Local Stop Smoking Services and support:

commissioning, delivery and monitoring guidance

NCSCT

Department of Health & Social Care

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About the National Centre for Smoking Cessation and Training

The National Centre for Smoking Cessation and Training (NCSCT) is a social enterprise set up to:

- help stop smoking services to provide high quality behavioural support to people who smoke based on the most up-to-date evidence available
- contribute towards the professional identity and development of stop smoking practitioners and ensure that they receive due recognition for their role
- research and disseminate ways of improving the provision of stop smoking support

www.ncsct.co.uk

Contents

List of abbreviations

A4C	Agenda for Change
ASH	Action on Smoking and Health
BCT	Behaviour change technique
CDTS	Cut Down to Stop
CLeaR	CLeaR tobacco control self-assessment tool
CO	Carbon monoxide
COPD	Chronic obstructive pulmonary disease
CQUIN	Commissioning for Quality and Innovation
DHSC	Department of Health and Social Care
FCTC	Framework Convention on Tobacco Control
FTCD	Fagerström Test for Cigarette Dependence
GSL	General sales list
HSI	Heaviness of Smoking Index
ICB	Integrated Care Board
ICS	Integrated Care System
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LGBTQ+	Lesbian, gay, bisexual, transgender, queer and ace
LSSS	Local Stop Smoking Service(s)
LTP	Long Term Plan
MECC	Making Every Contact Count
MHRA	Medicines and Healthcare products Regulatory Agency
NCSCT	National Centre for Smoking Cessation and Training
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NRT	Nicotine replacement therapy
OHID	Office for Health Improvement and Disparities
PGD	Patient group direction
ppm	Parts per million
QOF	Quality and Outcomes Framework
R/M	Routine and manual
SCS	Smoking Cessation Service
SIGN	Scottish Intercollegiate Guidelines Network
SMI	Severe mental illness
SOP	Standard operating procedure
STP	Standard Treatment Programme
STS	Smoking Toolkit Study
TDA	Tobacco Dependence Advisor
TDS	Tobacco Dependence Service
TDT	Tobacco Dependence Team
TLHC	Targeted Lung Health Check
VBA+	Very Brief Advice on Smoking
WHO	World Health Organisation

Foreword

Tobacco use, specifically cigarette smoking, continues to be the single largest preventable cause of ill-health, death and disability. Despite the significant success in driving down rates of smoking, there is still work to do to achieve a Smokefree England.

The commissioning and delivery of high-quality stop smoking support has played a leading role in saving lives, reducing health inequalities and improving health on an individual, local, regional and national level. Smoking prevalence has reduced significantly since the introduction of Local Stop Smoking Services, and quitting smoking remains the best thing that a person who smokes can do for their current and future health, with far reaching benefits for communities across England.

Local Stop Smoking Services are an effective and cost-effective way to support people who smoke to quit, and to stay quit. They are also extremely good at reaching population groups with high smoking prevalence and who face the challenges of comorbidities and health disparities.

The NCSCT led the way in 2014 with the publication of guidance for local authorities that provided evidence-based, best practice guidance for both commissioners and providers of stop smoking services. This resource has been the foundation of high-quality service delivery for over a decade.

The NCSCT guidance has now been updated and transformed into an accessible, dynamic reference that reflects the latest evidence and developments in stop smoking interventions and aids, and which takes a person-centred approach towards support for people who smoke. This document provides a renewed vision for stop smoking services, principles for high-quality service delivery, and quality standards for the benchmarking of stop smoking services. The guidance stresses the importance of targeting and tailoring services to meet the needs of priority groups where rates of smoking remain high. Recognising the significant changes in the NHS prevention agenda, the guidance also provides practical support for services to remove barriers for clients moving from hospital to community.

In October 2023, ambitious plans were introduced to create a *smokefree generation* with a smoking prevalence of 5% or less. The Government is investing significant additional funding for stop smoking services through the *Stopping the Start* programme. This investment will support local authorities to positively impact the reach, access and outcomes of Local Stop Smoking Services. This guidance gives local authorities, integrated care boards, commissioners, and service providers the information and tools to maximise the impact of this new investment and ensure that the effectiveness and reach of Local Stop Smoking Services are not only maintained but will grow.

Effective support to quit for people who smoke is a life-saving intervention for them and their families, and a cost-saving intervention for their community, and the county. All people who smoke, and those who support them, will benefit from a personalised, evidence-based and system-wide approach. The guidance in this important document will help to deliver this, and to achieve the Government's ambition of a Smokefree England by 2030.

Dr Andy McEwen
Chief Executive, NCSCT

About this Document

This document provides clear steps for commissioning, delivering and monitoring effective, evidence-based stop smoking support. This guidance, which replaces the previous document published in 2014, includes evidence updates and current developments in best practice.

The guidance aims to promote three principles of service commissioning, delivery and monitoring:

1. The needs of people who smoke should be at the heart of everything that we do
2. Interventions should be high-quality and evidence-based
3. Collaborative working across stop smoking systems should be standard operating procedure

The guidance has been written for commissioners and providers of Local Stop Smoking Services funded by local authorities. The document will also be useful to other local and regional health and social care agencies, including in primary care and secondary care, and to integrated care boards and integrated care systems.

The guidance is organised into four parts, reflecting distinct but related roles and responsibilities:

Part 1: Essential information for providing Local Stop Smoking Services

Part 2: Commissioning stop smoking services

Part 3: Delivering stop smoking services

Part 4: Monitoring stop smoking services

Part 1 is relevant for anyone involved in commissioning, delivering and monitoring Local Stop Smoking Services. Part 2 is directed at commissioners and Parts 3 and 4 are focused on providers of stop smoking services.

What's new in this guidance?

- A focus on a person-centred approach to stop smoking support
- Principles for delivering behavioural support
- Latest evidence on tailoring support to priority groups
- Developments in stop smoking medications and nicotine vapes
- Advice on Cut Down to Stop
- Updates on service monitoring

Current and imminent developments in policy, evidence and practice, including new stop smoking aids, mean that this document will be subject to dynamic updating to ensure it remains up to date. The guidance will be reviewed and edited as new policy, research and clinical guidance emerge and will undergo a formal annual review.

- If reading this guidance offline, please refer to the website for the most up-to-date document version
- The host webpage will include bullet points of any substantive edits for reference
- Please complete and submit the Feedback Form with any suggestions, corrections or comments

See **www.ncsct.co.uk/publications/commissioning-delivery-monitoring**

Part 1: Essential information for providing stop smoking services

Summary guidance:
Essential information for providing stop smoking services

- This document provides a road map to guide commissioners and providers of stop smoking services to fulfil three primary roles:
  1. Increase the number of people who make aided quit attempts, with a focus on local priority groups.
  2. Work collaboratively to support people who smoke who want to stop by providing access to person-centred, evidence-based stop smoking support and aids.
  3. Work in partnership and collaborate with other organisations across systems.
- Smoking remains the leading cause of preventable illness, death and disability, and a leading driver of health inequalities, in England. Tackling tobacco dependency is one of the most effective ways of eliminating health inequalities. Stop smoking services are extremely cost-effective and play an important role, alongside other tobacco control policies, in driving down rates of smoking at national and local level.
- Effective local commissioning of stop smoking support will include investment in motivating quit attempts through public health communication campaigns and outreach. It will also ensure that stop smoking support can be provided at scale, and that those who have the greatest challenges with quitting have access to intensive support.
- Tackling tobacco use and supporting quitting must be a shared ambition. Financial realities mean that joined-up work will be essential.
- Groups with higher prevalence of smoking and/or complex needs will benefit from specific targeting, including people in lower socio-economic groups, those living in social housing, people with mental illness, people with health conditions caused or made worse by smoking, people with multiple or complex needs (unemployed, experiencing homelessness, in contact with the criminal justice system, ethnic minorities, travellers, LGBTQ+) and pregnant women.
- Identifying local priority groups and providing effective support to meet their needs is a high priority to reduce health inequalities and should be reflected in local commissioning and service delivery models.
- Effective stop smoking interventions should be available to all, but the scale and intensity of interventions must be proportionate to the most disadvantaged.
- New developments in stop smoking products and models of support are emerging, including hybrid service delivery models, nicotine vaping products, other advances in the use of stop smoking aids, and digital solutions. Local stop smoking services should seek to ensure service delivery reflects latest evidence and best practice.

Aim and objectives of part 1

Aim

To provide essential information, latest evidence and best practice guidance to support the commissioning and delivery of stop smoking support.

Objectives

This guidance will:

- Describe the changing stop smoking landscape and the role of Local Stop Smoking Services (LSSS).
- Explain the nature of tobacco dependence and the role it has in smoking and smoking cessation.
- Highlight the relationship between smoking, deprivation and inequalities, and the important role of LSSS in reducing health inequalities.
- Identify priority groups and describe the challenges they face.
- Describe the three primary roles of LSSS and recommend quality standards to improve outcomes.
- Provide the evidence base for, and guidance on, the delivery of effective stop smoking support, including stop smoking aids and behavioural support.

1.0 Introduction

Part 1 includes essential information that everyone involved in commissioning and providing stop smoking services and support should use as a reference of the most current evidence and best practice guidance to deliver effective outcomes for people who smoke and want to quit.

1.1 Background

In England, **tobacco use is the leading cause of death and disability,** and is a key driver of health spending and health inequalities.[1,2]

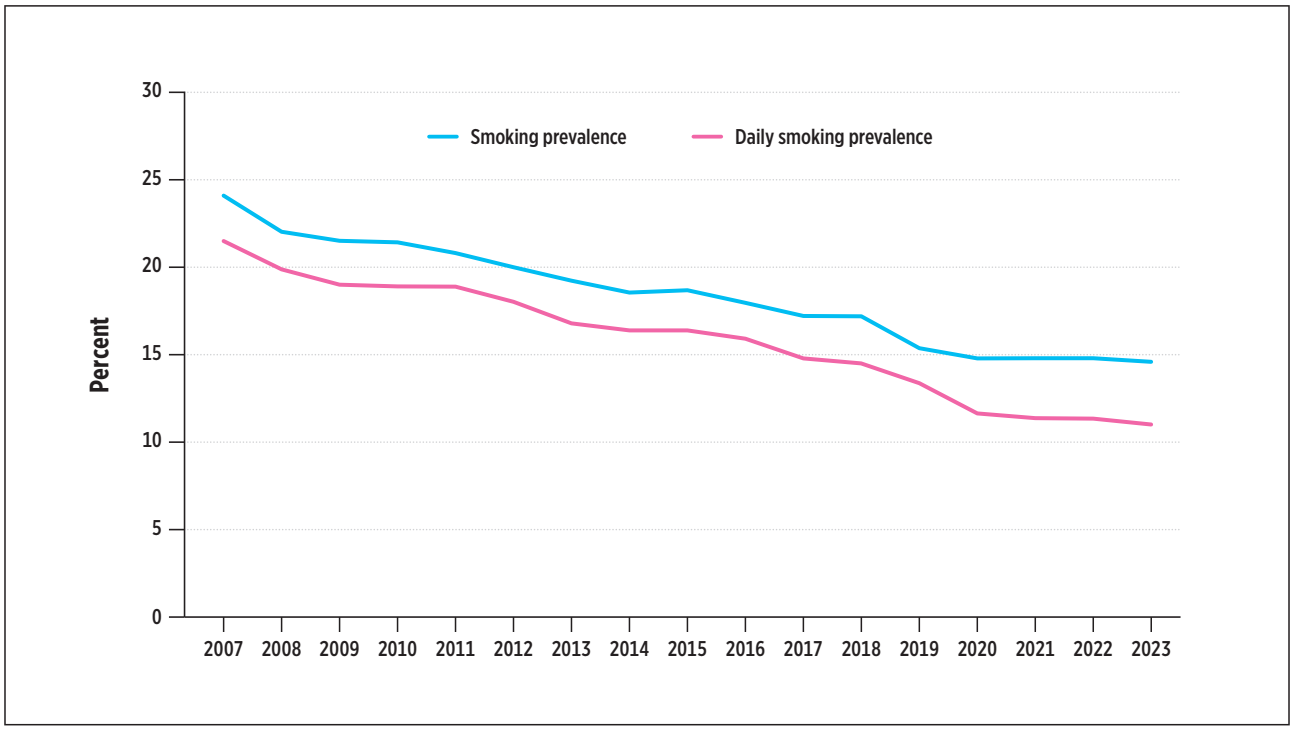
A staggering two in three people who smoke will die as a result of their tobacco use.[3] Smoking remains the leading cause of preventable heart disease, stroke, and respiratory illness; it is also associated with numerous other health effects.[4–7] Smoking is known to cause 16 types of cancers and poorer outcomes among those receiving cancer treatment.[5,8] Smoking during pregnancy is particularly harmful and associated with numerous adverse pregnancy and birth outcomes.[5,9]

Smoking is also a leading driver of health and social spending in England.[10] Smoking costs the economy an estimated £49.2 billion per year, £1.9 billion of which falls to the NHS and £15.0 billion in social care costs.[10] Additionally, there is an estimated £32.0 billion in lost productivity due to people who smoke being significantly more likely to become ill while working and be out of work.[10]

Addressing tobacco use is arguably the single most important investment that we can make to improve the health, wealth and social wellbeing of individuals, with significant and direct impacts on health inequalities and national, regional and local healthcare budgets.[2]

We have made progress, but there is a need for continued investment and action. Rates of smoking have steadily reduced, from 24% in 2007 to 15% in 2023 (see **Figure 1**) and this achievement is directly attributable to the investment in tobacco control and stop smoking support.[11] Despite this success, there remain more than six million people who smoke in England, with some parts of the country and segments of the population with very high rates of tobacco use. The fall in prevalence of smoking at a national level can mask the needs of groups of people with more complex social, health and economic circumstances. Effective support to quit can have a huge life-saving impact upon these individuals and groups. **In short, our work is not done.**

