Smoking cessation in secondary care: acute, maternity and mental health services

Issue date: November 2013

Update information

November 2021: NICE guideline PH48 (November 2013) has been updated and replaced by NG209.

This guideline contains the evidence and committee discussion for recommendations from PH48 dated [2013] and [2013, amended 2021].

See www.nice.org.uk/guidance/NG209 for all the current recommendations and the evidence behind them.

Overview

This guideline covers helping people to stop smoking in acute, maternity and mental health services. It promotes smokefree policies and services and recommends effective ways to help people stop smoking or to abstain from smoking while using or working in secondary care settings.

Who is it for?

- Health and social care professionals, including clinical leads in secondary care services and managers of clinical services
- Commissioners, leaders of the local health and care system and Trust boards
- Estate managers and other managers
- People using secondary care services and their families and carers

Introduction: scope and purpose of this guidance

What is this guidance about?

> The guidance supersedes recommendations 6, 7, 12, 15 and 16 in [Smoking cessation services](#) (NICE public health guidance 10), where they apply to secondary care.
>
> The guidance complements but does not replace, NICE guidance on stopping smoking. (For further details, see [Related NICE guidance](#).) In particular, it should be read alongside NICE guidance on [quitting smoking in pregnancy and following childbirth](#) (NICE public health guidance 26) and [tobacco: harm-reduction approaches to smoking](#) (NICE public health guidance 45).

Stopping smoking at any time has considerable health benefits for people who smoke, and for those around them. For people using [secondary care](#) services, there are additional advantages, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, better wound healing, decreased infections, and fewer re-admissions after surgery.

Secondary care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use, or work in, their services. This duty of care includes providing them with effective support to stop smoking or to abstain from smoking while using or working in secondary care services.

This guidance aims to support [smoking cessation](#), [temporary abstinence](#) from smoking and [smokefree](#) policies in all secondary care settings. It recommends:

- Strong leadership and management to ensure secondary care premises (including grounds, vehicles and other settings involved in delivery of

secondary care services) remain smokefree – to help to promote non-smoking as the norm for people using these services.

- All hospitals have an on-site [stop smoking service.](#)
- Identifying people who smoke at the first opportunity, advising them to stop, providing [pharmacotherapy](#) to support abstinence, offering and arranging [intensive behavioural support,](#) and following up with them at the next opportunity.
- Providing intensive behavioural support and pharmacotherapy as an integral component of secondary care, to help people abstain from smoking, at least while using secondary care services.
- Ensuring continuity of care by integrating stop smoking support in secondary care with support provided by community-based and primary care services.
- Ensuring staff are trained to support people to stop smoking while using secondary care services.
- Supporting all staff to stop smoking or to abstain while at work.
- Ensuring there are no designated smoking areas, no exceptions for particular groups, and no staff-supervised or staff-facilitated smoking breaks for people using secondary care services.

In this guidance, 'secondary care' refers to all publicly-funded secondary and tertiary care facilities, including buildings, grounds and vehicles. It covers drug and alcohol services in secondary care, emergency care, inpatient, residential and long-term care for severe mental illness in hospitals, psychiatric and specialist units and secure hospitals and planned specialist medical care or surgery. It also includes maternity care provided in hospitals, maternity units, outpatient clinics and in the community.

The term 'smokefree' is used to mean air that is free of tobacco smoke.

See [About this guidance](#) for details of how the guidance was developed and its current status.

Who is this guidance for?

The guidance is for: commissioners, clinical leads in secondary care services, health and social care practitioners, leaders of the local health and care system, managers of clinical services, estate managers and other managers, trust boards, and other staff with any aspect of secondary care or public health as part of their remit. The guidance may also be of interest to people using secondary care services, their families and carers and other members of the public.

1 Recommendations

The Programme Development Group (PDG) considers that the recommended approaches are cost effective.

The evidence underpinning the recommendations is listed in [The evidence](#).

See also [supporting evidence](#) for the evidence reviews and economic modelling report.

For the research recommendations and gaps in research, see [Recommendations for research](#) and [Gaps in the evidence](#) respectively.

Whose health will benefit?

The recommendations aim to benefit people of all ages who smoke and who use, or work in, [secondary care](#), including acute, maternity and mental health services.

Recommendation 1 Provide information for planned or anticipated use of secondary care

Who should take action?

- Health and social care practitioners and managers in primary care, including GPs, health visitors and midwives.

- Health and social care practitioners in acute, maternity and mental health services, including community services, drug and alcohol services, outpatient and pre-admission clinics.
- Managers of secondary care admissions and pre-admission assessment services.

What action should they take?

- Provide everyone with verbal and written information and advice about the smokefree policy before their appointment, procedure or hospital stay. This should convey:
  - the short- and long-term health benefits of stopping smoking at any time[1]
  - the risks of secondhand smoke
  - that all buildings and grounds are smokefree (see recommendation 11)
  - the types of support available to help them stop, or temporarily abstain from, smoking before, during and after an admission or appointment (see recommendations 3 and 4)
  - the different pharmacotherapies that can help with stopping smoking and temporary abstinence, where to obtain them (including from GPs) and how to use them.
- Before a planned or likely admission, work with the person to include the management of smoking on admission or entry to the secondary care setting in their personal care plan.
- Provide information for relatives, carers, friends and other visitors explaining why the hospital is smokefree and giving information about local stop smoking services.

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[1] Stopping smoking any time before surgery has no detrimental effects for surgery patients. There are significant positive effects of stopping smoking in the 8 weeks running up to surgery.

Recommendation 2 Identify people who smoke and offer help to stop

Who should take action?

- Health and social care practitioners in all acute, maternity and mental health services, including community services, drug and alcohol services, outpatient and pre-admission clinics.

- Health and social care practitioners responsible for the care of people after compulsory admission to hospital under the Mental Health Act.

- Stop smoking advisers and health and social care practitioners trained to provide intensive stop smoking support.

What action should they take?

- During the first face-to-face contact, ask everyone if they smoke or have recently stopped smoking. Record smoking status and the date they stopped, if applicable, in the person's records (preferably computer-based) and any hand-held notes. If a person is unable to or does not want to talk about smoking, note this in their records and ask about their smoking status at the first available opportunity.

- Advise everyone who smokes that secondary care settings are smokefree, and they must therefore abstain from smoking while admitted to or using secondary care services.

- Encourage everyone who smokes to stop smoking completely. Explain that help is available, and if necessary provide immediate access to licensed nicotine-containing products or other pharmacotherapies, if appropriate (see recommendation 6).

- Offer and, if the person agrees, arrange for them to receive intensive behavioural support, either during their current outpatient visit or during their inpatient stay (see recommendations 3 and 4).

- For people using secondary care services in a community setting, staff who are trained to provide intensive behavioural support should offer and provide support (in line with recommendations 3 and 4). Other staff should offer and, if accepted, arrange a referral to a local stop smoking service.

- Midwives should follow recommendation 1 in NICE guidance on [quitting smoking in pregnancy and following childbirth](#) (NICE public health guidance 26). This recommends that, in addition to the actions covered here, midwives should[2]:
  - assess the woman's exposure to tobacco smoke through discussion and use of a [carbon monoxide (CO) assessment](#)
  - refer all women who smoke (including those who smoke lightly or infrequently), have stopped in the last 2 weeks or have a CO reading indicative of smoking[3], to stop smoking services.
- Midwives should help women who do not smoke but register CO levels of 3 parts per million (ppm) or more to identify the source of CO and take further action as appropriate[4].
- If a person declines help to stop smoking, leave the offer open. At subsequent contacts, offer the support again.
- Ensure all actions, discussions and decisions related to stop smoking advice, referrals or interventions are recorded in the person's records (preferably computer-based).

Recommendation 3 Provide intensive support for people using acute and mental health services

Who should take action?

- Doctors, and stop smoking advisers, health and social care practitioners trained to provide intensive stop smoking support.

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[2] This is an edited extract – please see the full recommendation for details.
[3] [Quitting smoking in pregnancy and following childbirth](#) (NICE public health guidance 26) states that it is unclear what constitutes the best cut-off point for determining smoking status; some organisations suggest a CO level as low as 3 parts per million (ppm), others suggest a cut-off point of 6–10 ppm. While NICE public health guidance 26 recommends 7 ppm, it states that when trying to identify pregnant women who smoke, it is best to use a low cut-off point to avoid missing someone who may need help to quit.
[4] Other sources include, for example, household or other secondhand smoke, heating appliances or traffic emissions.

What action should they take?

- Discuss current and past smoking behaviour and develop a personal stop smoking plan as part of a review of their health and wellbeing.
- Provide information about the different types of stop smoking pharmacotherapies and how to use them.
- Provide information about the types of [intensive behavioural support](#) available.
- Offer and arrange or supply prescriptions of stop smoking pharmacotherapies (see [recommendation 6](#)).
- For anyone who does not want, is not ready or is unable to stop completely, encourage the use of licensed nicotine-containing products to help them abstain and provide intensive behavioural support to maintain abstinence from smoking while in secondary care. Follow recommendation 8 in NICE guidance on [tobacco: harm-reduction approaches to smoking](#) (NICE public health guidance 45) where appropriate.
- Offer, and if they agree, use measurements of exhaled carbon monoxide during each contact, to motivate and provide feedback on progress.
- Alert the person's healthcare providers and prescribers to changes in smoking behaviour because other drug doses may need adjusting (see [recommendation 7](#)).
- In addition, for people admitted to a secondary care setting:
  - Provide immediate support if necessary, and otherwise within 24 hours of admission.
  - Provide support (delivered in the setting) as often and for as long as needed during admission.
  - Offer weekly sessions, preferably face-to-face, for a minimum of 4 weeks after discharge. If it is not possible to provide this support after discharge, arrange a referral to a local stop smoking service.
- In addition, for people receiving secondary care services in the community or at outpatient clinics (including pre-operative assessments):
  - Provide immediate support in the outpatient setting.

