was introduced in England in July 2007, anyone who smokes in any enclosed or substantially enclosed public place or workplace commits an offence (HM Government 2006). Most NHS secondary care settings have smokefree policies that apply to their grounds (as well as enclosed areas), although there have been problems with compliance and enforcement (Ratschen et al. 2009; Shipley and Allcock 2008).

4 The guidance

Public health guidance will be developed according to NICE processes and methods. For details see section 5.

This document defines exactly what this guidance will (and will not) examine, and what the guidance developers will consider. The scope is based on a referral from the DH (see appendix A).

4.1 Who is the focus?

4.1.1 Groups that will be covered

The guidance will cover people who smoke from the following groups:

- Patients, outpatients and all users of acute and obstetric services, including those who are in the process of being referred to hospital and those who have recently been discharged.

- People living in the same household as a hospital patient or a woman receiving obstetric care, such as partners, parents, other family members and carers.

- Visitors to acute or obstetric care settings who are not receiving treatment or care, such as relatives or friends of patients.

- Staff working in acute or obstetric care settings, in particular those who have direct contact with patients and service users.

The guidance will focus in particular on groups that are more likely to smoke (this includes those in routine and manual occupations).

4.1.2 Groups that will not be covered

- People who have quit smoking for at least 12 months.

- People who have never smoked.

- Users of mental health services.

- Staff working in, and visitors to, secondary care mental health settings.

4.2 Activities

4.2.1 Activities/measures that will be covered

The guidance will focus on:

a) Smoking cessation and temporary abstinence interventions to help people from the groups listed in 4.1.1. This will include:

- offering smoking cessation information, advice and support integrated within care pathways.
- identifying and referring people to stop-smoking services or hospital-based stop-smoking services

- sharing information about quit attempts between clinicians and prescribers, and coordinating the use of pharmacotherapies for smoking cessation with other medications.

b) Smokefree strategies and interventions in hospitals and other acute or obstetric care settings – whether or not they are supported by the smokefree legislation (HM Government 2006). Examples include restrictions on smoking (including signage and enforcement) in the grounds, staff residencies and inside the hospital or maternity unit, and restrictions on staff smoking breaks. The strategies and interventions will also cover visits by acute and obstetric healthcare professionals to community settings, including private residences.

The guidance will also focus on links between these activities and, where possible, will identify ineffective measures and approaches.

4.2.2 Activities/measures that will not be covered

- Smoking cessation interventions in primary and secondary mental healthcare.
- Smokefree policies in primary and secondary mental healthcare.
- Programmes or interventions aimed at preventing the uptake of tobacco use.

4.3 Key questions and outcomes

Below are the overarching questions that will be addressed along with some of the outcomes that would be considered as evidence of effectiveness:

Smoking cessation interventions

Question 1a: How effective and cost effective are smoking cessation interventions in helping people from the groups listed in 4.1.1 to quit?

Question 1b: How effective and cost effective are interventions for temporary abstinence from smoking in acute and obstetric care settings?

Subsidiary questions may include:

- How do the effectiveness and cost effectiveness vary for different population groups or speciality care services?
- Are certain interventions more effective and cost effective when used in combination?
- What impact do the following have on effectiveness, cost effectiveness and acceptability of different interventions: deliverer, setting, timing (or point in the care pathway), frequency, duration, severity of dependence?

Question 2a: How effective and cost effective are the current approaches used by acute and obstetric care services to identify and refer people from the groups listed in 4.1.1 to stop-smoking services?

Question 2b: How effective and cost effective are the current approaches used by acute and obstetric care services to identify and provide patients and service users with smoking cessation information, advice and support?

Question 3: What approaches are an effective and cost effective way to encourage acute and obstetric care professionals to record the smoking status of the groups listed in 4.1.1, offer them smoking cessation information, advice and support or refer them to stop-smoking services?

Question 4: How can community, primary, acute and obstetric care providers collaborate more effectively to provide seamless smoking cessation services?

Question 5: What barriers and facilitators affect the delivery of effective interventions?

Question 6: What are the effects of nicotine intake, or changes in levels of nicotine intake, on the mental and physical health of patients and service users who are on medication and receiving support from acute and obstetric services?