Figure 1: Cigarette smoking and daily cigarette smoking prevalence in adults (2007–2023)



Source: Smoking Toolkit Study **https://smokinginengland.info/graphs/annual-findings**[11]

1.2 Local Stop Smoking Services

Over the past 20 years, Local Stop Smoking Services (LSSS) have delivered more than five million four-week quits.[12] English LSSS are internationally recognised and have played, alongside other policy initiatives, a key role in driving down rates of smoking in England. LSSS were established nationally in 2000 following the publication of the Smoking Kills White Paper.[13] LSSS were designed to ensure every person who smokes who is interested in quitting has access to high-quality, evidence-based stop smoking support. This included the establishment of a national standard and a universal offer of specialist multi-session support and stop smoking medications to give people the best chance of quitting.[14,15] LSSS have been rigorously evaluated and have evolved to integrate latest evidence-based practice.[16–18] People who quit with the support of **high-quality LSSS have at least triple the success with quitting,** compared to no support.[17]

1.3 The changing stop smoking landscape

There have been several changes to the stop smoking landscape that have impacted the way we commission, deliver and monitor stop smoking services and this guidance reflects these elements:

- **Investment in LSSS has reduced significantly over the last decade.** This has resulted in changes in the structure of LSSS, with direct impacts on the reach and quality of services.[12,19] This includes a reduction in localities retaining a specialist service and dedicated teams, and fewer services with a universal offer. Instead, local authorities (LAs) are commissioning from a broader range of providers and interventions to provide variable support services.
- **Who provides the services has changed.** In 2013, funding and commissioning of LSSS moved from the NHS to LAs.
- **COVID impacted on delivery models.** LSSS faced significant disruption caused by COVID restrictions. Many areas have adapted to providing remote delivery of behavioural support.
- **New digital technologies.** An increasing number of apps are available to support quitting. These range from static formats providing basic information to complex digital platforms that link people who smoke to trained practitioners and a supply of stop smoking medications and nicotine vapes.
- **Nicotine vapes (e-cigarettes).** There is now strong evidence that the use of nicotine vapes increases rates of quitting.[20–23] Ensuring nicotine vapes are part of the support offered in LSSS will be key to modernising services. The Swap to Stop programmes and vaping products procurement framework solutions (e.g. *'Crown Commercial Service Tail Spend Solution framework'*) are recent developments in this area which will improve access to nicotine vapes. See further information below.
- **NHS tobacco dependence services.** NHS England set a priority in 2019 for the NHS to have a greater role in helping people quit smoking. The NHS Long Term Plan commits to ensuring all people admitted to hospital who smoke will be offered NHS-funded tobacco dependence treatment and a referral to community support upon discharge.[24] This has led to the development of NHS-funded Tobacco Dependence Services in NHS secondary care, maternity, and mental health settings.
- **The national levelling up agenda.** The national levelling up agenda has reinforced the importance of tackling significant national health inequalities, and addressing tobacco use and supporting smoking cessation in priority groups has been identified as a key strategy to level up.[25]
- **Integrated care systems and boards.** These offer new mechanisms to support joined-up work and planning at local and regional levels. These include shared goals for addressing tobacco use and inequalities and meeting local health needs.[26]

1.4 NHS inpatient tobacco dependence programme

The NHS Long Term Plan has committed to **delivering tobacco dependence treatment to all people admitted to hospital who smoke and includes all NHS acute trusts and acute mental health trusts via a multi-year pathway rollout.** This national referral pathway is a key strategy of the English Department of Health and is supported as a best practice by the National Institute for Health and Care Excellence (NICE), the National Centre for Smoking Cessation and Training (NCSCT), the Royal College of Physicians, and Action on Smoking and Health (ASH).

The NHS Long Term Plan implementation framework set out a number of funding streams for targeted investment to develop NHS-funded tobacco dependence services. In 2022/23, this saw over £35m devolved to integrated care boards (the NHS component of integrated care systems) to design and commission local tobacco dependence services based on local population needs.

The NHS inpatient offer for acute trusts and acute mental health trusts

- Smoking status identified for every patient admitted to acute inpatient settings
- Opt-out referral to in-house tobacco dependence team
- Provision of combination NRT, or other stop smoking medication during inpatient stay
- Referral to post-discharge stop smoking support (Transfer of Care)
- Phone call 1–2 weeks post-discharge (recommended)
- Follow-up 1–2 weeks, and 28 days, following discharge from hospital.

1.5 Stopping the start: our new plan to create a smokefree generation

In October 2023 the government published a command paper setting out the actions they will take to tackle smoking and youth vaping, including £70 million of additional funding per year for five years for LSSS, beginning in 2024/25. This more than doubles existing funding through the public health grant and will play a key role in strengthening LSSS and increasing the reach and quality of support offered across England.

The aims of the additional funding are to enable:

- **Capacity building** within the stop smoking workforce
- **Building of demand** for stop smoking services and support

1.6 Transforming local stop smoking services into stop smoking systems

Effective local commissioning of stop smoking support will include investment in motivating quit attempts through public health communication campaigns and outreach. It will also ensure that stop smoking support can be provided at scale, and that those who have the greatest challenges with quitting have access to intensive support.

Tackling tobacco use and supporting quitting must be **a shared ambition.** Financial realities mean that joined-up work will be essential.

Further information

Stopping the start – click here

NCSCT briefing – Incorporating nicotine vaping products (e-cigarettes) into Stop Smoking Services – click here

2.0 Tobacco dependence and stopping smoking

Key points

- Smoking is the **leading cause of preventable illness, death and disability** in England.
- Most people who smoke are **dependent on nicotine** but the level of dependence varies.
- Nicotine dependence makes it **difficult for people who smoke to quit** and remain abstinent.
- While it is nicotine in combustible tobacco that is addictive, **nicotine does not cause the smoking-related death and illness.**
- Stop smoking **aids** help.
- **Behavioural support** from trained practitioners helps.
- **People who are more dependent** on smoking will need more support and more stop smoking aids for longer to quit.
- The **highest rate of relapse is in the first four weeks after quitting,** when withdrawal symptoms and cravings are at their greatest.

Despite the significant decline in smoking prevalence over the past 20 years, an estimated **6.1 million adults in England – approximately 13% of the adult population – smoke daily.**[11,27]

Tobacco dependence is a complex chronic relapsing condition that most often starts in childhood. It is often misunderstood as a 'lifestyle choice' or 'bad habit' and the inability to quit as simply lack of motivation or willpower. This is far from accurate and such views may prevent people who smoke from accessing services, and those who interact with them from signposting support.

Most people smoke because they are addicted to nicotine delivered via cigarettes. While nicotine is the addictive substance in tobacco products, it does not cause the negative health effects associated with smoking. It is the tar, carbon monoxide and other chemicals and carcinogens found in cigarette smoke that are responsible for these negative health effects. Nicotine delivered via cigarettes is particularly addictive because it is inhaled and delivered quickly to the brain. The speed of nicotine delivery is one of the key factors that leads to tobacco dependency.

When someone stops smoking, they are likely to experience withdrawal symptoms and urges to smoke. These are the primary reasons individuals find it difficult to stop smoking in the early period after quitting. The severity of withdrawal symptoms and urges to smoke can differ from person to person and moment to moment. They are at their most severe in the first few weeks of abstinence and most resolve themselves within four weeks of the quit date. Tobacco withdrawal symptoms are more severe in people who are more dependent and people with certain types of psychiatric disorders.[28] Genetic factors are also associated with tobacco dependence and severity of withdrawal symptoms.[29,30]

A key feature of tobacco dependence is that most people who smoke have developed long-standing smoking routines, habits and triggers that pose barriers to quitting. **To successfully stop smoking, people need to develop new routines and methods of coping with smoking triggers.** For this reason, stopping smoking is considered a complex behaviour change.

Importantly, **there is a very high rate of relapse in the first month following quitting,** when withdrawal symptoms and urges to smoke are at their greatest. Individuals who stop for at least one month have a substantially reduced rate of relapse.

Unsupported (i.e. no behavioural support or stop smoking aids used, 'cold turkey') quit attempts are the least successful, with 95% of people failing within the first year.[31,32] The likelihood of a successful quit can be significantly increased by accessing evidence-based stop smoking support and aids.

Only "hardcore" smoking remains

There have been comments made in recent years that LSSS in the UK have reached "all the low hanging fruit" and that "only a hardcore of people who smoke remains". The term 'hardcore' has been used to describe people who have smoked long-term and are unwilling or unable to quit smoking. As West and Jarvis discussed in 2017, this inaccurately merges two independent theories – motivation to quit and tobacco addiction. Additionally, it assumes a degree of stability that is not present, as neither are such a strong predictor of success in future quit attempts that they should define a person.[33]

Motivation to quit smoking in the UK is not declining. Quit attempts had been declining but are now increasing.[11,34] Markers of tobacco dependence are also not going up – as may be expected by a 'hardcore' as data shows a huge increase in the number of non-daily users.[34] The proportion of people who smoke with low socio-economic status has not increased in the UK.[11,34]

3.0 Smoking, deprivation and inequalities

Key points

- Smoking is responsible for **at least half the difference in life expectancy** between the richest and poorest in society.
- **Smoking rates vary across socio-economic and geographical communities,** with those in more deprived areas having higher smoking rates and poorer health outcomes.
- **The prevalence of smoking is particularly high among people with mental illness, experiencing homelessness, in the judicial system, in alcohol and drug treatment, and living in social housing.**
- **Higher rates of smoking both drive and exacerbate inequalities,** leading to poorer health outcomes and locking people into poverty.[2]
- Addressing tobacco use and supporting stopping smoking is a key area of achievement for the **UK levelling up programme, NHS England's Core20PLUS5 framework for addressing health inequalities** and the Government's overall commitment to addressing inequalities in health.[25]

"Smoking is not only the biggest cause of cancer, but it also hits the most deprived the hardest. Amidst the current cost of living crisis, smoking continues to pull our most disadvantaged communities further into poverty by costing them billions each year."

Michelle Mitchell, CEO of Cancer Research UK (The Khan Review, June 2022)

3.1 Smoking and life expectancy

The link between smoking and disadvantage is well established. Smoking is one of the most significant factors impacting on health inequalities and ill health, particularly cancer, coronary heart disease and respiratory disease.[35,36]

Smoking is responsible for half the difference in life expectancy between the richest and poorest in society.[35] Later in life, people who smoke are almost twice as likely to need some form of social care than people who have never smoked.[35]

Rates of smoking are also significantly higher among people with **mental illness,** those in the judicial system and those being treated for **drug and alcohol addiction.**[37] It is important to recognise that a significant proportion of people in these groups will also be in lower income groups and/or living in social housing.

3.2 Smoking and communities

Smoking rates are much higher among low-income groups. This is particularly true among people who are unemployed, living in social housing, living in poverty and those experiencing homelessness.[27] Housing tenure is the strongest independent predictor of smoking in England.[2,11] One in three people in **social housing** are currently smoking, compared to around one in ten people who own their home.[27,38] **People who smoke from lower socio-economic groups are less likely to be successful in stopping smoking** than more affluent people who smoke, even when using stop smoking support programmes.[39]

Tobacco dependency, and the loss of income it causes, can also exacerbate and lock people into poverty. Smoking is associated with an increased likelihood of unemployment and underemployment, with people who smoke long-term 7.5% less likely to be employed than people who don't smoke.[40] One in five (21%) smoking households in the UK are living below the poverty line, amounting to a million households.[35] When tobacco expenditure is included in the assessment of poverty this increases to nearly a third (32%), equivalent to 1.5 million households.[35]

3.3 Eliminating inequalities through treating tobacco dependency

Tackling tobacco dependency is one of the most effective ways of eliminating health inequalities. Addressing tobacco use and supporting quitting has been identified as an important strategy for reducing inequalities in health, with a direct impact on three of the 12 missions identified by the Levelling Up the United Kingdom White Paper.[41] Stop smoking support also contributes to all five of the key clinical areas identified as priorities in NHS England's Core20PLUS5 approach to reducing healthcare inequalities[42] and the Government's overall commitment to narrow the gap in healthy life expectancy between areas where it is highest and lowest by 2030, and to raise healthy life expectancy by five years by 2035.[43] There exists a unique opportunity to invest in stop smoking support to address multiple local, regional and national targets.

The Government's **Major Conditions Strategy,** published in 2023, brings a focus on improving health outcomes over the next five years by tackling the multimorbidity challenge.[43] The focus is on six groups of conditions: cancers, cardiovascular disease, musculoskeletal disorders, mental illness, dementia and chronic respiratory disease. One in four adults has at least two health conditions. The strategy is underpinned by the NHS Core20PLUS5 framework, with the emphasis on delivering whole-person care. The creation of integrated care systems (ICSs) was the first part of rebalancing towards a personalised approach to primary and secondary prevention through managing risk factors such as smoking tobacco.

4.0 Priority groups

Key points

- Priority groups have **high smoking rates,** face substantial barriers to quitting and have high rates of **relapse** to smoking.
- They are all more likely to suffer from a **long-term medical condition,** use NHS and/or social services, and experience worse treatment outcomes.
- People in these groups often **want to quit smoking** as much as the general population of those who smoke.
- They face many and varied structural, social and environmental **barriers to quitting** and staying quit.
- Effective stop smoking **interventions should be available to all.**
- **Services need to be tailored** in terms of when, where and how they are offered to engage clients in these groups.
- Approaches that provide more intensive, frequent and longer **behaviour support must be proportionate to the most disadvantaged.**
- Use intelligence such as the Joint Strategic Needs Assessment (JSNA) to **identify priority populations.**

"The more affluent people need less service to get the same outcome as someone who is more deprived."

Angela Baker, Public Health consultant, Coventry Council

Priority groups will be locally determined. Groups are included in this national guidance because they have nationally identified needs. This list is not exhaustive or exclusive. **Table 1** shows the high smoking prevalence of some of these groups.