- Offer weekly sessions, preferably face-to-face, for a minimum of 4 weeks after the date they stopped smoking. Arrange a referral to a local stop smoking service, if preferred by the person.

Recommendation 4 Provide intensive support for people using maternity services

Who should take action?

- Stop smoking advisers and health and social care practitioners trained to provide intensive stop smoking support.

What action should they take?

- Follow recommendation 3 on contacting referrals in NICE guidance on [quitting smoking in pregnancy and following childbirth](#) (NICE public health guidance 26).
- Follow recommendation 4 on initial and ongoing support in NICE guidance on [quitting smoking in pregnancy and following childbirth](#) (NICE public health guidance 26).

Recommendation 5 Provide information and advice for carers, family, other household members and hospital visitors

Whose health will benefit?

- People who smoke and live in the same household as someone who is using acute, maternity or mental health services. This includes partners, parents, other family members and carers.
- People who use or visit acute, maternity and mental health settings.

Who should take action?

- Health and social care practitioners in acute, maternity and mental health services.
- Stop smoking advisers.

What action should they take?

- During contact with partners, parents, other household members and carers of people using acute, maternity and mental health services:
  - provide clear information and advice about the risks of smoking and secondhand smoke
  - advise them not to smoke near the patient, pregnant woman, mother or child; this includes not smoking in the house or private vehicle
  - offer people who want to stop or reduce smoking a referral to a hospital or local stop smoking service, as appropriate.
- During contact with partners of pregnant and breastfeeding women, follow recommendation 7 in NICE guidance on [quitting smoking in pregnancy and following childbirth](#) (NICE public health guidance 26).
- Provide information and take the opportunity to explain to visitors that smoking is not allowed on the premises. Direct those who wish to use licensed nicotine-containing products for temporary abstinence to a point of sale in the hospital (see [recommendation 8](#)).
- Provide information and take the opportunity to provide advice to visitors about the benefits of stopping smoking and how to contact local stop smoking services (for people who are working in the setting, see [recommendation 13](#)).

Recommendation 6 Advise on and provide stop smoking pharmacotherapies

Who should take action?

- Stop smoking advisers and other healthcare practitioners who advise on, supply, or prescribe, pharmacotherapies.

What action should they take?

- Advise people who smoke that licensed nicotine-containing products and other stop smoking pharmacotherapies help people to stop smoking and reduce cravings.

- Emphasise that nicotine is not the major cause of damage to people's health from smoking tobacco, and that any risks from using licensed nicotine-containing products or other stop smoking pharmacotherapies are much lower than those of smoking.
- Recommend and offer:
  - licensed nicotine-containing products (usually a combination of transdermal patches with a fast-acting product such as an inhalator, gum, lozenges or spray) to all people who smoke[5] **or**
  - varenicline[6] or bupropion as sole therapy as appropriate. Do not offer varenicline or bupropion to pregnant or breastfeeding women or people under the age of 18. Varenicline and bupropion can be used with caution in people with mental health problems[7].
- Encourage people who do not want (or do not feel able) to stop smoking completely (including pregnant or breastfeeding women) to use licensed nicotine-containing products to help reduce cravings to smoke during their stay or visit.
- If stop smoking pharmacotherapy is accepted, ensure that it is provided immediately.
- The person should remove nicotine replacement therapy (NRT) patches 24 hours before microvascular reconstructive surgery and surgery using vasopressin injections.
- When people are discharged from hospital ensure they have sufficient stop smoking pharmacotherapy to last at least 1 week or until their next contact with a stop smoking service.
- Encourage people who are already using an unlicensed nicotine-containing product (such as unlicensed electronic cigarettes) to switch to a licensed

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[5] Ideally, pregnant or breastfeeding women should stop smoking without using licensed nicotine-containing products, but if this is not possible, these products may be used. For further information, see the summary of product characteristics (SPCs) for the individual drugs on the Electronic Medicines Compendium (EMC) website.
[6] See NICE guidance on varenicline (NICE technology appraisal guidance 123).
[7] See the summary of product characteristics (SPCs) for varenicline and bupropion on the Electronic Medicines Compendium (EMC) website for further information.

product[8]. Advise the person of local policies on indoor and outdoor use of unlicensed nicotine-containing products.

- See also NICE guidance on varenicline (NICE technology appraisal guidance 123) and smoking cessation services (NICE public health guidance 10).

Recommendation 7 Adjust drug dosages for people who have stopped smoking

Who should take action?

- Doctors and other healthcare practitioners who advise on, or prescribe, pharmacotherapies.
- Pharmacists.
- Health and social care practitioners in acute, maternity and mental health services.

What action should they take?

- Ensure people who use drugs that are affected by smoking (or stopping smoking) are monitored, and the dosage adjusted if appropriate. Drugs that are affected include clozapine, olanzapine, theophylline and warfarin. See relevant guidelines for further details, for example, UK Medicines Information.
- Discuss with secondary care users and their carers the potential to reduce the dose of some drugs when stopping smoking. Advise them to seek medical advice if they notice any side effects of changing smoking behaviour.

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[8] At the time of publication (November 2013), nicotine replacement therapy products were the only licensed nicotine-containing products. However, the Medicines and Healthcare products Regulatory Agency (MHRA) has decided that all nicotine-containing products should be regulated once the European Commission's revised Tobacco Products Directive comes into effect in the UK (this is expected to be in 2016). In the meantime, the UK government will encourage applications for medicines licences for nicotine-containing products and will make best use of the flexibilities within the existing framework to enable licensed products to be available. This means that there may be both licensed and unlicensed products available until that date. For further details, see the MHRA website.

Recommendation 8 Make stop smoking pharmacotherapies available in hospital

Who should take action?

- Hospital pharmacists and managers.

What action should they take?

- Ensure hospital pharmacies stock varenicline, bupropion and a range of licensed nicotine-containing products (including transdermal patches and a range of fast-acting products) for patients and staff (see [recommendations 6](#) and [13](#)).
- Ensure people using secondary care have access to stop smoking pharmacotherapies at all times.
- Ensure a range of licensed nicotine-containing products are available for sale in hospital to visitors and staff.

Recommendation 9 Put referral systems in place for people who smoke

Who should take action?

- Managers in publicly-funded trusts, hospitals and clinics providing acute, maternity and mental health services.
- Managers and providers of stop smoking services.
- GPs and practice managers in primary care.
- Commissioners.

What action should they take?

- Ensure there are systems for consistently recording and maintaining records of people's smoking status. The records should:
  - provide a prompt for action (including the referral of people to stop smoking support)
  - ensure smoking status is consistent in all patient records
  - be stored for easy access and audit.

- Make sure there is a robust system in place (preferably electronic) to ensure continuity of care between secondary care and local stop smoking services for people moving in and out of secondary care.

Recommendation 10 Provide leadership on stop smoking support

Who should take action?

- Directors and senior managers in publicly-funded secondary care services.

What action should they take?

- Assign a clinical or medical director to lead on stop smoking support for people who use, or work in, secondary care services. The designated lead should ensure:
  - an organisation-wide smokefree policy is in place (see [recommendation 11](#))
  - the organisation has an annual improvement programme for stop smoking support given to people who use, or work in, secondary care services
  - stop smoking support (for patients and staff) is promoted and communicated effectively (see [recommendation 12](#)) to initiate a cultural change within the organisation
  - referral and support pathways are part of the organisation's service plan
  - hospitals have an on-site stop smoking service
  - staff in secondary care services deliver stop smoking support to help people stop, or temporarily abstain, from smoking, in line with the recommendations in this guidance
  - the quality of stop smoking services continues to improve
  - progress and outcomes in each clinical area are monitored, for example, recording of individual smoking status (including at the time of giving birth), the number of referrals, uptake of interventions, prescribing of stop smoking pharmacotherapies, 4-week quit rates, training of staff
  - performance monitoring and feedback on outcomes is provided to all staff.

Recommendation 11 Develop smokefree policies

Who should take action?

- Directors and senior managers of publicy-funded secondary care services or their representatives (including occupational health services and estates management).

What action should they take?

- Develop a policy for smokefree grounds in collaboration with staff and people who use secondary care services, or their representatives. The policy should:
  - set out a clear timeframe to establish or reinstate smokefree grounds
  - identify the roles and responsibilities of staff
  - prohibit staff-supervised and staff-facilitated smoking breaks in secondary care
  - identify adequate resources to support the policy
  - prohibit the sale of tobacco products in secondary care settings
  - be periodically reviewed and updated, in line with all other organisational policies.
- Ensure smokefree implementation plans include the following:
  - stop smoking and temporary abstinence support for staff and people who use secondary care services (in line with the recommendations in this guidance)
  - training for staff (see recommendation 14)
  - removal of shelters or other designated outdoor smoking areas
  - staff, contractor and volunteer contracts that do not allow smoking during work hours or when recognisable as an employee (for example, when in uniform, or wearing identification, or handling hospital business)

- how to work with service users and carers to protect staff from tobacco smoke when they are visiting the homes of people using secondary care services[9].
- Ensure policies, procedures and resources are in place to:
  - facilitate compliance with, and resolve immediately, any breaches of smokefree policies, including a process for staff to report incidents
  - support staff to encourage compliance with the smokefree policy
  - work with services users, carers, staff and visitors to overcome any problems that may result from smoking restrictions (supported by 'personal care plans' as covered in recommendation 1).
- Ensure all staff are aware of the smokefree policy and comply with it.

Recommendation 12 Communicate the smokefree policy

Who should take action?

- Directors and senior managers of publicly-funded secondary care services or their representatives (including the communications team, occupational health services and estates management).