Question 7: What are the effects of nicotine intake, or changes in levels of nicotine intake, on the mental and physical health of patients and users of acute and obstetric services?

Expected outcomes:

- Successful quit attempts, defined as follows (where abstinence from smoking is biochemically validated or self-reported):
  - temporary: during a stay or visit at an acute or obstetric care setting
  - short term: at least 1 month after a quit attempt
  - medium term: at least 6 months after a quit attempt
  - long term: at least 12 months after a quit attempt.
- Increase in the number of referrals to and contacts with stop-smoking services.
- Increase in the number of people provided with smoking cessation information, advice and support by acute and obstetric care services.
- Increase in the number of smoking cessation referrals between acute or obstetric care and other settings.
- Health improvement, such as better recovery rates from illness, surgery or treatment or improved outcomes for babies.
- Positive changes in smoking-related knowledge, attitudes and behaviour.

Smokefree strategies and interventions

Question 8: How effective and cost effective are strategies and interventions for ensuring compliance with smokefree legislation and local smokefree policies in acute and obstetric care settings?

Question 9: Are there any unintended consequences from adopting smokefree approaches in acute and obstetric care settings?

Question 10: What are the barriers and facilitators affecting compliance with smokefree policies in acute and obstetric care settings? What are the views, perceptions and beliefs of acute and obstetric care staff, patients, service users and visitors?

Expected outcomes:

Compliance with smokefree policies.

4.4 Status of this document

This is the draft scope, released for consultation on 1-29 September 2011 to be discussed at a public meeting on 15 September 2011. Following consultation, the final version of the scope will be available at the NICE website in November 2011.

5 Further information

The public health guidance development process and methods are described in 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)' available at www.nice.org.uk/phprocess and 'Methods for development of NICE public health guidance (second edition, 2009)' available at www.nice.org.uk/phmethods

6 Related NICE guidance

Published

Quitting smoking in pregnancy and following childbirth. NICE public health guidance 26 (2010). Available from www.nice.org.uk/guidance/PH26

School-based interventions to prevent smoking. NICE public health guidance 23 (2010). Available from www.nice.org.uk/guidance/PH23

Preventing the uptake of smoking by children and young people. NICE public health guidance 14 (2008). Available from www.nice.org.uk/guidance/PH14

Smoking cessation services. NICE public health guidance 10 (2008). Available from www.nice.org.uk/guidance/PH10

Varenicline for smoking cessation. NICE technology appraisal 123 (2007). Available from www.nice.org.uk/guidance/TA123

Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007). Available from www.nice.org.uk/guidance/PH5

Brief interventions and referral for smoking cessation. NICE public health guidance 1 (2006). Available from www.nice.org.uk/guidance/PH1

Under development

Smokeless tobacco: South Asians. NICE public health guidance (publication expected September 2012).

Tobacco: harm reduction. NICE public health guidance (publication expected May 2013).

Smoking cessation: mental health services. NICE public health guidance (publication date to be confirmed).

Appendix A Referral from the Department of Health

The Department of Health asked NICE to focus on:

' … how routine identification and referral [of smokers] can be embedded in clinical care … (this would cover all secondary care services, including mental health and obstetrics where identification and referral of smokers is often poor)

… what infrastructure and systems are needed to support tobacco control activity (ie smoke-free grounds, how to make nicotine replacement therapy for temporary abstinence available to patients, staff and visitors)….'

Appendix B Potential considerations

It is anticipated that the Programme Development Group (PDG) will consider the following issues:

- Do individual factors such as gender, sexual orientation, age, ethnicity, religion or disability influence the effectiveness, cost effectiveness and acceptability of interventions?
- How do effectiveness and cost effectiveness vary in different settings?
- Are tailored services or interventions more effective and cost effective than generic offerings?
- What impact do interventions have on inequalities in health?
- Is the intervention based on an underlying theory or conceptual model?
- How do smoking cessation interventions interact with other types of secondary care services?
- What knowledge and skills do practitioners need to deliver interventions effectively? Do requirements vary for the different groups?
- Are the interventions available and accessible to different groups?
- How do patients and the public view local smokefree policies?
- Are there any factors that prevent, or support, effective implementation?
- Are there any unintended (positive or negative) consequences of interventions, such as effects on the clinician–patient relationship?

Appendix C References

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