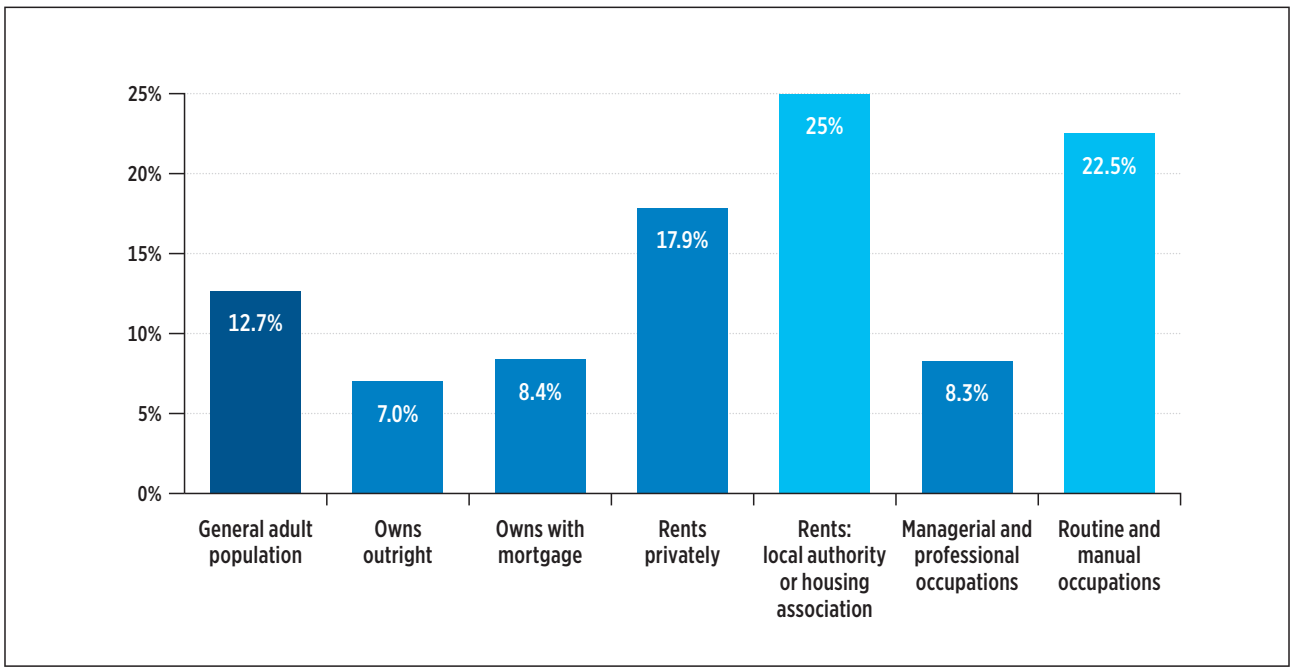
Table 1: Rates of smoking in the population and by high-risk group

Population group	Smoking rate	People who smoke
General population[27]	12.7%	1 in 10
C2DE (Manual occupation)[27]	22.5%	2 in 10
Social housing[27]	25–33%	3 in 10
People with severe mental illness[27]	40%	4 in 10
Drug and alcohol addiction centres[37]	53%	5 in 10
Judicial system[44]	80%	8 in 10
People experiencing homelessness[45–47]	76 – 85%	8 in 10

4.1 People experiencing socio-economic disadvantage and/or living in social housing

Higher rates of smoking are found in the most deprived areas of the country compared with the least deprived areas, and this gap is widening.[48] The more disadvantages a person faces, the more they are likely to smoke. Individuals in routine and manual (R/M) occupations have rates of smoking that are 7.3% higher than those in the general population.[11] Ill health in the poorest communities is significantly higher and these people experience higher rates of disability and premature death.[41] Higher rates of smoking have been identified as a key driver of the higher rates of illness, death and disability. In addition, people in lower socio-economic groups have greater barriers to stopping smoking and experience lower rates of success with quitting.[39]

Figure 2: Smoking prevalence comparing inequalities in smoking rates by socio-economic measure



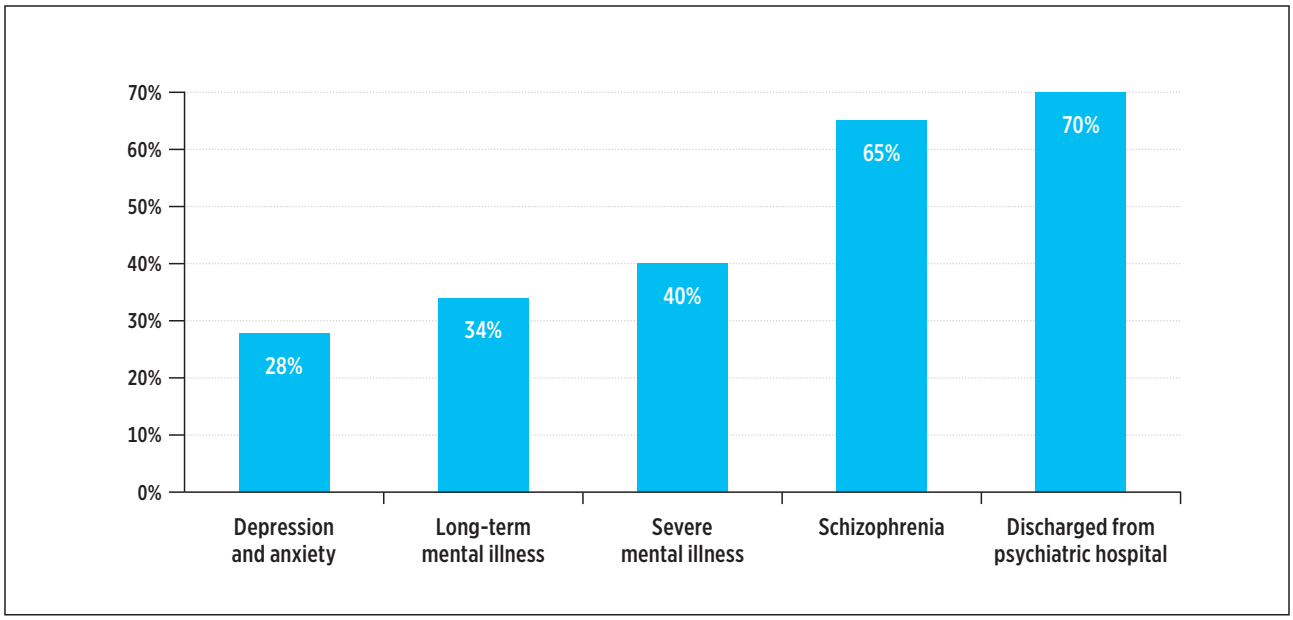
Source: 2022 Annual Population Survey[27]

4.2 People with mental health conditions

People with mental health conditions have significantly higher smoking rates than the general population.[49-51,52] People with a mental health condition die on average 10 to 20 years earlier than the general population and this is largely due to preventable smoking-related illness.[49,50,53,54]

Rates of smoking differ between specific patient groups and with severity of the illness (see **Figure 3**).

Figure 3: Rates of smoking among people with mental illness



Source: Annual Population Survey;[27] Kings Fund 2006;[51] De Leon 2005[52]

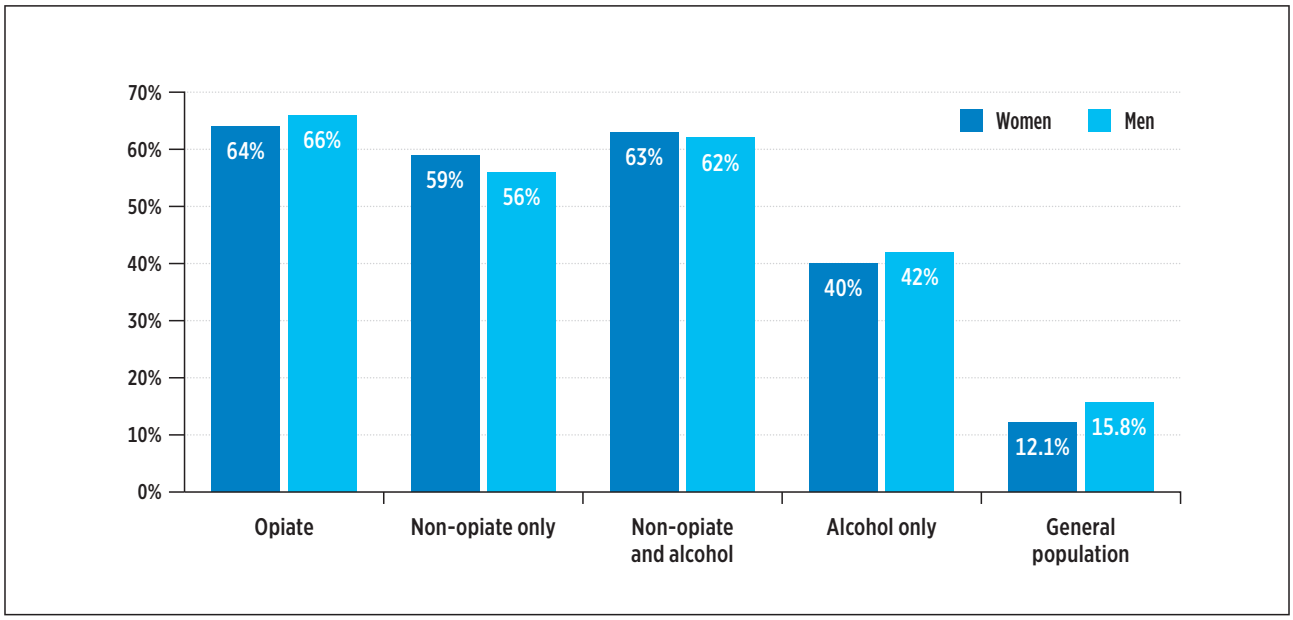
People with mental illness are just as likely to want to quit as the general population of people who smoke, with 61% of people with a long-term mental illness indicating they want to quit smoking.[55]

People who smoke who are admitted to hospital for their mental illness should receive treatment and support from the NHS to treat their tobacco dependence. However, the majority of people with a mental illness are based in the community and should remain a priority for LSSS.

4.3 People with substance misuse disorders and co-addictions

Smoking rates are significantly higher in people with substance misuse disorders and co-addictions than the general population (see **Figure 4**). Smoking tobacco may also inhibit the ability to stop using other drugs, particularly where they are commonly consumed alongside tobacco, such as cannabis.[56] It is therefore plausible that addressing smoking and addictions to other substances will improve outcomes for both. There have been concerns that supporting people to quit smoking may reduce their ability to respond to treatment for other addictions. However, providing stop smoking support to people in treatment for drug and alcohol addictions does not affect abstinence rates and positively impacts smoking rates.[57]

Figure 4: Smoking rates at start of substance misuse treatment[37]



4.4 People with health conditions caused or made worse by smoking

Smoking harms nearly every organ in the body. People who smoke are more likely to live with a long-term health condition (LTC) that is controlled but not cured. Both people who smoke and those with an LTC are more likely to be hospitalised and experience worse treatment outcomes. Many LTCs are caused or exacerbated by smoking, meaning stopping smoking is key to reducing complications and improving outcomes.

The UK Government's five year **Major Conditions Strategy** targets six major health conditions (cancers, cardiovascular disease, musculoskeletal disorders, mental illness, dementia and chronic respiratory disease) for each of which smoking is a major risk factor for incidence and poorer treatment outcomes.[43]

Examples of long-term health conditions

In 2022, chronic obstructive pulmonary disease (COPD) was responsible for 25,791 deaths in England, and smoking accounts for 86% of COPD-related deaths.[58] There are significant short-term health benefits to stopping smoking for people with COPD, including improved treatment outcomes, quality of life and reduced mortality.

People with asthma who smoke experience higher rates of hospitalisation, worse symptoms and more rapid decline in lung function than those with asthma who do not smoke.

Smoking significantly increases the risk of heart disease and stroke. People who smoke are six times more likely to have a stroke. People with diabetes who smoke have an increased risk of complications and premature death.

4.5 People with multiple or complex needs

Smoking rates are higher in some community groups, many of whom already experience poorer lives, higher deprivation and worse health outcomes. The resulting financial and health burdens compound existing difficult situations and inequalities.