What action should they take?

- Develop, deliver and maintain a communications strategy[10] about local smokefree policy requirements. This should include information for people who use secondary care services and their parents or carers, staff and visitors, and the wider local population. The strategy should include:
  - clear, consistent messages about the need to keep buildings and grounds smokefree
  - positive messages about the health benefits of a smokefree environment

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[9] In accordance with smokefree legislation, employers should take action to reduce the risk to the health and safety of their employees from secondhand smoke to as low a level as is reasonably practicable.

[10] Communications could include newsletters, pamphlets, posters and signage. Smokefree signs for vehicles or areas that are enclosed or substantially enclosed must comply with regulations under the Health and Safety at Work etc Act 1974.

- acknowledgement of the duty of the health and social care profession to provide a safe and healthy environment for staff and people who use or visit secondary care services
- information about stop smoking support and how to access services, including support for temporary abstinence, for staff and people who use secondary care services
- information emphasising that staff should not smoke at any time during working hours or when recognisable as an employee, contractor or volunteer (for example, when in uniform, wearing identification, or handling hospital business).

Recommendation 13 Support staff to stop smoking

Whose health will benefit?

- People who work in secondary care settings, in particular, those who have direct contact with people using the services. (This includes support staff, volunteers, those working for agencies or as locums and people employed by contractors.)

Who should take action?

- Directors, managers and staff in secondary care services.
- Providers of occupational health and hospital stop smoking services.

What action should they take?

- Take action in line with NICE guidance on [workplace interventions to promote smoking cessation](#) (NICE public health guidance 5):
  - advise all staff who smoke to stop
  - offer staff in-house stop smoking support
  - provide contact details for community support if preferred
  - allow staff to attend stop smoking services during working hours without loss of pay.
- Advise staff who do not want, or are not ready or able to stop completely, to use licensed nicotine-containing products to help them abstain during working hours. Advise them where to obtain them (including from GPs).

- Offer and provide intensive behavioural support to maintain abstinence from smoking during working hours. Follow recommendation 8 in NICE guidance on [Tobacco: harm-reduction approaches to smoking](#) (NICE public health guidance 45) where appropriate.

Recommendation 14 Provide stop smoking training for frontline staff

Who should take action?

- Organisations providing training in [smoking cessation](#) and temporary abstinence such as the [National Centre for Smoking Cessation and Training (NCSCT)](#).
- Royal colleges, medical, midwifery and nursing schools, undergraduate and postgraduate training providers.
- Healthcare professional training schools.
- Local education and training boards.
- Public health commissioners, health and wellbeing boards, clinical commissioning groups.
- Directors, managers and healthcare professionals in medical, surgical and maternity hospitals and clinics.
- Directors and managers in mental health services, including drug and alcohol treatment services.
- Managers of stop smoking services.
- Health Education England.

What action should they take?

- Ensure relevant curricula for frontline staff include the range of interventions and practice to help people stop smoking, as outlined in this guidance.
- Ensure all frontline staff are trained to deliver advice around stopping smoking and referral to intensive support, in line with [recommendations 1](#) and [2](#). They should know what local and hospital-based stop smoking services offer and how to refer people to them.

- Ensure online training can be completed and updated annually as part of NHS mandatory training (for example, training provided by the NCSCT).
- Ensure all frontline staff are trained to talk to people in a sensitive manner about the risks of smoking and benefits of stopping.
- Ensure all staff who deliver intensive stop smoking support are trained to the minimum standard described by the NCSCT (or its equivalent), with additional training that is relevant to their clinical specialism.
- Ensure all staff are provided with information about smokefree policies and instructions about their roles and responsibilities in maintaining a smokefree work environment. They should be advised on what action to take in the event of negative responses to smoking restrictions.

Recommendation 15 Ensure local tobacco control strategies include secondary care

Who should take action?
- Directors and senior managers in publicly-funded secondary care services.
- Directors of public health.
- Public health commissioners, clinical commissioning groups.
- Local government, health and wellbeing boards and tobacco control alliances.

What action should they take?
- Ensure the joint strategic needs assessment considers the impact of smoking on local communities. Ensure it also identifies expected numbers of particular groups of people who are at very high risk (for example, people with different mental health problems), the proportion reached by services and the numbers who successfully stop smoking.
- Make it explicit in the local tobacco control strategy that people working in secondary care should:
  – communicate key messages about tobacco-related harm to everyone who uses services
  – develop policies and support to help people stop smoking

- identify people who wish to stop smoking and, if appropriate, refer them on to a stop smoking adviser
- implement a comprehensive smokefree policy that includes the grounds.

- Develop a local stop smoking care pathway and referral procedure to ensure there is continuity of care between primary, community and secondary care.

Recommendation 16 Commission smokefree secondary care services

Who should take action?

- Commissioners of health services.

What action should they take?

- Ensure all secondary care buildings and grounds are smokefree.
- Ensure the NHS standard contract and local authority contract includes smokefree strategies.
- Ensure services are commissioned to provide a range of stop smoking pharmacotherapies.
- Ensure health and social care practitioners in secondary care identify people who smoke and offer them advice, support and treatment, or offer them a referral to a stop smoking service.
- Ensure all hospitals have an on-site stop smoking service.
- Ensure there is a requirement within service specifications and service level agreements that all staff are trained to deliver advice on stopping smoking and to make a referral to intensive support. It should also require that relevant staff undertake regular continuing professional development in how to provide intensive stop smoking support.
- Monitor and audit the implementation and impact of the recommendations in this guidance. This may include recording of individual smoking status (including at the time of giving birth), the number of referrals, uptake of interventions, prescribing of stop smoking pharmacotherapies, 4-week quit rates, training of staff. Ensure the needs of higher risk groups identified in

the joint strategic needs assessment are being met (see [recommendation 15](#)).

- Ensure there are resources to enable secondary care providers to maintain smokefree policies.
- Ensure care pathways include: identification of people who smoke, provision of advice on likely smoking-related complications, advice to stop smoking and proactive referral to stop smoking services.
- Ensure stop smoking pharmacotherapies are included in secondary care [formularies](#).
- Include sale of licensed nicotine-containing products in secondary care settings (for example, in hospital shops) within formulary and guidelines policy.

2   Public health need and practice

Introduction

Tobacco smoking remains the single greatest cause of preventable illness and premature death in England. It is also the largest single cause of inequalities in health and accounts for about half of the difference in life expectancy between the lowest and highest income groups. Deaths caused by smoking are 2 to 3 times higher in low income than in wealthier groups (Jarvis and Wardle 2005). Smoking prevalence is particularly high among people with mental health problems, and has changed little in this group in the past 20 years (Royal College of Physicians 2013). Most of the reduction in life expectancy among people with serious mental illness is attributable to smoking (Royal College of Physicians 2013).

Smoking causes a range of diseases including cancer, cardiovascular disease and respiratory diseases. It causes many other debilitating conditions such as age-related macular degeneration, gastric ulcers, impotence and osteoporosis. Further, it can cause complications in pregnancy, including increased risk of miscarriage, premature birth and low birthweight. It is also associated with lower survival rates, delayed wound healing, increased infections, prolonged hospital stays and repeated admissions after surgery (Delgado-Rodriguez et al. 2003; Theadom et al. 2006).

In England in 2011, an estimated 79,100 adults aged 35 and over died as a result of smoking, accounting for 18% of all deaths. An estimated 462,900 hospital admissions of people from the same age group were attributable to smoking, accounting for 5% of all admissions (Health and Social Care Information Centre 2013).

There is no risk-free level of exposure to secondhand smoke (US Surgeon General 2006) and breathing it in 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, it can increase the

risk of smoking-related diseases (Royal College of Physicians 2005; Scientific Committee on Tobacco and Health 2004).

People with medical conditions (such as respiratory illnesses), pregnant women and children are particularly vulnerable to secondhand smoke. A UK report on children 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 each year. These consequences were strongly associated with maternal smoking (Royal College of Physicians 2010).

Treating smoking-related illnesses cost the NHS an estimated £2.7 billion in 2006 (Callum et al. 2010). The overall financial burden of all smoking to society has been estimated at £13.74 billion a year. This includes both NHS costs and loss of productivity because of illness and early death, as well as other factors (Nash and Featherstone 2010).

Treating smoking-related illnesses in people with mental health problems has been estimated to cost the NHS £720 million a year in primary and [secondary care](). Given that smoking can reduce their effect, smoking increases psychotropic drug costs in the UK by up to £40 million (Royal College of Physicians 2013).

The strong association between smoking and both physical and mental ill-health means that many people who use secondary care services are smokers. When smokers use these services, it presents a valuable opportunity to use interventions of proven effectiveness and cost effectiveness to initiate and support stop smoking attempts or other strategies to reduce harm.

Smoking behaviour

Although the prevalence of cigarette smoking has fallen markedly in the last 30 years, 1 in 5 adults aged 16 or over in England (20%) still smoked in 2010. On average, they smoked just under 13 cigarettes a day. Smoking prevalence remains higher in certain groups as follows.

People with mental health problems

A third (33%) of people with mental health problems (McManus et al. 2010; Royal College of Physicians 2013) and more than two-thirds (70%) of people in psychiatric units smoke tobacco (Jochelson and Majrowski 2006). Smoking is also common among young people with mental health problems. According to the child and adolescent mental health survey of Great Britain (2004), young people aged 11–16 years with an emotional, hyperkinetic or conduct disorder were much more likely to be smokers (19%, 15% and 30% respectively) than other young people (6%) (Green et al. 2005).

Recent studies show that people with mental health problems are just as likely to want to stop as the general population – and are able to stop when offered evidence-based support (Jochelson and Majrowski 2006; Siru et al. 2009; Royal College of Physicians 2013). However, research also shows that effective stop smoking treatment is not always offered to them (Ratschen et al. 2009a).