Despite competing priorities, and the often difficult circumstances that people with multiple and complex needs face, quitting smoking can have significant benefits:[59]

- Increased income
- Greater chance of long-term abstinence from illicit drugs and alcohol
- Reduced infections
- Improved mental health

People with multiple needs include those experiencing homelessness, those with contact with the criminal justice system, ethnic minorities, travellers, and members of the LGBTQ+ community.[59]

4.5.1 People experiencing homelessness

Homelessness does not just mean sleeping rough on the streets – it also affects those not living in secure, permanent, and adequate accommodation. At levels of 76 – 85%, **people experiencing homelessness have among the highest rates of smoking in the country**.[44–47] They also have higher rates of tobacco dependency and smoke more cigarettes per day than the general population (20+ per day, versus 13 per day).[45,60] People experiencing homelessness have a three times greater chance of dying of respiratory illness and a greater risk of lung cancer compared to the general population.[45–47]

At least 50% of those who smoke and are experiencing homelessness want to quit but face barriers to quitting, including access to information about quitting and support, peer group pressure, and the use of smoking to relieve boredom and/or stress.[45,47,60] Poverty associated with smoking can lead to riskier smoking behaviour, including using discarded butts. Poor mental health, a higher use of alcohol and illicit drugs, along with the chaotic life of being homeless makes effective smoking cessation support harder to access.[46]

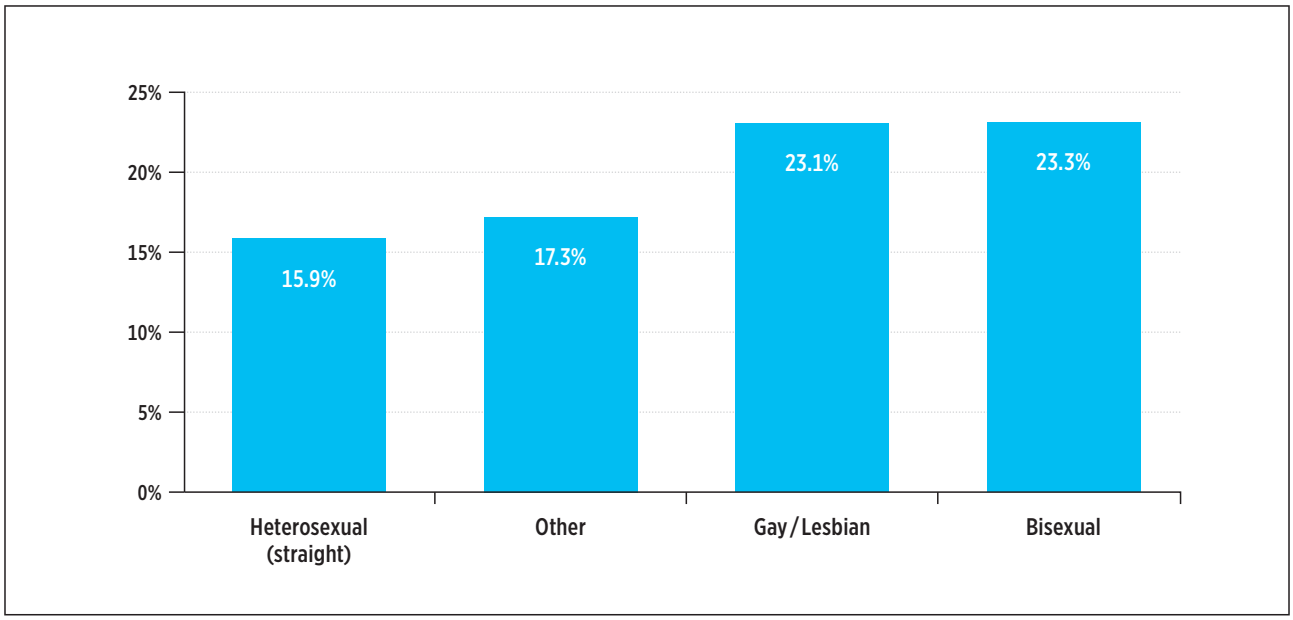
4.5.2 People with contact with criminal prosecution services (CPS)

Smoking rates among prisoners on admission are estimated to be around 80%.[44,61,62] People in contact with the CPS are more likely to be from a disadvantaged background and mental illness is more common. Prisons in England have been smokefree since 2018, except for outdoor areas in open prisons, and ensuring stop smoking support is available to prisoners is a priority.[63] Release from prison is a stressful time that can also interrupt the provision of support to stay quit.[64] Relapse back to smoking is highly likely at this time.

4.5.3 Members of the LGBTQ+ community

Members of the LGBTQ+ community report higher rates of smoking than the general population (see **Figure 5**).[27] While there is very limited research into why LGBTQ+ people smoke, it is likely related to the discrimination and prejudice they face as a result of their sexual orientation.[65]

Figure 5: Adult smoking habits in UK by sexual orientation



Source: ONS. Annual Population Survey[27]

4.6 Pregnant women and those with infants and children in the home

Smoking during pregnancy is the leading modifiable risk factor for poor birth outcomes, including stillbirth, miscarriage, and pre-term birth.[66] Smoking during pregnancy also increases the risk of children developing several respiratory conditions, attention and hyperactivity difficulties, learning difficulties, problems of the ear, nose and throat, obesity, and diabetes (see Table 2).[5,66] Smoking during pregnancy is a health inequality, with **women in lower socio-economic groups being eight times more likely to smoke during pregnancy.**

Reducing smoking rates in those who are pregnant is a government and NHS priority.[67] Prevalence of smoking among pregnant women has yet to fall dramatically and in 2022–23 it was 8.8%.[68] **Rates of smoking are higher among poorer, younger parents,** often having chaotic complex lifestyles and living in challenging circumstances.[69]

Whilst pregnant women don't, on average, have high rates of smoking, there are high rates of relapse to smoking during pregnancy and in the post-partum period. Secondhand smoke exposure among children is significantly higher when the mother smokes and is associated with the same adverse effects as first-hand exposure to smoking (see **Table 2**).[70] Because of this, pregnant women and other family members who smoke are an important target for specialist treatment throughout pregnancy and into the post-partum period. The best way to prevent secondhand smoking is to stop smoking.

Pregnant women are now treated by NHS tobacco dependence services. However, they may decide to directly access LSSS, or an LSSS may be contracted by the NHS to deliver a service as part of the NHS maternity tobacco treatment pathway. Their partners and family members may also access LSSS.

Table 2: Impact of smoking and exposure to secondhand smoke during pregnancy

Health effect	Maternal smoking	Secondhand smoke
Low birth weight (<2500g)	Double the likelihood	Increased risk
Stillbirth	Double the likelihood	Increased risk
Miscarriage	24–32% more likely	Possible increase
Preterm birth	27% more likely	Increased risk
Heart defects	50% more likely	Increased risk
Sudden Infant Death	2–3 times the risk	Increased risk
Neonatal death and admissions	Increased risk	Increased risk
Behavioural and learning problems	Increased risk	Increased risk
Respiratory problems	Increased risk	Increased risk

Source: Passive Smoking and Children, Royal College of Physicians and Royal College of Paediatrics and Child Health, 2010[70] and ASH Smoking, pregnancy and fertility[66]

5.0 Local Authority Stop Smoking Services

English LSSS are a national network of funded clinical services to help people to stop smoking. Most LSSS are commissioned by LAs and are funded through the public health grant.

LSSS are a key investment in addressing tobacco use and tackling inequalities in smoking.[39] It is estimated that 15% of the decline in smoking between 2001–2016 was attributable to English LSSS.[71]

Between April 2022 and March 2023, 175,566 quit dates were set with an LSSS and 95,400 (54%) of these led to self-reported quits four weeks after the quit date.[72] **People who use LSSS are at least three times more likely to still not be smoking at one year compared to those without any form of support.**[16,17,73]

LSSS provide a combination of behavioural support and medication and/or nicotine vapes. For many years, people who smoke in England have been offered a highly effective universal service. In recent years, some LAs have been looking at new ways of providing this service, often in response to budget constraints. We provide guidance on service delivery models in **Part 2, section 5**.

5.1 Role of Local Stop Smoking Services

LSSS have three primary roles:

1. **Increase the number of people who make aided quit attempts, with a focus on local priority groups.**

   Ensure that effective services are accessible and engage with all local people to trigger quit attempts. The scale and intensity of interventions must be proportionate to the most disadvantaged.

2. **Provide people who smoke with access to person-centred, evidence-based stop smoking support and aids.**

   Ensure services are informed by local intelligence and offer a range of evidence-based behavioural support tailored to the needs of local people who smoke. The range of support should include minimal support, a structured 6–12-week programme and more intensive specialist interventions.

   Stop smoking support should be delivered by an NCSCT Certified Stop Smoking Practitioner.

   Services should offer people who smoke an informed choice and easy access to first choice stop smoking aids (combination nicotine replacement therapy (NRT), nicotine vapes and nicotine analogue medications) for their recommended duration, and ideally for extended periods where needed, to help prevent relapse to smoking.

3. **Work in partnership and collaborate with other organisations across systems.**

   Ensure services provide leadership, expertise and collaborate with partner organisations to maximise the reach, equity, and impact of stop smoking resources and support integrated models of service delivery.

5.2 Quality standards

These evidence-based standards define and measure high-quality, cost-effective stop smoking services that improve quit outcomes:

- **At least 5% of the estimated local population who smoke** should receive a stop smoking intervention delivered by an NCSCT Certified Stop Smoking Practitioner.
- **Self-reported four-week quit rates** should be monitored nationally to assess effectiveness of all forms of stop smoking support.
- **Services should aim to have a four-week quit rate of at least 35%.** Services treating high numbers of people from priority groups might experience lower quit rates.
- **Self-reported 12-week quit rates** should be monitored and reported locally to assess effectiveness of all forms of stop smoking support.
- **Carbon monoxide (CO)** validated quit rates should be reported for at least 85% of in-person, face-to-face and hybrid specialist support interventions.
- **All required monitoring data** should be reported to NHS England (formerly NHS Digital) through the quarterly reporting and evaluation system.
- Services are **evaluated and audited at least annually** by service commissioners against the minimum quality standards set out within the SDMG. Quality improvement plans are implemented where standards are not being met. Ideally, services are independently audited at least every three years.
- **Priority group** access and outcomes should be monitored and reported locally to assess effectiveness of engagement and stop smoking interventions.

6.0 Effective stop smoking support

Key points

- There is strong evidence that the most effective method of stopping smoking is **the combination of first choice stop smoking aids and behavioural support delivered by a trained stop smoking practitioner.**[17,74,75]
- **Face-to-face, telephone/video link, and group-based support** are all effective. There is less evidence for digital interventions, but the use of digital support may be an effective way to extend the reach of behavioural support.
- **First choice stop smoking aids** provide the greatest success with quitting smoking. First choice stop smoking aids are: **combination NRT** (use of an NRT patch plus a faster-acting NRT product), **nicotine vapes** and **nicotine analogue medications** (varenicline [Champix] and cytisine).
- Nicotine-containing stop smoking aids should be used at **high enough doses and for long enough** for effective management of tobacco withdrawal symptoms and urges to smoke to minimise the risk of relapse.
- Some clients will benefit from **extended use of stop smoking aids** and this is safe and good practice. LSSS should have mechanisms to support extended use.

Evidence ratings of recommendations

Every recommendation in the intervention sections of this guidance has a rating to show the extent to which it is evidence-based. This is based upon an adapted version of the Scottish Intercollegiate Guidelines Network (SIGN) rating system,[76] an internationally-recognised scale used to rate research evidence. These ratings are as follows:

A	The recommendation is supported by good (strong) evidence
B	The recommendation is supported by fair (reasonable) evidence, but there may be minimal inconsistency or uncertainty
C	The recommendation is supported by expert opinion (published) only
I	There is insufficient evidence to make a recommendation
✓	Good practice point (in the opinion of the guidance development group)

6.1 Evidence-based stop smoking support

Behavioural support, stop smoking medications and nicotine vapes are effective when used alone for treating tobacco dependence, but there is strong evidence that the combination of support and medications and/or vapes is more effective than either alone (see **Figure 6**).[75,77] **Table 3** provides a summary of the evidence rating for forms of stop smoking support.

Figure 6: Rates of smoking abstinence by treatment[23]

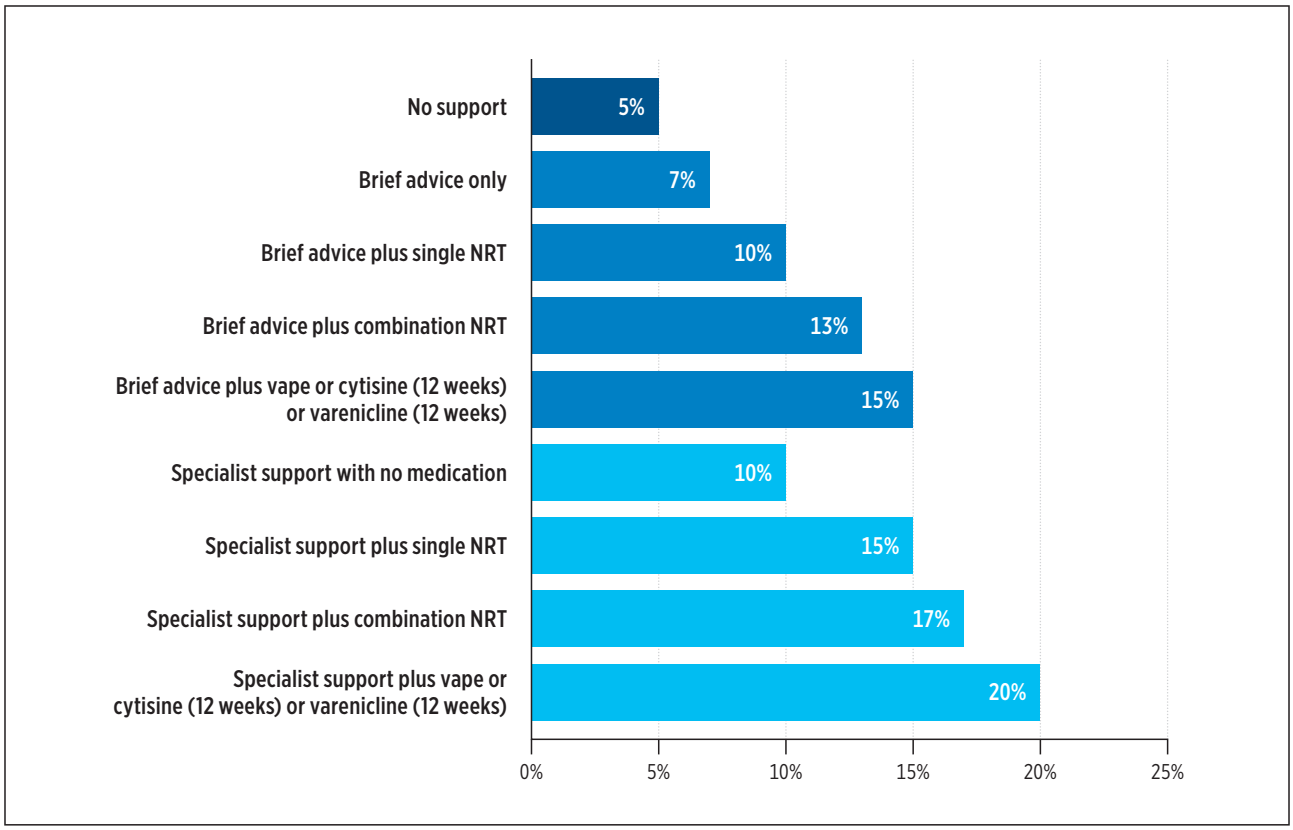


Table 3: Summary of interventions and their evidence rating

Intervention	Evidence rating
Behavioural support	A
Very brief advice	A
Intervention types	
Digital support	
Digital applications (apps)	B–C
Hybrid support (digital + person)	B–C
Online support (not live)	B
Text messages	B
Drop-in support	I
Group support	
Closed group support	A
Open (rolling) group support	B
One-to-one support	A
Couple/family support	I
Multi-session support (Standard treatment programme)	A
Single-session support	B
Tailored specialist, multi-session support	A–B
Telephone or video support	
Proactive telephone	A
Reactive telephone	B
Real time video-link (live)	C–D
Assessing nicotine dependency and smoking status	
Carbon monoxide testing	A
Cotinine testing	A
Quantitative approach to assessing nicotine dependency	A
Stop smoking aids	
First choice	
Combination nicotine replacement therapy (patch plus faster-acting product)	A
Cytisine	A
Nicotine vapes	A
Varenicline	A
Second choice	
Bupropion (Zyban)	A
Non-nicotine vapes	I
Single form NRT	A

Intervention	Evidence rating
Methods of use	
Cut Down to Stop without stop smoking aid	I
Cut Down to Stop with NRT	B
Cut Down to Stop with varenicline	B
Extended use of NRT	A
Extended use of vapes	A
Extended use of varenicline	A
Preloading NRT	B
Populations	
Black and minority ethnic groups	B
Children and young people Prevention and tobacco control Stop smoking interventions	 B I
LGBTQ+ communities	B–C
People experiencing homelessness	B
People in prison	C
People in routine and manual occupations	B
People who use cannabis	I
People with mental health conditions	B
People with severe mental illness (SMI)	B
People with substance misuse disorders and co-addictions	B
Pregnant women Behavioural support NRT NRT in teenage pregnancy Vapes	 A B ✓ B
Treated in secondary care with follow-up for at least 1 month	A
Treated in secondary care with follow-up for less than 1 month	B
Incentives	
General population	B
Incentives among pregnant women	A
Relapse prevention	
Extended behavioural support	A–B
Extended use of stop smoking medication/vape	A–B
Other strategies	I

6.2 Behavioural support

Behavioural support is a term that summarises multiple components of assistance with a quit attempt. Behavioural support interventions include multi-session group therapy programmes or individual counselling sessions, either in-person or by telephone or video-link.

Evidence-based behaviour change techniques (BCTs) that increase quit rates have been identified and should be the focus of behavioural support programmes.[78–80] These BCTs include: boosting motivation to quit, enhancing self-regulation and use of stop smoking aids, and improving the ability to cope with withdrawal symptoms, urges to smoke, and high-risk situations. BCTs are further summarised in **Part 2** of the guidance and all stop smoking practitioners should be trained in the delivery of these.

Providing behavioural support for people using pharmacotherapy, whether in-person or via telephone, increases quit rates (see **Table 4**).[77] Individual, group, and telephone counselling are effective, and their effectiveness increases with treatment intensity (i.e. contact time).[75,81]

Increasing the amount of behavioural support is likely to increase the chance of success by about 10% to 20%.[77] The optimal amount of support – in terms of both frequency and duration – is dependent on client need as determined by their level of nicotine dependence and motivation to quit. There is evidence that some client groups require more intensive support for a longer duration. These include, but are not limited to, pregnant women and people with severe mental illness (SMI).

Table 4: Efficacy of behavioural support

Type of support	OR (95% CI)
Group counselling[82]	1.88 (1.52 – 2.33)
Individual counselling[83]	1.57 (1.40 – 1.77)
Multi-session proactive telephone-based counselling[84]	1.38 (1.19 – 1.61)
Text-messages[63,85]	1.59 (1.09 – 2.33)
Digital apps[85]	1.00 (0.66 – 1.52)

Notes:
OR: Odds ratio, indicates how many times more likely the people receiving this treatment are to stop smoking versus not receiving any treatment. E.g. people receiving group support are 88% more likely to achieve abstinence compared with no support.

95% CI: 95% confidence interval, indicates the range of values that you can be 95% confident contains the true value. E.g. people receiving group support are between 52% and 133% more likely to achieve abstinence compared with no support.

Individual behavioural support

There is strong evidence that individual behavioural support is effective in supporting quitting.[83] The evidence is greatest for multi-session support delivered by a trained stop smoking practitioner whose main role is delivering stop smoking support.[17]

Group-based behavioural support

Closed-group support, where the whole group starts together and has the same quit date, has the highest success rate of all forms of behavioural support.[82] Logistical challenges in coordinating and running these groups means they are not offered as frequently as individual support. Rolling groups, where people join the group at different stages in their quit attempt, do not have strong evidence of effectiveness.

Note: Allen Carr's Easyway (ACE) method of stopping smoking is identified in the 2022 NICE guidance as an effective stop smoking intervention.[74] However, NICE acknowledged that the lack of evidence limited their ability to place the intervention in a hierarchy in terms of effectiveness.[86] The two trials that evaluated ACE reviewed by NICE showed mixed results and had significant limitations.[87–89] Prior to the Cochrane Tobacco Addiction Group's infrastructure funding ceasing (along with all UK-based Cochrane groups) at the end of March 2023, they had not completed a review of this evidence due to the lack of studies. There was insufficient evidence to reliably place this method within our effectiveness hierarchy.

Telephone support

Telephone support has a similar effectiveness to group and individual support.[84] Multi-session proactive (practitioner contacts client) support is the most effective form.[84] There is less support for reactive (client contacts the service as needed) telephone support. Three or more calls have been shown to a have a greater benefit than one or two telephone interactions.[84] The benefit of telephone-based support in addition to intensive face-to-face support is unclear.[84] However, telephone support may serve as a method for extending treatment between face-to-face contacts.

Digital support

Digital support includes a wide variation of support, including:

- Automated text messaging
- Basic money saving calculator apps
- Personalised, interactive apps
- Highly complex digital platforms with access to real-life in-person support from NCSCT trained practitioners and stop smoking aids

Digital stop smoking interventions delivered via the use of information technology such as text messages or smartphone applications may assist with expanding the reach of LSSS among people who might not otherwise access support.

Automated text message interventions may be effective in supporting people to stop smoking when compared to minimal support, or alongside other forms of stop smoking support.[63]

At present, the research to make strong recommendations concerning digital interventions is lacking and we do not have clear evidence that they are as effective as face-to-face or telephone-based support from a trained stop smoking practitioner.[85] This does not necessarily mean digital interventions are not effective, however, and there is some limited evidence to suggest that they can have a positive effect on stopping smoking when compared to self-help or no intervention.[85,90,91]

We know that digital interventions should be designed to deliver the same evidence-based BCTs as other interventions to maximise their effect on smoking behaviours, in particular those that address cravings or anxiety.[90,91] There is some data to suggest that interventions that are personalised and interactive are more effective.[90] Furthermore, there is some evidence that the addition of digital interventions to in-person support can increase success with stopping smoking. However, this evidence is limited to four studies.[85]

Importantly, a recent study found the use of first choice stop smoking aids alongside digital support increased effectiveness compared to digital support alone.[92] This is consistent with evidence regarding the efficacy of stop smoking medications when delivered alongside behavioural support.[77,93]

Digital interventions provide both opportunities and threats in terms of inequalities. They could be more accessible and convenient to people who have the technology and knowledge to engage, but those with poorer technology access and capability will be excluded and further marginalised, contributing to worse health inequalities.

6.3 Stop smoking aids

Stop smoking aids include NRT, stop smoking medications (bupropion, cytisine and varenicline) and nicotine vapes. Stop smoking aids can be categorised as first choice and second choice based on how effective they are.[74]

First choice stop smoking aids are the most effective (see **Table 5**):

- **Combination NRT** (use of a nicotine patch plus a faster-acting NRT product)
- **Nicotine vapes**
- **Nicotine analogue medications** (varenicline and cytisine)

Second choice stop smoking aids include:

- Single-form NRT
- Bupropion

One of the main challenges of using stop smoking aids is ensuring clients use them in high enough doses for long enough, and use them correctly. The standard treatment course is 8 – 12 weeks. See **section 6.6** for extended use of stop smoking aids.

Table 5: Efficacy of stop smoking aids

First choice stop smoking aids	OR (95% CI)	4-week quit rates SSS
Combination NRT (patch plus fast-acting NRT product) [23,94,95]	1.93 (1.61 – 2.34)	56%
Nicotine vapes [23,96]	2.37 (1.73 – 3.24)	63%
Nicotine analogue medications Varenicline [23,97] Cytisine [23]	 2.33 (2.02 – 2.68) 2.21 (1.66 – 2.97)	59%
Second choice stop smoking aids		
Single NRT product [23,94,95] Patch alone Fast-acting NRT alone	1.55 (1.49 – 1.61) 1.37 (1.20 – 1.53) 1.41 (1.29 – 1.55)	43%
Bupropion [23,98]	1.43 (1.26 – 1.62)	–

Notes:
OR: Odds ratio, indicates how many times more likely the people receiving this treatment are to stop smoking versus not receiving any treatment. E.g. people receiving group support are 88% more likely to achieve abstinence compared with no support.

95% CI: 95% confidence interval, indicates the range of values that you can be 95% confident contains the true value. E.g. people receiving group support are between 52% and 133% more likely to achieve abstinence compared with no support.

6.3.1 First choice stop smoking aids

Combination NRT

NRT provides a clean form of nicotine, is very safe and there are only mild to moderate side effects associated with its use. NRT is typically used for 8 – 12 weeks, when risk of relapse is at its highest. NRT can be gradually reduced (using a step-down approach) over the weeks of use or the dose kept the same.

Combination NRT – combining the NRT patch with a faster-acting NRT product – gives superior relief of withdrawal symptoms and urges to smoke, and is **more effective in helping people quit than using just one form of NRT.**[74,99] Specifically, the patch provides a steady supply of nicotine throughout the day (helping with withdrawal symptoms and background urges to smoke) and the faster-acting NRT product can be used by clients in high-risk situations or in response to 'breakthrough' urges to smoke. Combination NRT results in long-term quit rates comparable to varenicline.

Nicotine vapes (electronic cigarettes)

Vapes (also known as electronic cigarettes or e-cigarettes) **are the most popular stop smoking aid in England**.[11] Vapes deliver an inhalable aerosol vapour to the user via a mouthpiece. There is no combustion involved, meaning the vapour does not contain carbon monoxide and other dangerous chemicals associated with tobacco combustion.

Nicotine vapes assist with managing withdrawal and urges to smoke by providing doses of nicotine.

Nicotine vapes are effective cessation aids and are recommended as a **first choice stop smoking aid.** [20,21,23,96] High-quality randomised controlled trials have found nicotine vapes to be an effective aid to quit smoking. The use of nicotine vapes as a stop smoking aid has been endorsed by NICE, the NCSCT, the British Thoracic Society, the Royal College of General Practitioners, the Royal College of Physicians, the Royal College of Obstetrics and Gynaecology, and the Royal College of Midwives.

While vaping is not risk-free, the latest review of evidence concludes that vaping, in the short and medium term, is **significantly less harmful than smoking cigarettes** and poses a small fraction of the risks of smoking.[21]

In the UK, nicotine vapes are regulated under the Tobacco Products Directive. Importantly, UK regulations have, since 2016, prohibited the use of any ingredient in nicotine-containing e-liquid that poses a risk to human health in heated or unheated form. The maximum amount of nicotine available in e-liquid sold in the UK is 20 mg per ml. Sales and provision of nicotine vapes to persons under the age of 18 is prohibited by law.

People who smoke cigarettes and vape (dual users) do not receive the same health benefits as those who switch completely to vaping.[21] Importantly, people who have never smoked should not start vaping.

Nicotine analogue medications

1. Varenicline

Licensed Varenicline is currently not available in the UK.

Varenicline is a prescription-only medicine that has been available in the UK since 2007. Varenicline reduces nicotine withdrawal symptoms and urges to smoke, and blocks some of the rewarding effects of smoking. Varenicline is a **first choice stop smoking medication** with strong evidence of its effectiveness.[23,97] Varenicline is twice as effective as bupropion and single-form NRT, and slightly more effective than combination NRT.[23,97] There had been concerns in the past about the link between varenicline and neuropsychiatric and cardiac events. Large high-quality studies have provided evidence that there is no link between varenicline and suicidal ideation, adverse neuropsychological events or worsening of cardiac events.[97,100–102] Varenicline is typically taken for 12 weeks. It has been shown to be safe and effective to extend treatment to 26 or 52 weeks for relapse prevention in clients who may benefit or as part of a Cut Down to Stop intervention.[100,102]

Unlicenced varenicline is available in the UK. Unlicenced medications are, unfortunately, not as accessible as licenced ones. Details on the medication, and how it can be obtained, are provided by Thistle Pharma in the further information link below.

Further information

NCSCT publications – Unlicensed varenicline – click here

2. Cytisine

Cytisine has been approved by the Medicines and Healthcare products Regulatory Agency (MHRA) as a prescription-only medication in the UK, and has been available since January 2024. While new to the UK, cytisine has been used as a stop smoking aid in Eastern European countries since the 1960s and has been approved for use in Canada since 2017.

Like varenicline, cytisine acts to reduce withdrawal symptoms and cravings by stimulating nicotine receptors. It also reduces the reward and satisfaction associated with smoking. A cytisine treatment course is 25 days. One of the benefits of cytisine is that it is relatively low in cost – the 25-day treatment cost is about £115.