In addition, there is a lack of support for smokefree policies among healthcare staff working in mental health. Staff are reported to lack specific knowledge about the influence of smoking – and cessation activities – on a person's mental health (McNeill 2004; McNally et al. 2006; Ratschen et al. 2009a).

A survey also showed that more than a third of doctors in an NHS mental health trust were unaware that the dosage of some antipsychotic medications may need to be reduced when a person stops smoking (Ratschen et al. 2009a).

People in routine and manual occupations

People in routine and manual occupations are about twice as likely to smoke as those in managerial or professional occupations (27% compared with 13%) (Health and Social Care Information Centre 2013).

Women who are or who have been pregnant

Many teenage women smoke during pregnancy. According to the Infant Feeding Survey 2010, women aged 20 and younger were 6 times more likely than those aged 35 and over to have smoked throughout pregnancy (35% compared with 6%). Pregnant women from routine and manual occupations are much more likely to smoke and to have done so through pregnancy than those from professional and managerial occupations (20% compared with 4%) (McAndrew et al. 2012).

Overall, more than a quarter (26%) of mothers in England smoked before pregnancy. More than half (55%) gave up at some stage before the birth. Although most women who had stopped before or during pregnancy were still not smoking shortly after the birth, nearly a third (31%) were smoking again less than a year later (McAndrew et al. 2012). Because of the stigma attached to smoking in pregnancy, there is likely to be a significant under-reporting by pregnant women who smoke.

Tobacco control

The 2011 white paper [Healthy lives, healthy people](#) sets out a comprehensive list of tobacco control objectives for England. This includes:

- reducing smoking during pregnancy
- reducing smoking among people with mental health problems
- reducing the health effects of secondhand smoke
- promoting quitting smoking through providers of secondary care.

The Health Act introduced in England in July 2007 made it illegal to smoke in enclosed, or substantially enclosed, public places or workplaces, including work vehicles. Mental health units were given a temporary exemption until July 2008 (HM Government 2006).

Benefits of smokefree legislation have included a fall in hospital admissions for heart attacks (Sims et al. 2010). In addition, an estimated 6802 fewer children were admitted to hospital in England with asthma symptoms in the

first 3 years following its implementation. This is a reversal of what was a steady annual increase (Millett et al. 2013).

Many NHS secondary care settings have smokefree policies that apply to their grounds (as well as to enclosed areas). However, there have been problems with compliance and enforcement (Ratschen et al. 2009b; Shipley and Allcock 2008).

3 Considerations

The Programme Development Group (PDG) took account of a number of factors and issues when developing the recommendations, as follows. Please note: this section does **not** contain recommendations. (See Recommendations.)

Background

3.1 Smoking rates and related morbidity and mortality are much higher in certain groups, particularly the most vulnerable in society. These differences in smoking rates are a major contributor to inequalities in health status and outcomes. Smoking also exacerbates poverty. Reducing smoking among people who use secondary care services can help reduce these effects.

3.2 There is relatively limited evidence on the effectiveness of stop smoking and temporary abstinence interventions for people who use mental health services. Much of what is available originated from the USA. The PDG noted, however, the importance of offering the same level of support to people who use mental health services to prevent a further widening of the already substantial health gap. It also noted that there may be a need for more intensive or tailored support to meet the needs of highly addicted smokers facing challenging life circumstances (see Recommendations for research).

3.3   There is evidence from the USA to show financial incentives are an effective way to encourage pregnant women to quit. However, there is limited evidence on the type of rewards that would be effective or acceptable in the UK.

3.4   Smokers who undergo surgery are more likely to have longer hospital stays and are more likely to need intensive care compared with people who don't smoke. Smokers also have an increased risk of emergency readmission. Stopping smoking as soon as possible before surgery can reduce these risks. The PDG noted the results of a recent systematic review and meta-analyses of studies that validated smoking status (Myers et al. 2011). This showed that there is no detrimental effect from stopping smoking just before surgery – and a significant positive effect of stopping smoking in the short term.

3.5   Some people who use secondary care services find it difficult to tell healthcare professionals that they smoke, if asked, for fear of disapproval. This is particularly true of pregnant women or people who know or suspect that their illness is related to smoking.

3.6   Current NICE public health guidance 26 on quitting smoking in pregnancy and following childbirth recommends that carbon monoxide (CO) assessments are used to establish exposure of pregnant women to tobacco smoke or other CO sources such as traffic emissions or leaky gas appliances. Many midwives are routinely using CO assessments. Interpretation of the reading can be established through sensitive and non-judgemental discussions with the person to establish smoking status. The PDG felt that CO assessments help monitor smoking and act as a motivational tool for stopping, and identify environmental factors that may cause harm. They also help to identify those at greater risk of adverse, smoking-related outcomes and help with the planning of antenatal care. This non-invasive CO assessment is similar to other common

tests that are routinely used in healthcare settings (for example, temperature or blood pressure tests).

3.7   Current NICE public health guidance 26 on quitting smoking in pregnancy and following childbirth recommends that all pregnant women with a CO reading of 7 parts per million (ppm) or above should be referred to stop smoking services. The guidance acknowledges that it is unclear what constitutes the best cut-off point for determining smoking status. The guidance indicates that low levels may go undetected or be undistinguishable from exposure to secondhand smoke and that it is best to use a low cut-off point to avoid missing someone who may need help to quit.

3.8   When this piece of NICE guidance on Smoking cessation in secondary care: acute, maternity and mental health services was put out for consultation it referred to the recommendation from NICE public health guidance 26 on quitting smoking in pregnancy and following childbirth that all pregnant women with a CO reading of 7 ppm or above should be referred. However, several stakeholders commented that the CO assessment cut off for a referral to stop smoking services was too high and should be reduced from 7 ppm to 4 ppm, in line with publications from other organisations. Some PDG members agreed that the level should be reviewed, and felt that future updates of the NICE public health guidance 26 on quitting smoking in pregnancy and following childbirth should address this issue.

3.9   Stop smoking support for healthcare staff is important in its own right. Healthcare staff may find it difficult to admit they smoke or to seek support to help them quit. They may also find it difficult to act as a health champion or to advise people to stop. In addition, the PDG heard evidence that staff who do not smoke are more likely to support hospital smokefree strategies and interventions aimed to help people stop smoking.

3.10   Trials in secondary care that use intensive behavioural interventions to support attempts to stop smoking have been shown to be effective. The effect is significantly increased when nicotine replacement therapy is also offered as part of these interventions. There is relatively little evidence from trials in secondary care that include bupropion or varenicline as a means of helping people to stop smoking. However, these pharmacotherapies are highly effective in trials with the general population, and the PDG felt there was no reason why this would not apply to people in secondary care settings.

3.11   The PDG noted that although stopping smoking is associated with improvements in longer-term mental health, evidence identifies both potential short-term negative and positive effects (such as increased agitation or improvements in mood). Prompt provision of evidence-based treatment can help alleviate negative effects associated with nicotine withdrawal. The PDG also heard evidence that some health and social care practitioners have a limited knowledge and understanding of the specific links between tobacco dependence and mental illness, including the effects of stopping smoking on psychiatric symptoms.

Delivering stop smoking support

3.12   Evidence shows that intensive behavioural support with stop smoking pharmacotherapy delivered during a stay in hospital and continued for at least 4 weeks after discharge is effective. However, this requires coordinating care between hospitals and community services, and routine implementation and post-discharge follow-up is not widespread. The PDG noted the importance of formal systems for recording smoking status and arranging referrals. In addition, rapid response to a referral request, including support provided during a hospital stay, improved service uptake and quit rates.

3.13   The PDG noted that good clinical practice requires clinicians to take a holistic view of patients' physical health, and failing to offer stop smoking treatment is poor practice. The PDG also noted the Department of Health's [Make Every Contact Count](#) initiative. This sends a strong message that, given the right support and training, frontline staff are equipped to provide important health messages and refer (or direct) people for further advice and interventions to stop smoking.

3.14   The PDG felt that other health promotion interventions (for example, on alcohol-related harm or weight management) would ideally be offered at the same time as stop smoking advice, where appropriate. Such activities were, however, beyond the scope of the guidance.

3.15   The PDG considered that healthcare staff should be competent and proactive, but recognised there are barriers to offering stop smoking advice and support. For example, they may have limited time, knowledge and skills, or they may feel that addressing smoking is beyond their role or responsibility. There is also a perception among some that asking about a person's smoking behaviour could damage the staff-patient relationship. The PDG considered that training on how to raise the topic of smoking with people, and when, how and where to refer them for specialist treatment, would overcome these barriers.

3.16   Most smokers will have been encouraged to stop on various occasions. During a quit attempt, they may have found it very difficult to abstain, despite being aware of the harmful effects of continuing to smoke. They may also have stopped in the past but subsequently relapsed. The PDG noted that, in a supportive secondary care environment, where healthcare staff have a positive, non-judgemental attitude, smokers can be encouraged and helped to try again.

3.17   The PDG noted that the role of carers, partners, family and friends is important. They can help to protect people who use secondary care services from secondhand smoke in the home. They can also help with an attempt to stop, by stopping smoking themselves, changing their own behaviour (if they smoke) and providing other support and encouragement.

Smokefree strategies and interventions

3.18   The PDG considered that secondary care providers are more likely to make a strong commitment to smokefree strategies if there is national level support from NHS England and Public Health England.

3.19   The PDG considered evidence from the UK and elsewhere on outcomes after the implementation of smokefree policies. The Group was clear that smokefree policies are self-perpetuating if properly supported and maintained (including through communication, staff training and measures to ensure compliance). The PDG noted that problems arise where smokefree policies are not maintained.