Studies evaluating cytisine as a stop smoking aid have been promising and data suggests cytisine is **significantly more effective than both placebo and single-form NRT** in supporting quitting at six months.[97] The data comparing cytisine to varenicline suggests that it may not work quite as well as varenicline.[97]

Resources

NCSCT briefing – Combination NRT – click here

NCSCT briefing – Vaping: A guide for health and social care professionals – click here

ASH – Addressing common myths about vaping – click here

NCSCT briefing – Cytisine – click here

Further information

NICE – 2024 exceptional surveillance of tobacco: preventing uptake, promoting quitting and treating dependence – click here

6.3.2 Second choice stop smoking aids

Second choice stop smoking aids include single-form NRT and bupropion.[74,94] These medications have good evidence to show they increase the chance of quitting. However, they are less effective when compared to first choice stop smoking aids.

Single-form NRT

There is strong evidence that single-form NRT is **less effective than combination NRT.**[94] There is no evidence of significant differences in effectiveness between the different types of NRT product (patch, gum, lozenge, inhalator, etc).[94]

Bupropion

While bupropion has been shown to be effective as a stop smoking treatment, it is **less effective than first choice stop smoking aids.**[93,98,104] Bupropion has numerous contraindications and a relatively complex side effect profile, and for this reason it is considered a second choice medication.

6.4 New development in stop smoking products

Nicotine pouches

Tobacco-free nicotine pouches are small sachets that contain a nicotine extract which the user places between the lip and gum, allowing nicotine to dissolve and be absorbed in the oral cavity and enter the bloodstream. Nicotine pouches are a relatively new product that were introduced to the UK market in 2019. They are sold in tins and are available in a variety of flavours and nicotine strengths, ranging from 3 – 18 mg per pouch. Data indicates that nicotine pouches deliver nicotine more rapidly than some other oral nicotine-containing products (snus and nicotine gum).[105,106–108] Due to the lack of evidence of effectiveness, nicotine pouches are **not a recommended stop smoking aid,** although this could change in the future.

6.5 NRT preloading

NRT preloading involves the use of NRT before stopping smoking, generally one to a few weeks prior to the client's quit date. Nine studies have tested the effect of NRT preloading compared to using NRT from the quit date onward. There is moderate-certainty evidence of NRT preloading increasing rates of stopping smoking (RR 1.25, 95% CI 1.08 to 1.44).[94]

6.6 Extended use of stop smoking aids

Some clients may benefit from the use of stop smoking aids for extended periods, most often 3 – 12 months, of time. This is **safe practice and recommended if there is a risk of relapse** to smoking.[74,103,109] There is some evidence to show that extended use of stop smoking aids can be particularly useful in reducing rates of relapse among people with SMI.

6.7 Combining first choice stop smoking aids

First choice stop smoking aids **can be safely combined.** Combining drugs with different mechanisms of action, such as varenicline and NRT, **has increased quit rates in some studies** compared with use of a single product.[110,111] The combination of varenicline and NRT has been used among people with higher tobacco dependence, those who continue to experience urges to smoke and/or withdrawal symptoms, and those who have reduced their cigarette consumption but not quit completely.[110,112–117]

6.8 Client in priority groups

Clients with low tobacco dependence

There is limited strong evidence on the efficacy of stop smoking aids for people who are less dependent on tobacco, meaning those who typically smoke less than 10 cigarettes per day. However, **NRT or nicotine vapes will still be beneficial to these clients,** in particular those who struggle with urges to smoke.

Clients with higher tobacco dependence

People who are more dependent on tobacco generally benefit from higher doses of NRT or nicotine vapes. High-dose NRT is **well tolerated and safe among those who are more dependent on tobacco.**[118–120] Research has shown that a higher dose of NRT patch (42/44 mg or two patches) is more effective in managing withdrawal symptoms in those who are highly tobacco-dependent compared to a single NRT patch (21/25 mg).[118,121–123] There is also evidence that varenicline is more effective than NRT or bupropion in those who are more tobacco-dependent.[97]

Clients who are pregnant

NRT is **safe and effective** in supporting pregnant women to quit smoking.[124,125] The SNAP study found the NRT patch doubled four-week quit rates and did not result in adverse maternal or infant outcomes at two-year follow-up.[124] Routinely collected data from 44 LSSS in England of 3,880 pregnant women attempting to quit smoking showed the use of **combination NRT resulted in significantly higher four-week quit rates** (37%) than single-form NRT (25%) or no medication (16%).[126] Combination NRT can be used for pregnant women who smoke and might be particularly helpful to those who are more dependent on tobacco or who are struggling with withdrawal symptoms and/or urges to smoke.

While very little research exists on the safety of vaping during pregnancy, a recent study found that **vaping nicotine has a similar safety profile to NRT.** The study also found that nicotine vapes were **more effective than NRT** in preventing low birth weight and helping those who are pregnant to quit smoking.[127]

Varenicline, cytisine and bupropion are not licensed for pregnant and breastfeeding women.

Clients with mental illness

While the early period of stopping can be more challenging for clients with mental illness, evidence has shown that **stopping smoking does not adversely affect mental health.** If clients are psychiatrically stable at initiation of stopping smoking, tobacco dependence treatment does not worsen their mental state.[128,129] In fact, going smokefree has been shown to **improve mental health,** including a reduction in anxiety and depressive symptoms, and the size of the effect is the equivalent to taking antidepressants.[128,129]

The SCIMITAR study reported that success with stopping smoking could be increased with structured stop smoking support delivered over an extended period (12 weeks) alongside the use of stop smoking aids.[130,131] Identified as key to the study's success was the **flexible treatment and service delivery model.**

Combination NRT, vapes, varenicline and cytisine can be safely used by people with stable mental illness.[97,100,102] Stopping smoking, regardless of the use of stop smoking aids, may result in changes to mood and treatment response. It is recommended that people with mental illness who quit smoking be monitored for changes in mood, as this can occur when someone quits smoking. Evidence indicates **varenicline is one of the most effective treatments** for people with mental illness. The EAGLES study reported quit rates achieved with varenicline as superior to NRT, bupropion and placebo.[102]

Resources

NCSCT briefing – Smoking cessation and smokefree policies: Good practice for mental health services – click here

NCSCT briefing – Smoking Cessation Intervention for People with Severe Mental Ill Health: SCIMITAR+ Trial – click here

Clients with cardiovascular disease

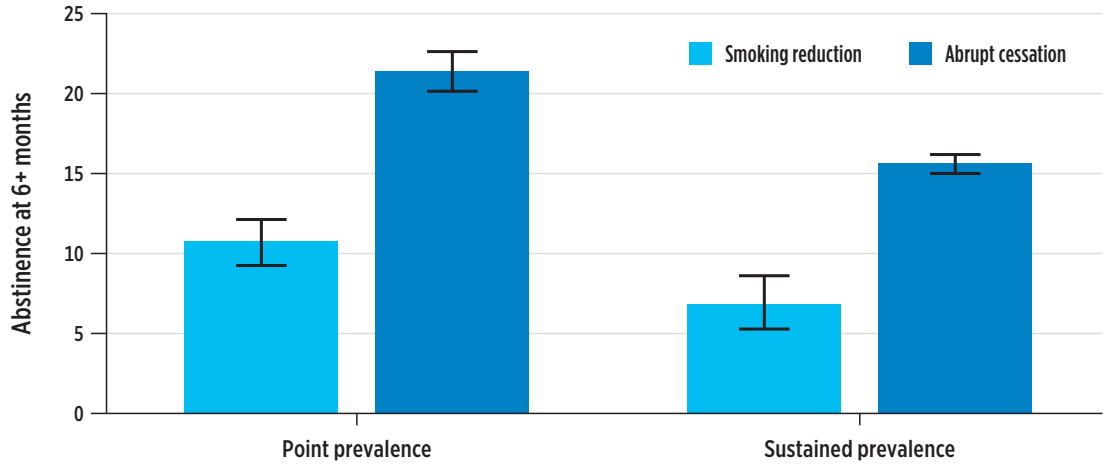
There is high-quality evidence that combination **NRT and varenicline can be safely used** in people with cardiovascular disease.[132,133] There is no evidence of any significant increase in any adverse cardiac outcomes or other ill effects to patients.

6.9 Quit method

6.9.1 Abrupt quitting

The standard way to stop smoking is by quitting abruptly on a designated quit day. Abrupt quitting is the preferred approach to quitting. People who gradually reduce their smoking do not successfully quit at the same rates as those who quit abruptly (see **Figure 7**). In fact, we know that **95% of people who have a single puff on a cigarette will relapse to smoking.**[134] One effective BCT involves commitment to the 'not-a-puff' rule, not having even a single puff on a cigarette after the quit date.[134–137]

Figure 7: Long-term abstinence rates using NRT by quit method



Resources

NCSCT briefing – The 'Not-a-Puff' rule – click here

6.9.2 Cut Down to Stop (CDTS)

Individuals who feel unable to commit to stopping smoking abruptly can be supported to cut down the amount they smoke **with the help of NRT, a nicotine vape or varenicline** as part of a structured Cut Down to Stop (CDTS) programme. This strategy is supported by NICE.[74] CDTS is different from the harm reduction strategy of supporting reduced tobacco consumption because, with CDTS, the intention is to **stop smoking completely in the near future.** CDTS should be viewed as a second choice stop smoking support intervention, to be implemented when quitting in one go is not suitable, in order to extend the reach and impact of LSSS.

There is strong evidence CDTS interventions are significantly more effective when they **combine structured behavioural support and a first choice stop smoking aid.**[103] The use of NRT or varenicline as part of CDTS has been shown to significantly increase success and is associated with higher long-term abstinence rates, as well as reducing daily smoking.[103]

NRTs that were previously licensed only for abrupt quitting have recently been granted a new licensed indication called 'cut down to stop', 'nicotine assisted reduction to stop (NARS)' or 'cut down to quit (CDTQ)'.

CDTS has been shown to be particularly useful in engaging **people experiencing homelessness and people with SMI** in stop smoking support. Therefore, staff who are working with these priority groups should be trained in supporting clients with a structured CDTS programme.

CDTS is **not recommended for women who are pregnant** due to the significant risk of tobacco exposure to the fetus.

6.10 Incentives

Financial incentives, including monetary incentives and vouchers, have been used to promote and reinforce stopping smoking. There is good evidence that incentives **improve smoking cessation rates and are cost-effective.**[138] The effectiveness of incentives appears to be sustained even after the withdrawal of incentives. There is particularly good evidence that incentive schemes **can double rates of quitting among pregnant women,** both at the end of pregnancy and post-partum.[138,139] The cost-effectiveness of financial incentives among pregnant women is particularly good, given the offsetting of costs that would result from smoking-related complications to pregnancy and birth.[140] For this reason, incentive schemes for supporting smoking cessation among pregnant women have been endorsed by NICE.

Resources

ASH briefing – Evidence into Practice: Supporting smokefree pregnancies through incentive schemes – click here

6.11 Interventions that are not recommended

Table 6 provides a summary of those interventions that are not recommended due to insufficient evidence or evidence of no effectiveness.

Table 6: Other interventions

Intervention / product
Some evidence of effectiveness but not currently recommended
Rapid smoking[141]
Allen Carr's Easyway seminars[87–89]
Insufficient evidence: not currently recommended
Nicobrevin
NicoBloc
Glucose
Lobeline[142]
Nicotine pouches
St John's Wort
Evidence of no effectiveness: not recommended
Hypnosis[143]
Acupuncture[144]
Acupressure[144]
Laser therapy[144]
Electrostimulation[144]
Anxiolytics[145]

Resources

OHID – Public Health Profiles (Fingertips) – click here

OHID – Local Tobacco Control Profiles – click here

ASH – Economic and health inequalities dashboard – click here

ASH – Tackling health inequalities toolkit – click here

The Khan review: Making smoking obsolete – click here

Levelling Up the United Kingdom White Paper – click here

Core20PLUS5 – click here

ASH – Impact of smoking on Core20PLUS5 – click here

Major conditions strategy: case for change and strategic framework – click here

Health equity in England: the Marmot review 10 years on – click here

Asthma and Lung UK – Clearing the smoke:
Levelling up health by stamping out tobacco – click here

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Part 2: Commissioning stop smoking services

Summary guidance:
Commissioning stop smoking services

- Commissioning effective stop smoking services should be a top public health priority.
- Commissioning should be based on intelligence and supported by a local vision and strategy that includes clearly defined goals and targets for increasing reach, quality, and outcomes of LSSS with a focus on high priority groups and consistent with principles of stop smoking support.
- ICB Joint Health and Wellbeing Strategies (JHWSs) and Joint Forward Plans (JFP) provide the opportunity for smoking to be addressed as part of the ICB prevention agendas.
- The new funding from national government should be guided by an evidence-based analysis of how best to meet local needs to extend the reach and effectiveness of services.
- Effective stop smoking interventions should be available to all, but the scale and intensity of interventions must be proportionate to the most disadvantaged. Partnerships and collaborative working across systems should be used to enhance engagement with priority groups.
- Maximising the number of people who use the services requires a strong communication and outreach plan to ensure that people who smoke in all target categories: 1) are fully aware of the services on offer and the benefits of using them, 2) have any barriers to attending the services addressed, and 3) be regularly prompted to use the services, from a range of sources including health professionals, community organisations and local media.
- The communication and outreach plan should include development of strong NHS referral networks with a focus on priority populations.
- The most effective method of stopping smoking is a combination of first choice stop smoking aids and behavioural support delivered by a trained stop smoking practitioner. The effectiveness and reach of the services should be maximised by offering a range of evidence-based options for people who smoke. Treatment should include access to all first choice stop smoking aids. It should also include behavioural support from a trained stop smoking practitioner, delivered individually or in groups, in person, by phone or online. Support via a mobile application or an automated chat or messaging facility should also be considered. LSSS should have mechanisms to support extended use of treatment and aids for those at risk of relapse.
- Services should have clear pathways for continuing treatment for people who smoke who are discharged from NHS inpatient care.
- Investment in a well trained, highly qualified workforce will have direct impact on service delivery outcomes. All staff who deliver support to quit attempts, in specialist stop smoking and community settings, should be NCSCT Certified Stop Smoking Practitioners.

Aim and objectives of part 2

Aim

To support the commissioning of effective, evidence-based local stop smoking services, referral systems and tobacco control networks.

Objectives

This guidance will:

- Highlight information and intelligence used to commission stop smoking services that reflect local needs and provide guidance on measuring the success of commissioned services.
- Make recommendations on identification and referral of people who smoke, including national referral pathways.
- Describe effective communication, marketing and branding strategies.
- Provide guidance on intervention principles to protect consistency, quality and effectiveness of services, and summarise the evidence of effective methods of stopping smoking.
- Review models of delivery and their place in the current commissioning landscape.
- Provide advice on balancing reach and efficacy of interventions when commissioning services.
- Highlight considerations for targeting priority groups to reduce health inequalities.

1.0 Effective commissioning of Local Stop Smoking Services

1.1 Principles for effective local commissioning, partnerships, and investment

- Local Stop Smoking Services (LSSS) need appropriate **investment** and **resources targeted** to meet local needs.
- Commissioning decisions should be based on **local intelligence** and **evidence of what works.**
- **A system approach** to addressing tobacco use requires all relevant partners to work together to commission evidence-based comprehensive stop smoking support for the people who need it most.
- Services should be person-centred and **co-designed with service users.**
- A **checklist for commissioners (Annex B)** is designed to support decision making and implementation of effective commissioning of LSSS.

1.2 Information and intelligence: meeting local needs

Person-centred integrated care delivers services and systems that are designed around the individual and outcomes important to them, developed with those who use or provide services.

Local intelligence and local needs assessments are central to high-quality planning, commissioning, and service delivery. Services and interventions that are configured to meet local needs, and have evaluated what support local populations are likely to engage with, will make the greatest contribution to reducing inequalities and disparities, as well as being the most cost effective.

Commissioning should take into consideration the needs of **priority groups** who face additional barriers to accessing services and to quitting smoking. Services should enable easy access to all people who smoke.

1.2.1 Tools to guide local needs assessments

The following tools are recommended to guide local needs assessments:

The **CLeaR local tobacco control assessment** offers free self-assessment and an opportunity to bring partners together for in-depth assessments of their tobacco control work. CleaR is based on evidence of the most effective tobacco control methods, effective leadership for comprehensive action and results shown by outcomes achieved against national and local priorities (see **Resources** below).

A **health equity impact assessment** is helpful when commissioning LSSS to ensure that they are responsive to meeting the needs of local high priority groups. It can be carried out at any stage of the commissioning cycle to identify actions that can be taken to tackle health inequalities.

The Local Tobacco Control Profiles provide information on the extent of tobacco use, tobacco related harm and measures being taken to reduce this harm at a local level. The aim of these profiles is to assess the effect of tobacco use on local populations (see **Resources** below).

The **Action on Smoking and Health (ASH) Ready Reckoner** is an easy-to-use cost calculator showing the costs at national, regional, integrated care board (ICB) and LA levels (see **Resources** below).

Local Joint Strategic Needs Assessments (JSNAs) are key to ensuring that services are aligned to the needs of the local population. The best JSNAs are undertaken through strong and collaborative partnerships across local services, using the analysis and assessment to drive innovation and improved ways of working. It is important to ensure that they are completed and reviewed regularly.

The National Institute for Health and Care Excellence (NICE) Guidance NG209, Tobacco: preventing uptake, promoting quitting, and treating dependence covers support to stop smoking for everyone aged 12 and over (see **Resources** below).

Resources

CLeaR local tobacco control assessment – click here

Local Tobacco Control Profiles – click here

ASH Ready Reckoner – click here

ASH Return on Investment calculator – click here

NICE Guidance NG209 – Tobacco: preventing uptake, promoting quitting and treating dependence – click here

1.3 Cost-effectiveness of LSSS

Smoking cessation remains an incredibly cost-effective treatment. Analysis consistently shows that, when smoking cessation interventions are effective, they are cost-effective.[1,2] The cost-effectiveness of LSSS are well below the NICE threshold of £20K to 30k per quality adjusted life year (QALY), above which interventions are unlikely to be recommended. This is largely due to their relatively low cost and the big impact that stopping smoking has on health outcomes.

1.3.1 Cost of smoking locally

The financial costs of smoking to individuals, communities, regions and the nation are significant, as described in **Part 1.** The ASH Ready Reckoner is an easy-to-use cost calculator showing the costs at national, regional, ICB and LA levels (see **Resources** above).

1.4 Funding of LSSS

The national tobacco control team use the finance data reported in LSSS quarterly data returns to carry out ad-hoc analysis of the cost-effectiveness of stop smoking services (see **Part 4, section 1**).

The analysis is used to understand which regions are investing the most into stop smoking services and is also mapped against other data, such as smoking prevalence, to help target further investment into LSSS and tobacco control.

Total spend on LSSS and tobacco control has fallen significantly, from £148.5m in 2013/14 to £91.4m in 2020/21. Reduced budgets have led to some services ceasing to provide universal support (e.g. restricting support to certain patient groups), limiting the duration and/or intensity of behavioural support, delivering support through less effective integrated health behaviour services and using digital apps as primary support.

A recent upturn in spend has been noted as local governments identify the important role addressing tobacco use and supporting stopping has on local health, social, and inequality goals. Furthermore, new investment as part of the government **Stopping the Start** plan, beginning in 2024/25, signals government commitment to reinvesting in LSSS.

Resources

ASH toolkit for developing a system-wide tobacco control programme – click here

1.5 Stopping the Start: new five-year government plan

The **Stopping the Start** plan includes an additional £70m funding per year for LSSS, beginning in 2024/25, for a period of five years. This funding will be used to help bring all services in line with quality standards set out by National Centre for Smoking Cessation and Training (NCSCT) guidance. Government guidance on this framework, the grant agreement process and expected reporting mechanisms is available below.

This document's guidance is intended to support commissioners of LSSS with ensuring new investment in supporting people with stopping is grounded in local needs, focuses on priority groups and is commissioned and delivered in line with latest evidence and intervention principles.

Key success indicators for the funding are:

- Number of recorded quit dates per 100,000 people who smoke
- Percentage of people engaging with services who successfully quit smoking (recorded quit rate)
- Number of recoded quits per 100,000 people who smoke

The Stopping the Start plan also includes two priority initiatives:

1. **Swap to Stop Programme**
2. **Financial incentives scheme for pregnant women**

Additional details on these priority initiatives are found in **sections 5.5** and **5.6** respectively.

Resources

Stopping the Start – click here

2.0 A local systems partnership approach to commissioning LSSS

Key points

- A **local vision or strategy that sets out the agreed ambition for tobacco control** is important for reducing local smoking prevalence and for facilitating synergistic working to increase **demand** for, and **success** of, LSSS.
- LSSS that are **commissioned as an element of a comprehensive tobacco control strategy** will produce the greatest impact on **health inequalities** and **disparities.**
- **Well-functioning partnerships** between LA public health, the NHS, community pharmacies and other health and care services that deliver support at scale will better serve needs, expand the reach of services and ensure greatest value for money.
- **Partnerships and alliance with voluntary, community and social enterprises** will enhance reach and access to services by priority groups.
- **Pathway development across systems supports person-centred smoking cessation.**

2.1 Local tobacco vision and strategy

Local directors of public health are a key driver for a local ambition and provide the leadership to bring organisations together and champion the programme. **Local strategy** should focus on reducing **uptake of tobacco** and **increasing the number of quit attempts, and number of successful quits, amongst people who smoke.**

Mapping and understanding the existing tobacco control and smoking cessation landscape is a critical first step in this process. It is important that a regional plan does not replace or duplicate activity happening at a local level. There are a range of boundaries and geographies to consider.

Strategies and visions have been shown to be most effective when localities have **individually committed to the local ambition.** Regional examples include the Fresh (North East) and Breathe2025 (Yorkshire and Humber) shared regional alliance target to achieve 5% smoking prevalence by 2025 and Buckinghamshire County Council's strategy of five-year targets for 2019 – 2024.

2.2 Joint Health and Wellbeing Strategies

Joint Health and Wellbeing Strategies (JHWSs) should be informed by other relevant local strategies and needs analyses. The JHWS is a unique opportunity for health and wellbeing board members to explore local issues and how they can be effectively addressed. Adopting an outcomes-based approach to smoking prevalence will help establish LSSS that fully meet the needs of people in the most cost-effective way.

Joint Forward Plans

ICB Joint Forward Plans provide the opportunity for smoking to be addressed as part of the ICB prevention agenda. There are two recommended sets of outcomes for smoking for inclusion in ICB Joint Forward Plans:

- Reduce prevalence of smoking across all social groups to put them on track to meet the government's smokefree 2030 ambition.
- Systematic screening, assessment and treatment of people, especially inpatients in acute and mental health settings and in maternity services.

2.3 LA and NHS partnerships and pathway development

Investment from the NHS to develop Tobacco Dependence Services (TDSs) in primary care, acute inpatient, inpatient mental health and maternity settings provides opportunities to engage more people in quitting. Through **Transfer of Care,** LSSS have a key role to play in providing continued support on discharge from hospital to patients who initiate a supported quit attempt with the NHS TDS. Strong working relationships between the NHS and LA that include partnership agreements, **establishing local referral pathways for Transfer of Care from inpatient support to LSSS, performance monitoring and quality improvement cycles** are best practice. See **section 4.7** for further information.

2.4 The roles of integrated care boards and integrated care systems

The independent review of **integrated care systems (ICSs)**, published in April 2023, reinforced the crucial role that ICSs have to play in prevention of ill health.[3] Effective tobacco control is essential if ICSs are to achieve their goals in relation to inequalities. Commissioners and providers of LSSS should use ICS plans, health and wellbeing strategies and other relevant local strategies and plans to make the range of stop smoking interventions accessible to people.

The commitment of ICBs to wider tobacco control is diverse, with some having detailed plans to address inequalities and others remaining focused almost solely on implementing the NHS TDS. This perhaps reflects the challenge faced by ICBs of balancing priorities to deliver treatment to support people to quit smoking with wider action to bring down the prevalence of smoking. At a minimum, LA JHWSs should include tobacco control measures.

ASH findings from a survey of ICBs, reported in June 2023, found that a key factor in the successful implementation of TDSs was ICB leadership.

Best practice highlight

An example of the power of joined-up working across an ICS is seen in the Humber and North Yorkshire Health and Care Partnership. They ensure services are seamless, making information and treatment easily accessible and making stopping smoking more achievable for everyone. They are also supporting NHS staff to quit smoking with an enhanced stop smoking service.

Click here for details

Resources

DHSC Guidance on JSNAs and JHWSs – click here

The Kings Fund – Prevention at scale through ICSs: Lessons from tobacco control – click here

ASH – Strategy and vision roadmap – click here

ASH – ICB briefing for Joint Forward Plans – click here

ASH – Integrated care systems and tobacco control – click here

ASH – Developing a system-wide tobacco control programme – click here

ASH – The end of smoking. A brief guide for local authority members and officers and their partners on Health and Wellbeing Boards – click here

ASH – 10 high impact actions for local authorities and their partners – click here

ASH – Resources for Integrated Care Systems – click here

ASH – Local Alliances Roadmap for evidence-based activity – click here

Association of Directors of Public Health North East Position Statement (ADPHNE) on helping smokers to quit – click here

Professor Robert West – Modelling to get us down to 5%. What is the data telling us and what will be the key to achieving this? – click here

The North East declaration for a Smokefree Future – click here

3.0 Service workforce and local leadership considerations

3.1 Workforce and staffing

Stop smoking services are the staff who work in them. It is a false economy to limit investment in this core service component. Appropriate salaries and work environments, and structures that support staff, including training, supervision and continuing professional development, should be a minimum quality standard. Building local capacity ensures services are fit to contribute effectively to wider tobacco control objectives.

Key points

- **Leadership:** Experienced stop smoking leads are important to manage and supervise service delivery and direction.
- **Pay structure:** Invest in appropriately remunerated staff to deliver better outcomes. To work effectively, LSSS should be configured with:
  - a service manager with up-to-date and extensive knowledge and experience of providing specialist behavioural support and supervision for smoking cessation. Agenda for Change (A4C) Band 7 equivalent is the minimum recommended for service managers.
  - a core group of stop smoking practitioners trained to an appropriate standard and working from evidence-based treatment manuals. A4C Band 4 equivalent is the recommended minimum for stop smoking practitioners.
  - appropriate administration capacity and staff training.

Across LSSS there is a mix of grades and salaries as practitioner roles and responsibilities vary considerably. Many practitioners working with priority groups and clients with complex needs are employed at A4C Band 6 equivalent.

A core team of specialist staff providing intensive support to the most complex clients, combined with community pharmacy and general practice staff who provide less intensive stop smoking support as an adjunct to their day job, will provide a cost-effective workforce that makes the best use of limited budgets.

NHS Long Term Plan (LTP) funding for inpatient Tobacco Dependence Advisors (TDAs) was modelled on A4C Band 3. However, some trusts have recruited practitioners at Bands 4 to 6.

3.2 Training

Key point

- **Training:** Properly trained staff deliver better quit outcomes. Investment in both induction training and professional development for LSSS staff is highly cost-effective.

Stop smoking practitioners who have NCSCT certification have significantly better quit rates than untrained practitioners.[4,5] Specialist stop smoking practitioners – meaning those whose main role is providing stop smoking support – have quit rates twice those of community stop smoking practitioners, who have a generalist role in pharmacies and general practice.[4–7]

To maintain the effectiveness of interventions, it is important that those providing support are NCSCT Certified Stop Smoking Practitioners, receive face-to-face (virtual) training in line with the national training standard, receive support and supervision, have access to continuing professional development and participate in update training at least once a year.