3.20   A total ban on smoking in the buildings and grounds of secondary care services complements the duty of care on healthcare staff and the organisation to protect the health of people in their care and promote healthy behaviour. Furthermore, the PDG felt that the resources needed to support smoking in the grounds would be more suitably directed towards stop smoking support and maintaining a smokefree policy. (Examples of the expense caused by smoking include: the time used for smoking breaks by staff and the erection of smoking shelters.)

3.21   The PDG was concerned that public support for hospital smokefree policies may be diminished if staff are seen smoking in hospital grounds or near entrances. This could give the impression that

there is only a low commitment to the smokefree strategy, and could result in visitors dismissing or challenging smokefree policies and related restrictions.

3.22   People who are unable to leave a secondary care setting – for example, when detained under the Mental Health Act or because mobility is restricted – will have to abstain from smoking. Other people using the same service may not be subject to the same restrictions because they are able to leave the building and grounds. The PDG was aware that this situation would need careful and sympathetic management.

3.23   The episodic nature of mental health conditions can impact on a person's ability or willingness to stop smoking. However, in a smokefree secondary care environment, mental health service users will be subject to enforced abstinence – even during an acute phase of illness – and will need help to abstain.

3.24   The PDG heard evidence from UK studies of staff accepting or at times encouraging people to smoke in mental health settings. This could be for a variety of reasons including: as a reward or incentive for good behaviour; to help build relationships or avoid confrontation; as part of a shared smoking culture between staff and people in their care; and to relieve boredom. The PDG noted that helping people to smoke can take up a considerable amount of staff time (for example, when escorting smokers off a ward). It also has an implication in terms of being able to manage the movement of people who are being detained. It considered that these resources could and should be more usefully spent on therapeutic activities for smokers and non-smokers alike. The PDG discussed the need for clear leadership to change this culture. The Group also recognised that this would present many challenges and require significant changes in practice for some mental health services. It also recognised that mental health trusts would need to develop

policies and procedures to encourage compliance and resolve any breaches in a variety of local treatment settings (including psychiatric intensive care units and rehabilitation units).

3.25   The PDG heard expert testimony concerning the implementation of smokefree strategies and stop smoking support on a hospital's mental health wards. Before implementation it was identified that a very large proportion of service users (up to 92% on 1 ward) currently smoked, although most of them had previously stopped at some point. Further, many who had previously stopped while at secure institutions where smoking was not permitted started smoking on admission to the hospital. The PDG heard that the following factors played a key role in successful implementation: involving staff and service users in planning and promoting the strategy (such as scoping objectives and creating publicity materials); agreeing individual plans to stop smoking (including risk management); involving primary care providers; reducing boredom through ward plans; encouraging and motivating service users (for example, recognising potential drug dose reductions and financial benefits); providing licensed nicotine-containing products; holding stop smoking groups and planning meetings. Although not recommended, the use of unlicensed nicotine-containing products (such as electronic cigarettes) was allowed. Despite concerns at the outset about the potential negative reactions to smokefree policies, the PDG heard that the number of violent incidents actually reduced.

3.26   The PDG was aware that High Court judges had ruled, in a case involving patients at Rampton high-security hospital where they were not permitted to leave the building to smoke, that patients should not endanger their own (and anyone else's) health by smoking indoors. The judges stated that: 'On the view we take of the evidence, substantial health benefits arise from the ban and the disbenefits are insubstantial'. The judges ruled that both health and

security considerations justified the smoking ban even though smoking in the grounds, which might be possible at other hospitals, is not feasible at secure hospitals.

3.27   There is limited evidence on the effectiveness of interventions to help people to temporarily abstain from smoking. However, the PDG agreed that smokers who use secondary care services may need help to comply with national legislation and smokefree policies for hospital buildings and grounds. The same is true of staff and volunteers who smoke.

Unlicensed nicotine-containing products

3.28   Unlicensed nicotine-containing products are being used increasingly by people who smoke to help them stop smoking completely, cut down on smoking, or abstain temporarily from smoking.

3.29   Although unlicensed and of variable quality, safety and effectiveness, these products are expected to be less harmful than smoking. Therefore whilst not actively endorsing the use of unlicensed products, the PDG recognised that some people may find these helpful, either alone or in combination with licensed nicotine-containing products, to support abstinence from smoking. However, some members of the PDG were also concerned by the potential of electronic cigarettes to normalise 'smoking' within a hospital environment.

3.30   The Medicines and Healthcare products Regulatory Agency (MHRA) has decided that all nicotine-containing products should be regulated (for further details, see the MHRA website). This means that there may be a period when both licensed and unlicensed products (such as electronic cigarettes) are being used by the public as a means to abstain from smoking. In this situation, the PDG recognised that it would be very difficult and possibly

counterproductive to disallow the use of unlicensed products in all secondary care settings. NHS Trusts would need to formulate their own local policies on the use of such products, depending on local circumstances and judgement.

Economic modelling

3.31   The PDG noted that both the benefits and cost effectiveness of stop smoking interventions for people with mental health problems may be underestimated. One of the most commonly reported measures of quality of life is the EQ-5D. This comprises 5 dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. The PDG considered that this measure was not sensitive to some of the improvements in health arising from stopping smoking. This was of particular concern in relation to measuring the cost effectiveness of stop smoking interventions for people with mental health problems.

3.32   The PDG noted that a number of the benefits of stopping smoking were not included in the economic model. Examples include: a reduction in the harms associated with exposure to secondhand smoke, a reduction in the costs of social care for people with smoking-related diseases, and the effect on the uptake of smoking among children.

3.33   The economic modelling showed that high-intensity stop smoking interventions (including the use of pharmacotherapies) are a highly cost-effective way of helping people to stop smoking. Indeed, many of the interventions assessed were estimated to be cost saving (cheaper and more effective than the comparator).

3.34   The modelling found that interventions are cost effective for different groups with different conditions. This includes: pregnant women, people in secondary care with chronic obstructive pulmonary disease (COPD) and cardiac conditions, pre-operative

patients, general patients and hospital employees. The same applies to interventions for people with common mental health problems, such as post-traumatic stress disorder (PTSD). In the case of those with schizophrenia, the interventions showed an effect in the short term. No impact was observed on smoking rates at 12 months. However, based on estimated cost savings made on antipsychotic drugs, if 1 in 10 of these patients quit smoking for a year, the interventions would be cost effective.

3.35   The PDG noted that, as with any modelling exercise, the results are subject to uncertainty and numerous assumptions. However, the sensitivity analysis showed that most interventions remain cost effective, even when the costs and effects of the interventions are randomly varied.

4   Recommendations for research

The Programme Development Group (PDG) recommends that the following research questions should be addressed. It notes that 'effectiveness' in this context relates not only to the size of the effect, but also to cost effectiveness and duration of effect. It also takes into account any harmful or negative side effects.

4.1   How can interventions to increase the uptake and effectiveness of stop smoking interventions in acute, maternity and mental health settings be improved? (Examples include the identification and referral of smokers and staff training.) What components of an intervention help ensure someone will take up the support they are offered? How many people in these settings complete stop smoking treatment?

4.2   How can the effectiveness and cost effectiveness (in terms of 4-week, 6- and 12-month quit and relapse rates) of intensive stop smoking interventions for people using mental health services be improved and tailored for this group?

- Does effectiveness or cost effectiveness differ by age, diagnosis, ethnicity, gender, inpatient or outpatient, sexual orientation or socioeconomic status?
- What type of training do health professionals need to deliver these interventions? Examples might include training to: build up knowledge related to tobacco dependence, its treatment and links with mental illness; develop skills in delivering support; develop a positive attitude towards delivering interventions.

4.3   What is the effect and acceptability of approaches that aim to match nicotine dose (through licensed nicotine-containing products) to level of smoking addiction among women who are using maternity services?

4.4   Are stop smoking interventions that include incentives to quit effective and cost effective for people using secondary care services, including women who are pregnant or have recently given birth?

4.5   How effective and cost effective are stop smoking interventions for partners of pregnant and breastfeeding women?

4.6   How effective and cost effective are stop smoking interventions for parents and carers of children who are using secondary care services?

4.7   How effective and cost effective are interventions that use varenicline for people who are using acute, maternity and mental health services?

4.8   How effective and cost effective are relapse prevention interventions aimed at people who use secondary care services who have quit?

4.9 How can people who use secondary care services (particularly mental health services), staff and visitors, best be helped to temporarily abstain from smoking while in secondary care settings?

More detail identified during development of this guidance is provided in Gaps in the evidence.

5 Related NICE guidance

Tobacco: harm-reduction approaches to smoking. NICE public health guidance 45 (2013)

Smokeless tobacco cessation: South Asian communities. NICE public health guidance 39 (2012)

Quitting smoking in pregnancy and following childbirth. NICE public health guidance 26 (2010)

School-based interventions to prevent smoking. NICE public health guidance 23 (2010)

Preventing the uptake of smoking by children and young people. NICE public health guidance 14 (2008)

Smoking cessation services. NICE public health guidance 10 (2008)

Smoking cessation: varenicline. NICE technology appraisal guidance 123 (2007)

Behaviour change: the principles for effective interventions. NICE public health guidance 6 (2007)

Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007)

Brief interventions and referral for smoking cessation. NICE public health guidance 1 (2006)

6   Glossary

Carbon monoxide (CO) assessment

A carbon monoxide assessment is a non-invasive biochemical method for measuring CO from expired breath. It can detect exposure to CO which may come from tobacco smoke, traffic emissions or leaky gas appliances.

Formulary

A formulary is a list of healthcare treatments and drugs approved for use within a health economy, service or organisation.

Intensive behavioural support

Intensive interventions typically involve scheduled face-to-face meetings between someone who smokes, either alone or in a group, and a counsellor trained to provide stop smoking support. The discussions may include information, practical advice about goal-setting, self-monitoring and dealing with the barriers to stopping smoking as well as encouragement. Intensive behavioural support also includes anticipating and dealing with the challenges of stopping. Established and effective behaviour-change techniques should be used (see NICE public health guidance 6 on Behaviour change). Support is typically offered weekly for at least the first 4 weeks of a quit attempt (that is, for 4 weeks after the quit date) or 4 weeks after discharge from hospital (where a quit attempt may have started before discharge), and normally given with stop smoking pharmacotherapy.

Joint strategic needs assessment

A joint strategic needs assessment provides a profile of the health and social care needs of a local population. Joint strategic needs assessments are used to develop joint health and wellbeing strategies. They are also used for commissioning to improve health outcomes and reduce health inequalities.

Licensed nicotine-containing products

Nicotine-containing products that are licensed have been given marketing authorisation by the Medicines and Healthcare products Regulatory Agency

(MHRA). At the time of publication (November 2013), [nicotine replacement therapy (NRT) products](#) were the only type of licensed nicotine-containing product. However, the MHRA has decided that all nicotine-containing products should be regulated and this is expected to come into effect in 2016. In the meantime, the UK government will encourage applications for medicines licences for nicotine-containing products and will make best use of the flexibilities within the existing framework to enable licensed products to be available. For further details, see the [MHRA website](#).

Nicotine-containing products

Products that contain nicotine but do not contain tobacco and so deliver nicotine without the harmful toxins found in tobacco. Some, such as [nicotine replacement therapy (NRT)](#), are regulated by the MHRA (see [licensed nicotine-containing products](#)). Unlicensed products that are currently being marketed, such as electronic cigarettes, and products new to the market will need a medicines licence once the European Commission's revised Tobacco Products Directive comes into effect in the UK (this is expected to be in 2016). For further details, see the [MHRA website](#).

Nicotine replacement therapy (NRT) products

Nicotine replacement therapy products are [licensed nicotine-containing products](#) for use as a stop smoking aid and for [temporary abstinence](#), as outlined in the [British national formulary](#). They include: transdermal patches, gum, inhalation cartridges, sublingual tablets and a mouth and nasal spray.

Pharmacotherapies

Pharmacotherapy is the treatment of addiction through the administration of drugs. Stop smoking advisers and healthcare professionals may recommend and prescribe [licensed nicotine-containing products](#), varenicline or bupropion as an aid to help people to stop smoking. Licensed nicotine-containing products may also be offered to support [temporary abstinence](#) from smoking in the [secondary care](#) setting.

Secondary care

Secondary care refers to all publicly-funded secondary and tertiary care facilities, including buildings, grounds and vehicles. It covers drug and alcohol services in secondary care, emergency care, inpatient, residential and long-term care for severe mental illness in hospitals, psychiatric and specialist units and secure hospitals and planned specialist medical care or surgery. It also includes maternity care provided in hospitals, maternity units, outpatient clinics and in the community. It can be planned or emergency care. Planned secondary care generally follows a referral from a primary care provider, such as a GP.

Smokefree

Smokefree means air that is free of smoke and applies to hospital buildings, grounds and vehicles.

Smoking cessation (stopping smoking)

Stopping smoking with the intention to stop permanently. Stopping may be abrupt or by cutting down before stopping.

Stop smoking services

Stop smoking services provide a combination of behavioural support and pharmacotherapy to aid smoking cessation. NHS behavioural support is free but the pharmacotherapy may incur a standard prescription charge. The evidence-based treatment is based on the National Centre for Smoking Cessation and Training (NCSCT) standard programme and involves practitioners trained to their standard or equivalent.

Temporary abstinence

Not smoking for a limited period of time. This could be for a particular event, for example, during a hospital stay or contact with secondary care providers, or in preparation for planned use of secondary care services such as elective surgery, or while visiting or working in a secondary care setting.

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8 Summary of the methods used to develop this guidance

Introduction

The reviews, primary research, commissioned reports and economic modelling report include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the Programme Development Group (PDG) meetings provide further detail about the Group's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in About this guidance.

Guidance development

The stages involved in developing public health programme guidance are outlined in the box below.

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1. Two draft scopes released for consultation

2. Stakeholder meeting about the draft scopes

3. Stakeholder comments used to revise the scopes

4. Final scopes and responses to comments published on website

5. Evidence reviews and economic modelling undertaken and submitted to PDG

6. PDG produces draft recommendations

7. Draft guidance (and evidence) released for consultation

8. PDG amends recommendations

9. Final guidance published on website

10. Responses to comments published on website

Key questions

The key questions were established as part of the 2 original scopes developed for guidance on smoking cessation for acute and maternity services and for separate guidance on mental health services. (These 2 pieces of guidance have now been amalgamated.) They formed the starting point for the reviews of evidence and were used by the PDG to help develop the recommendations. The overarching questions were:

1. How effective and cost effective are smoking cessation interventions in secondary care settings in helping people to quit?

2. How effective and cost effective are interventions in secondary care settings to help people temporarily abstain from smoking?

3. How effective and cost effective are the current approaches used by secondary care services to identify and refer people to [stop smoking services](#) or to provide them with smoking cessation information, advice and support?

4. What type of approaches are effective and cost effective at encouraging secondary care professionals to record smoking status, offer smoking cessation information, advice and support, or to refer people to stop smoking services?

5. How can community, primary and secondary care providers collaborate more effectively to provide seamless smoking cessation services?

6. What barriers and facilitators affect the delivery of effective interventions in secondary care?

7. What are the effects of nicotine intake, or changes in levels of nicotine intake, on the mental and physical health of people using secondary care services who are on medication? What are the effects of tobacco consumption, or changes in tobacco consumption on this group?

8. What are the effects of nicotine intake, or changes in levels of nicotine intake, on the mental and physical health of people using secondary care services?

9. How effective and cost effective are strategies and interventions for ensuring compliance with [smokefree](#) legislation and local smokefree policies in secondary care settings?

10. Are there any unintended consequences from adopting a smokefree approach in secondary care settings?

11. What factors encourage or discourage compliance with smokefree policies in secondary care settings? What are the views, perceptions and

beliefs of secondary care staff and people who use or visit these services?

These questions were made more specific for each review (see reviews for further details).

Reviewing the evidence

Below is a summary of the review methods. For full details see the reviews and economic analysis: available [online](#).

Effectiveness reviews

Three reviews of effectiveness were conducted. For more details on the reviews see [What evidence is this guidance based on?](#) These covered:

- Smoking cessation interventions in acute and maternity services (review 2).
- Smoking cessation interventions in mental health services (review 4).
- Smokefree strategies and interventions in secondary care settings (review 6).

Identifying the evidence

A number of databases and national and international websites were searched as follows:

Review 2 A search was conducted in December 2011 for systematic reviews and randomised controlled trials (RCTs) from January 1990 onwards.

Review 4 A search was conducted in February 2012 for evidence from January 1985 onwards. This included: reviews of reviews, systematic reviews, RCTs, non-randomised controlled trials, controlled before-and-after studies, interrupted time series and uncontrolled before-and-after studies.

Review 6 A search was conducted in February 2012 for evidence from January 1990 onwards. This included: reviews of reviews, systematic reviews, RCTs, non-randomised controlled trials, controlled before-and-after studies,

interrupted time series, uncontrolled before-and-after studies and retrospective comparison studies.

See each review for details of the databases and websites searched.

A call for evidence from registered stakeholders was made in June 2012.

Selection criteria

Studies were included in the effectiveness reviews if they covered the following:

- people who:
  - use secondary care services or people who live in the same household as someone who is using these services
  - visit secondary care settings
  - work in secondary care settings
- interventions to:
  - identify and refer people to stop smoking services or to increase general uptake of stop smoking services
  - help people stop smoking
  - help people temporarily abstain from smoking
  - smokefree strategies and interventions in hospitals and other secondary care settings.

Studies were excluded if they:

- were aimed at people who use primary care services
- covered interventions aimed at preventing people from taking up smoking.

See each review for details of the inclusion and exclusion criteria.

Other reviews

Three reviews of the barriers to and facilitators for quitting smoking were conducted. These covered:

- acute and maternity services (review 3)

- mental health services (review 5)
- smokefree strategies and interventions in secondary care settings (review 7).

Identifying the evidence

A number of databases and national and international websites were searched:

Review 3 A search was conducted in December 2011 for evidence from January 1990 onwards. This included: systematic reviews, trials (controlled and non-controlled), descriptive studies (including questionnaire surveys and views or process evaluations), qualitative studies and discussion papers or reports.

Review 5 A search was conducted in February 2012 for evidence from January 1985 onwards. This included: systematic reviews, trials (controlled and non-controlled), descriptive studies (including questionnaire surveys and views or process evaluations), qualitative studies and reports.

Review 7 A search was conducted in February 2012 for evidence from January 1990 onwards. This included: systematic reviews, trials (controlled and non-controlled), descriptive studies (including questionnaire surveys and views or process evaluations), qualitative studies and reports.

Selection criteria

The selection criteria for the barriers and facilitators reviews were the same as for the effectiveness reviews (see above).

See each review for details of the inclusion and exclusion criteria.

Review 1: Review of effects of nicotine in secondary care

Identifying the evidence

A number of databases and national and international websites were searched in December 2011 for studies published from January 1990 onwards.

This included quantitative (both experimental and observational) studies, qualitative studies, systematic reviews, reviews of reviews and reports (see review for details).

See review 1 for details of the databases and websites searched.

A call for evidence from registered stakeholders was made in June 2012.

Selection criteria

Studies were included in review 1 if they covered people who use secondary care (acute, maternity or mental health) services and:

- reported on the effects of nicotine use, or withdrawal
- reported on safety issues related to acute abstinence and use of [nicotine replacement therapy (NRT)](#).

Studies were excluded if they reported on the long-term health effects of tobacco use or of stopping smoking.

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in [Methods for the development of NICE public health guidance](#). Each study was graded (++, +, –) to reflect the risk of potential bias arising from its design and execution.

Study quality

++   All or most of the checklist criteria have been fulfilled. Where they have not been fulfilled, the conclusions are very unlikely to alter.

+   Some of the checklist criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are unlikely to alter the conclusions.

–   Few or no checklist criteria have been fulfilled. The conclusions of the study are likely or very likely to alter.

Summarising the evidence and making evidence statements

The review data were summarised in evidence tables (see full reviews).

The findings from the review were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements were prepared by the external contractors (see About this guidance). The statements reflect their judgement of the strength (quality, quantity and consistency) of evidence and its applicability to the populations and settings in the scope.

Cost effectiveness

There was a review of economic evaluations and an economic modelling exercise.

Review of economic evaluations

Three economic evaluation databases were searched in February 2012 for studies from January 1990 onwards.

To supplement database and website searches, potentially relevant economic studies were identified using the screening results from the searches carried out for the effectiveness reviews.

Studies were included if they reported on a full economic evaluation with the same populations and interventions as in the effectiveness reviews (see above). Included studies were then quality-assessed.

Economic modelling

A number of assumptions were made that could underestimate or overestimate the cost effectiveness of the interventions (see economic modelling report for further details).

Economic models were constructed to incorporate data from the reviews of effectiveness and cost effectiveness as follows:

A general model that considered the long-term impacts of smoking (which are similar for all population groups including patients, staff and visitors).

Six models based on case studies which focus on the specific impact of smoking in a secondary care context (recovery times and the likelihood of complications associated with secondary care, generally within 12 months).

The results are reported in 'Smoking cessation in secondary care: cost-effectiveness review' and 'Economic analysis of smoking cessation in secondary care' (see [What evidence is the guidance based on?](#)).

How the PDG formulated the recommendations

At its meetings between March 2012 and July 2013 the Programme Development Group (PDG) considered the evidence, expert papers and cost effectiveness to determine:

- whether there was sufficient evidence (in terms of strength and applicability) to form a judgement
- where relevant, whether (on balance) the evidence demonstrates that the intervention or programme/activity can be effective or is inconclusive
- where relevant, the typical size of effect (where there is one)
- whether the evidence is applicable to the target groups and context covered by the guidance.

The PDG developed recommendations through informal consensus, based on the following criteria:

- Strength (type, quality, quantity and consistency) of the evidence.
- The applicability of the evidence to the populations/settings referred to in the scope.
- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).

- Balance of harms and benefits.

- Ease of implementation and any anticipated changes in practice.

Where possible, recommendations were linked to an evidence statement(s) (see The evidence for details). If a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

9   The evidence

The evidence statements from the reviews provided by external contractors (see What evidence is the guidance based on?) are available in a separate document (see The evidence statements).

This section lists the evidence statements and expert papers, links to the recommendations and sets out a brief summary of findings from the economic analysis.

The evidence statements are short summaries of evidence in a review. Each statement has a short code indicating which document the evidence has come from (see The evidence statements). The letter(s) in the code refer to the type of document the statement is from, and the numbers refer to the document number, and the number of the evidence statement in the document.

For example, **evidence statement 1.2.10** indicates that the linked statement is numbered 2.10 in review 1. **Evidence statement 2.2.3** indicates that the linked statement is numbered 2.3 in review 2 and **evidence statement 3.2.6** indicates that the linked statement is numbered 2.6 in review 3. **Evidence statement CE.2.3** indicates that the linked statement is numbered 2.3 in the cost-effectiveness review.

The reviews, expert papers and economic analysis are available online. Where a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by IDE (inference derived from the evidence).

Recommendation 1: evidence statements 1.1.2.2, 3.1.7, 5.2.7, 5.15.1; expert paper 1

Recommendation 2: evidence statements 1.2.9, 3.1.3, 3.1.7, 3.2.4, 5.2.3, 5.2.7, 5.3.2, 5.3.5, 5.12.1, 5.14.2, 5.15.4, 6.1.2, 7.2.28, CE1.7.0; expert papers 1, 2, 3, 4, 5, 6, 7

Recommendation 3: evidence statements 1.2.9, 1.3.5, 2.1.3, 2.1.5, 2.1.8, 2.1.10, 4.1.1, 4.1.2, 4.4.3, 4.4.4, 4.9.1, 4.9.4, 4.10.1, 4.12.1, 4.13.2, 4.13.2, 5.2.3, 5.3.6, 6.1.5, CE1.1.0, CE1.2.0, CE1.2.1, CE1.2.2, CE1.2.3, CE1.3.0, CE1.6.0, CE1.7.0; expert papers 4, 5, 6, 7

Recommendation 4: evidence statements 1.2.9, 2.2.3, 2.2.9, 3.2.6, CE1.4.0, CE1.4.1; expert papers 3, 4

Recommendation 5: evidence statements 5.2.4, 5.2.8

Recommendation 6: evidence statements 1.1.2.2, 1.1.2.3, 1.3.5, 5.2.1, 5.9.1, 5.9.2, 7.2.28

Recommendation 7: evidence statements 1.1.1.7, 1.1.1.8, 1.1.3.7, 1.2.10, 1.2.31, 1.2.33, 6.3.5, 6.3.6, 7.3.9, 7.3.10

Recommendation 8: evidence statements 3.1.2, 5.3.1, 6.2.2, 7.2.30; expert papers 1, 2, 8; IDE

Recommendation 9: evidence statements 3.1.2, 3.1.3, 3.1.6, 3.2.4, 5.12.1, 5.13.2, 5.14.2, 7.2.28; expert papers 1, 2; IDE

Recommendation 10: evidence statements 3.1.5, 3.2.3, 3.2.6, 5.1.1, 5.8.1, 5.8.1, 5.8.3, 5.15.1, 5.15.4, 7.2.9, 7.2.13, 7.2.30; expert papers 1, 2, 8; IDE

Recommendation 11: evidence statements 3.1.0, 3.1.1, 3.1.5, 3.2.3, 5.1.6, 5.4.2, 5.4.3, 5.5.4, 6.1.2, 6.1.3, 6.1.4, 6.1.5, 6.1.6, 6.1.10, 6.2.1, 6.2.2, 6.2.3, 6.2.5, 6.3.1, 6.3.2, 6.3.3, 6.3.5, 6.3.6, 6.3.8, 7.1.1, 7.2.7, 7.2.10, 7.2.11, 7.2.13, 7.2.15, 7.2.16, 7.2.17, 7.2.18, 7.3.3, 7.3.4, 7.3.8, 7.3.12, 7.3.14; expert papers 6, 8

Recommendation 12: evidence statements 3.1.5, 3.2.3, 5.2.5, 5.2.6, 5.5.2, 6.1.5, 7.2.4, 7.2.18, 7.3.3; expert papers 6, 8; IDE

Recommendation 13: evidence statements 2.1.13, 3.1.0, 5.5.3, 6.2.3, 7.1.2, 7.2.2, 7.2.29

Recommendation 14: evidence statements 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.2.1, 3.2.2, 3.2.6, 5.1.4, 5.2.5, 5.3.7, 5.4.3, 5.5.1, 5.5.2, 5.5.5, 5.7.1, 5.7.2, 5.7.3, 5.7.4, 5.9.2, 7.2.16, 7.2.17, 7.2.26, 7.3.1, 7.3.3, 7.3.9, 7.3.10; expert papers 2, 8; IDE

Recommendation 15: evidence statement 7.2.8; IDE

Recommendation 16: For relevant evidence statements and expert papers, see recommendations 1, 2, 3, 4, 8, 9, 10, 11 and 12 above.

Economic modelling

The economic model estimates that stop smoking interventions are cost effective for groups of secondary care service users. This includes: pregnant women, patients presenting at secondary care with chronic obstructive pulmonary disease (COPD) and cardiac conditions, pre-operative and general inpatients, and hospital employees.

The same applies to interventions for people with common mental health problems, such as post-traumatic stress disorder (PTSD). In the case of people with schizophrenia, the interventions showed a positive effect in the short term. No impact was observed on 12-month smoking rates. However, the model estimated that there would be potential cost savings in the use of antipsychotics. It demonstrated that if 1 in 10 patients with schizophrenia successfully quit smoking for a year, the interventions would be cost effective.

For the majority of interventions and population groups, the interventions were a cost-effective use of public resources. This holds true not only when the lifetime benefits of smoking cessation are considered, but also when a more short-term perspective is adopted. This means that, for many interventions,

the costs needed to deliver them are smaller than the benefits they would generate within the first 3 years of implementation.

As with any modelling exercise, the results are subject to uncertainty and numerous assumptions. However, the sensitivity analysis showed that most interventions remain cost effective even when the costs and effects are randomly varied.

10 Gaps in the evidence

The Programme Development Group (PDG) identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence. These gaps are set out below.

1. There is a lack of evidence on the effectiveness and cost effectiveness of interventions that aim to increase the uptake of stop smoking interventions in secondary care settings. (An example includes interventions that identify and refer people to stop smoking services.)

2. There is a lack of evidence about the effectiveness of interventions to support temporary abstinence for people who use, work in or visit secondary care services.

3. There is a lack of high quality research to establish the long-term effectiveness and cost effectiveness of stop smoking interventions for people using mental health services (including Child and Adolescent Mental Health Services [CAMHS]).

4. There is a lack of evidence on the effectiveness and cost effectiveness of stop smoking interventions aimed at:

(a) secondary care staff

(b) partners, parents, other family and household members and friends or carers of someone using acute, maternity and mental health services

(c) secondary care patients and involving the use of varenicline or bupropion.

5. There is a lack of UK evidence on the effectiveness and cost effectiveness of incentives to encourage women who are pregnant or postpartum to quit.

6. There is a lack of data on the use of stop smoking services by people with a history of mental illness, because mental health history is rarely recorded by stop smoking service providers.

7. There is a lack of evidence on quality-of-life measures (such as EQ-5D) by smoking status for people using mental health services.

8. There is a lack of data to support economic evaluations of the cost effectiveness of stop smoking interventions for people who are using secondary care services.

9. There is a lack of evidence about the safety and efficacy of varenicline treatment for pregnant women.

10. There is a lack of evidence to determine the effect and acceptability of approaches that aim to match licensed nicotine-containing product(s) dose to level of smoking addiction among people who use acute, maternity and mental health services.

11. There was very limited evidence, particularly from the UK, on strategies for ensuring compliance with smokefree legislation and local smokefree policies. There was no evidence from well-conducted trials. There was little evidence about the effect of policies on smoking cessation or staff absenteeism.

The Group made 9 recommendations for research into areas that it believes will be a priority for developing future guidance. These are listed in Recommendations for research.

11 Membership of the Programme Development Group (PDG) and the NICE project team

Programme Development Group

PDG membership is multidisciplinary. The Group comprises public health practitioners, clinicians, representatives of the public, academics and technical experts as follows.

Matthew Alford
Community Member

Gary Bickerstaffe
Health Improvement Specialist, Bolton Council

John Britton (Chair)
Director, UK Centre for Tobacco and Alcohol Studies, University of Nottingham

Jonathan Campion
Director, Public Mental Health; Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust

Amanda Farley
Lecturer in Epidemiology, Department of Public Health, Epidemiology and Biostatistics, University of Birmingham

Elizabeth Fisher
Health Improvement Service Manager, Tobacco control lead, Head of Hertfordshire Stop Smoking Services

Liz Gilbert
Delivery Manager, National Centre for Smoking Cessation and Training

Gill Grimshaw
Community Member

Yvonne Hermon

Smoking and Pregnancy Coordinator, Office of Public Health, Dudley

Jo McCullagh

Public Health Specialist, Tobacco Control and Stop Smoking Services, Lancashire County Council

Lisa McNally

Consultant in Public Health, Bracknell Forest Council

John Moxham

Professor of Respiratory Medicine, King's College London School of Medicine; Consultant Physician, King's College Hospital NHS Foundation Trust

Rachael Murray

Lecturer, Health Policy and Promotion, UK Centre for Tobacco and Alcohol Studies, University of Nottingham

Carmel O'Gorman

Specialist Midwife, Smoking Cessation in Pregnancy, Heart of England Foundation NHS Trust

Shalini Patni

Consultant, Obstetrics and Feto-maternal Medicine, Birmingham Heartlands, Heart of England Foundation NHS Trust

Giri Rajaratnam

Deputy Regional Director, Public Health England – Midlands and the East

Elena Ratschen

Lecturer, Tobacco Control, University of Nottingham

Fraser Serle

Community Member

Matthew Taylor

Director, York Health Economics Consortium

Hilary Wareing

Director, Public Management Associates; Director, Tobacco Control Collaborating Centre

NICE project team

Mike Kelly

CPH Director

Tricia Younger

Associate Director (until December 2012)

Simon Ellis

Associate Director (from December 2012)

Pete Shearn

Lead Analyst

Amanda Killoran

Analyst (until June 2012)

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Denise Jarrett

Coordinator

Sue Jelley

Senior Editor (until February 2013)

Jaimella Espley

Senior Editor (from February 2013)

Alison Lake

Editor (until May 2013)

Rebecca Boucher

Editor (from May 2013)

12   About this guidance

Why has this guidance been produced?

NICE public health guidance makes recommendations on the promotion of good health and the prevention of ill health.

The Department of Health (DH) asked the National Institute for Health and Care Excellence (NICE) to produce this guidance.

The guidance should be implemented alongside other guidance and regulations (for more details see [Implementation](#) and [Related NICE guidance](#)).

How was this guidance developed?

The recommendations are based on the best available evidence. They were developed by Programme Development Group (PDG).

Members of the PDG are listed in [Membership of the Programme Development Group (PDG) and the NICE project team](#).

For information on how NICE public health guidance is developed, see the NICE [public health guidance process and methods guides](#).

What evidence is the guidance based on?

The [evidence](#) that the PDG considered included:

- Evidence reviews:

- Review 1: 'Review of effects of nicotine in secondary care' was carried out by Tobacco Dependence Research Unit, Queen Mary University of London. The principal authors were: Hayden McRobbie, Peter Hajek and Katie Myers.

- Review 2: 'Smoking cessation interventions in acute and maternity services: review of effectiveness' was carried out by Tobacco Dependence Research Unit, Queen Mary University of London. The principal authors were: Katie Myers, Hayden McRobbie and Peter Hajek.

- Review 3: 'Smoking cessation interventions in acute and maternity services: review of barriers and facilitators' was carried out by Tobacco Dependence Research Unit, Queen Mary University of London. The principal authors were: Katie Myers, Hayden McRobbie, Oliver West and Peter Hajek.

- Review 4: 'Effectiveness of smoking cessation interventions in mental health services' was carried out by UK Centre for Tobacco Control Studies, University of Nottingham. The principal authors were: Jo Leonardi-Bee, Leah Jayes, Alison O'Mara-Eves, Clare Stansfield, Kate Gibson, Elena Ratschen and Ann McNeill.

- Review 5: 'Barriers to and facilitators for smoking cessation interventions in mental health services' was carried out by UK Centre for Tobacco Control Studies, University of Nottingham. The principal authors were: Jo Leonardi-Bee, Leah Jayes, Alison O'Mara-Eves, Clare Stansfield, Kate Gibson, Elena Ratschen and Ann McNeill.

- Review 6: 'A review of the effectiveness of smokefree strategies and interventions in secondary care settings' was carried out by University of Stirling and University of Nottingham. The principal authors were: Kathryn Angus, Rachael Murray, Laura MacDonald, Douglas Eadie, Alison O'Mara-Eves, Clare Stansfield and Jo Leonardi-Bee.

- Review 7: 'A review of the barriers to and facilitators for implementing smokefree strategies and interventions in secondary care settings' was carried out by University of Stirling and University of Nottingham. The principal authors were: Douglas Eadie, Laura MacDonald, Kathryn

Angus, Rachael Murray, Alison O'Mara-Eves, Clare Stansfield and Jo Leonardi-Bee.

- Review of economic evaluations: 'Smoking cessation in secondary care: cost-effectiveness review ' was carried out by Matrix Evidence. The principal authors were: Maria Rizzo, Alison Martin, Victoria Clift-Matthews, Louise Lombard, Oluwaseye Abogunrin, Obinna Onwude, Jacque Mallender and Rupert Lee.

- Economic modelling: 'Economic analysis of smoking cessation in secondary care' was carried out by Matrix Evidence. The principal authors were: Jacque Mallender, Evelina Bertranou, Mariana Bacelar and Sarah Roberts.

- Expert papers:

  - Expert paper 1: 'Stop smoking interventions in secondary care' by Liz Gilbert, National Centre for Smoking Cessation and Training.

  - Expert paper 2: 'Streamlined secondary care system: project report' by Liz Gilbert, National Centre for Smoking Cessation and Training.

  - Expert paper 3: 'Bedside interventions for smoking cessation: A randomised controlled trial of systematic identification and treatment of smokers' by Rachael Murray, UK Centre for Tobacco Control Studies, University of Nottingham.

  - Expert paper 4: 'Association between smoking and mental disorders' by Jo Leonardi-Bee, UK Centre for Tobacco Control Studies, University of Nottingham.

  - Expert paper 5: 'The prevalence of smoking in people with mental health problems' by Lisa Szatkowski, UK Centre for Tobacco Control Studies, University of Nottingham.

  - Expert paper 6: 'Ethical issues for smoking cessation and smokefree policies' by Richard Ashcroft, School of Law, Queen Mary University of London.

  - Expert paper 7: 'Smoking and mental disorder' by Jonathan Campion, South London and Maudsley NHS Foundation Trust.

- Expert paper 8: 'South London and Maudsley NHS Foundation Trust Smoke-free pilot' by Mary Yates, South London and Maudsley NHS Foundation Trust.

The reviews, expert papers and economic analysis are available online.

Note: the views expressed in the expert papers above are the views of the authors and not those of NICE.

In some cases the evidence was insufficient and the PDG has made recommendations for future research.

Status of this guidance

The draft guidance, including the recommendations, was released for consultation in April 2013. At its meeting in July 2013, the PDG amended the guidance in light of comments from stakeholders and experts. The guidance was signed off by the NICE Guidance Executive in October 2013.

The guidance is available on NICE's website. The recommendations are also available in a pathway for professionals whose remit includes public health and for interested members of the public.

Implementation

NICE guidance can help:

- Commissioners and providers of NHS services to meet the requirements of the NHS outcomes framework 2013–14. This includes helping them to deliver against domain 1: preventing people from dying prematurely.
- Local health and wellbeing boards to meet the requirements of the Health and Social Care Act (2012) and the Public health outcomes framework for England 2013–16.
- Local authorities, NHS services and local organisations determine how to improve health outcomes and reduce health inequalities during the joint strategic needs assessment process.

NICE has developed tools to help organisations put this guidance into practice.

Updating the recommendations

This guidance will be reviewed 3 years after publication to determine whether all or part of it should be updated. Information on the progress of any update will be posted at the [NICE website](#).

Your responsibility

This guidance represents the views of the Institute and was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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