Quality standards:

- All people who deliver support to stop smoking, including those in specialist stop smoking and community settings, should be NCSCT Certified Stop Smoking Practitioners.
- LSSS stop smoking practitioners working with priority groups, such as pregnant women and people with mental illness, should complete the relevant specialist NCSCT online training and assessment programme(s).
- On the job supervision and mentorship, and annual continuing education, should be available to ensure practitioners are up to date on the latest evidence-based practice.
- It is recommended that practitioners support a minimum of 20 clients to set a quit date each year (see **Further information** below).

Further information

NCSCT guidance – Minimum number of clients – click here

Training

NCSCT Online training and assessment programme – click here

NCSCT Training Standard – click here

NCSCT Competences required for delivering a Standard Treatment Programme – click here

3.3 Engagement with the tobacco Industry

There is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests. The UK is a party to the World Health Organisation (WHO) **Framework Convention for Tobacco Control** (FCTC), a global health treaty designed to help countries work to eliminate the harm caused by tobacco. WHO guidelines are intended to protect public health policy from the influence of the tobacco industry and state: *'In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.'*

All LSSS should have a strict policy to avoid contact with the tobacco industry. This includes no funding, sponsorship or influence from the tobacco industry on LSSS. There should be no direct contact between LSSS staff and tobacco industry representatives.

The FCTC defines the tobacco industry as 'tobacco manufacturers, wholesale distributors and importers of tobacco products'. This includes, but is not limited to:

- organisations or individuals with commercial or vested interests in the tobacco industry
- those that receive funding from the tobacco industry
- those that work to further the interests of the tobacco industry, including organisations with directors from the tobacco industry
- tobacco growers
- associations or other entities representing any of the above
- industry lobbyists

3.3.1 Nicotine vapes and the tobacco industry

Some nicotine vapes are manufactured and marketed by the tobacco industry. However, there are many independent (non-tobacco industry) sector nicotine vaping products to choose from. In the UK the largest share of the market is independent vape manufacturers. Article 5.3 does not mean that you cannot support people who want to use tobacco industry products, but it does mean that you should avoid contact with the manufacturers and marketers of these products to avoid any possible influence in health policy and practice.

Further information

WHO – Framework Convention on Tobacco Control (FCTC) – click here

WHO – Guidelines for implementation of Article 5.3 – click here

Guidance for government engagement with the tobacco industry – click here

Engagement with the tobacco industry: Guidance for local government – click here

4.0 How to reach people who smoke and promote quitting

4.1 Principles for increasing reach and access to support to quit

1. Engage with people who smoke to motivate quit attempts.
   - **Promote services through local and regional media channels** to motivate people who smoke to make a quit attempt and raise awareness of the support available for people who want to stop smoking.
   - **Re-engage with past service users:** follow-up contact at three, six and 12 months post-quit date or Transfer of Care.
   - **Use real local people in case studies.**
2. Let people who smoke know that support exists locally, how to find it, and what the offer is.
   - **Advertising LSSS as widely as possible** increases the number of people making and being successful with a quit attempt.
   - **Ensure person-centred, online and hard copy information is available** (and kept up to date) about the range of stop smoking support, the benefits of using each of the options, the commitment required and how to access them.
   - A **single point of access** to all support services with a dedicated helpline, as well as digital access, is best practice.
   - Include the most locally prevalent non-English languages and British Sign Language in communications. Interpreter services should be available.
3. Train and support healthcare professionals to deliver Very Brief Advice (VBA+).
   - **Everyone** in contact with health and social care services should be routinely asked about their smoking status, and given advice and referral as appropriate, using **VBA+.**
   - **All** health and social care staff should receive **training in VBA+** and refresh this training regularly.
4. Ensure all referral pathways are easy to access and navigate.
   - **Ensure clear, efficient, and seamless referral pathways are embedded** throughout health and social care services.
   - **Consider Opt Out** as opposed to Opt In referrals.
   - **Proactive case finding** of people who smoke within health care settings (e.g. sending invitation letters to patients recorded as smoking in general practice records) can reach additional people who smoke.

5. Ensure referrals are responded to effectively.
    - **Responding to referrals** within two working days (or one working day for pregnant women) builds on motivation to quit and helps to engage people in stop smoking support.
    - **Client self-booking** of the initial appointment is the optimal option.
6. Ensure that stop smoking support is delivered in multiple settings at different times throughout the day and week that appeal to priority groups.
    - **Ensure stop smoking support is routinely offered,** and made **easily accessible,** to all people who smoke, particularly priority populations and those identified as at risk in the needs assessment.
    - **Take the service** to people who smoke in locations such as housing association premises, homelessness services and primary care settings.

4.2 Communication and marketing to clients

Motivating people who smoke to make quit attempts and encouraging them to use the most effective methods available is a critical part of tobacco control strategy to reduce smoking prevalence and save lives.

Ensure communications and marketing strategies are:

- Proven to be effective, preferably with a good evidence base and developed through local audience research.
- Offer hope and help. Use 'what' and 'how to stop' messages that are non-judgemental, empathetic and respectful. Use testimonials and case studies from local people who used to smoke.
- Involve community pharmacies in local campaigns and maintain links with other professional groups such as dentists, fire services and voluntary groups.
- Ensure campaigns are sufficiently extensive and sustained to have a reasonable chance of success. Link with national campaigns such as Stoptober.
- Consider targeting and tailoring campaigns towards priority groups.
- The government is investing an **additional £5 million** in 2024 – 5 and **£15 million per year** in 2025 – 6 and 2026 – 7 to support stop smoking campaign activity.

The Department of Health and Social Care's (DHSC's) Better Health is the overarching brand for government health campaigns. The Quit Smoking section (which has replaced the Smokefree site) of the Better Health site includes a search engine for LSSS and details of the **NHS Quit Smoking app.**

Better Health campaigns are intensively researched and tested and can be adapted for local requirements where necessary. DHSC can work with LAs that want to use national campaigns locally, including helping them to co-brand and signpost to local services.

If you would like to discuss this, please contact: **partnerships@dhsc.gov.uk**

The Campaign Resource Centre is part of the Office for Health Improvement and Disparities (OHID). It contains a wide range of resources for use in motivating and engaging with people who smoke which LAs are encouraged to use (see Further information below). New materials are made available as campaigns evolve.

People who smoke need information on locally available support. Marketing is critical to enable people to identify what is available and what would work for them. A simple website that sets out the range of options, including self-support, and has links to other sources of information is recommended.

Let local people who smoke know where you are and what is available. Strategies for promoting local services should be supported by research and based on local intelligence, including a JSNA.

Jointly funded and integrated local activity over a wider geographical area will co-ordinate and make better use of funding. Where possible, local communications activity should be integrated with regional and national campaigns to enhance effectiveness and avoid duplication (see Further information below).

Communications campaigns are a highly effective behaviour change intervention that can motivate people who smoke to try to stop smoking and to access the most effective stop smoking aids and support.[8,9] **Regional targeted behaviour change campaigns** will inform and motivate people to access interventions.

Health and social care professionals are a highly effective part of communicating health messages and explaining the links between smoking and illness. Local public health experts can communicate the impact of smoking on local communities.

Services should ensure that key communication materials on access to support is provided in the most locally prevalent non-English languages and British Sign Language. Access to interpreter services, including British Sign Language, is a minimum standard.

Websites and services should be accessible and comply with accessibility regulations to ensure as many people as possible can use them (see **Further information** below).

4.3 Branding of stop smoking services

All service providers can use the Smokefree brand, providing its use is in accordance with the brand guidance (see **Further information** below). Where NHS services are provided by NHS organisations, they should be branded with their NHS organisational logo so that it is clear who is accountable and responsible for the service (see **Best practice examples** below). The overall design of materials must follow the NHS Identity Guidelines.

Best practice examples

Fresh – Media Communications and Education – click here

Stop Smoking London – click here

Resources

ASH – Evidence into Practice:
Motivating quitting through behaviour change communications – click here

Further information

Dr Sharon Cox – Supporting smokers to stop:
Who needs the most support to stop and what works best? – click here

DHSC Campaign Resource Centre – click here

NICE Guidance on planning mass media campaigns – click here

Guidance on accessibility requirements for public bodies – click here

NHS Identify guidelines – click here

For further information on **communications and marketing resources,** see **Annex C.**

4.4 Very Brief Advice on Smoking (VBA+)

Identification and referral of people who smoke creates an opportunity for them to make a supported quit attempt. In line with **Making Every Contact Count (MECC)**, systematic identification of people who smoke and delivery of VBA+ by health and social care professionals at every opportunity prompts quit attempts and encourages use of the most effective stop smoking support available. The original VBA model was updated to **VBA+** in 2021. The updated model includes advice on tailoring the referral to the best locally available stop smoking support.

VBA+ is a 30-second lifesaving intervention delivered by health and social care professionals and community workers that triggers quit attempts. There are three elements to **VBA+**: establishing and recording smoking status (ASK), advising on how to stop smoking (ADVISE), and offering help with stopping (ACT). VBA+ is designed to promote quitting and generate referrals to LSSS.

VBA+ is recommended by NICE as evidence-based and cost effective.[10] VBA+ can be easily delivered by all health and social care professionals working in any setting.

Further information

NCSCT – Very Brief Advice+ – click here

Making Every Contact Count – click here

Training

NCSCT VBA+ Training for health and social care workers – click here

NCSCT VBA+ for pregnant women – click here

NCSCT VBA+ for homelessness services – click here

e-learning for healthcare – Alcohol and Tobacco Brief Interventions – click here

e-learning for healthcare – Saving Babies' Lives VBA training – click here

e-learning for healthcare – MECC programme – click here

NHS-NCSCT Inpatient Acute and Mental Health Admission Team training – coming soon

4.5 Engagement with, and training of, health and social care professionals

Providing training programmes and information to health and social care professionals is not guaranteed on its own to ensure identification and referral of people who smoke into local services. In its 2018 report Hiding in Plain Sight, the Royal College of Physicians identified that education and training for healthcare professionals in treating tobacco dependency is inadequate.[1]

Barriers to engagement in smoking cessation include:[1]

- Competing demands on staff time and resources
- Lack of knowledge
- Professional role and identity
- Lack of patient motivation
- Smoking among staff and/or health and social care professionals
- Poor referral pathways

Enabling factors include:

- Dedicated local leadership
- Appropriate training
- Raising awareness of resources
- Clear guidelines and referral pathways for staff
- Support for staff to quit smoking
- Smokefree champions in NHS wards/departments

Working in partnership with local health and care system leadership to remove barriers and increase engagement with professionals is recommended.

Further information

Hiding in Plain Sight: Treating tobacco dependency in the NHS – click here

4.5.1 Supporting NHS staff with stopping

There are more than one million people working in the NHS. This offers an opportunity to support workplace interventions to assist stopping among NHS staff. The NHS has an important role in leading by example in addressing tobacco use among staff, promoting quitting, and providing access to evidence-based stop smoking support. In addition to the individual benefits to staff, health and social care professionals who stop smoking are known to be more likely to deliver VBA+ and tobacco dependence support to patients.[1,2]

A new digital tobacco treatment service will be launched early in 2024 by NHS England (NHSE), with the choice of three apps that will provide behavioural support, nicotine vapes and/or NRT to people who smoke and want to quit. Initially for NHS staff, the scheme will be rolled out to the wider population after an assessment of effectiveness.

4.6 Referral pathways by setting and client group

To support effective referral of all clients, but notably those in priority groups, it is important to ensure efficient pathways are established and integrated with the various health and social care settings. These include primary and secondary care, mental health and maternity services, and homelessness and social housing groups. It is also important to include private healthcare providers and voluntary, community and social enterprises.

See **Part 3** for further information and resources.

4.7 The NHS Tobacco Dependence Service (TDS)

There is strong evidence to show that tobacco dependence treatment initiated in hospital will be more successful when follow-up support is provided for a **minimum of one month post-discharge**.[1,11] Some patients will need **more intensive and longer support to remain smokefree,** including those with severe mental illness (SMI).

4.7.1 Post-discharge follow-up support (Transfer of Care)

The NHS TDS pathway includes Transfer of Care to stop smoking support following discharge from hospital for those who have engaged with support and initiated a quit attempt. The pathway recommends patients from acute trusts be followed for a **minimum of 28 days post-discharge** and patients discharged from acute mental health trusts for up to **12 weeks post-discharge.**
The extended follow-up support for people discharged from acute mental health trusts is due to the known increase in risk of relapse in this priority group. Ongoing support should include both behavioural support and stop smoking aids.

4.7.2 Guidance for transfer of care from NHS acute and mental health trusts to LSSS

LSSS have an important role to play in supporting patients following discharge with follow-up support. Unlike other referral pathways, patients referred from inpatient acute and acute mental health trusts will have received specialist tobacco dependency support and stop smoking aids (most commonly combination NRT) during their inpatient admission. As such, post-discharge follow-up may be viewed as a **Transfer of Care** and referral pathways should be in place to allow LSSS to deliver complementary high-quality support post-discharge.

Transfer of Care should recognise that quit dates will not be set with LSSS as clients are already engaged in stop smoking support. This document provides new guidance and working definitions to support LSSS with the inclusion of Transfer of Care clients in national monitoring data sets (see **Part 4**). Reporting the 28-day outcome for Transfer of Care clients back to the referring NHS trust is best practice as this is a mandatory performance indicator for trust tobacco dependence treatment programmes.

Principles for post-discharge follow-up support:

1. **Partnership and system design**

   - **LA representation on Multidisciplinary Project Steering Group.** LA representation and early engagement with trust or Regional Project Steering Group.
   - **Cross-organisational pathways developed.** Agreed pathways should ensure that care for patients is seamless when they change organisations, such as when transferring into LSSS or social care services. This should include decisions on any criteria that would direct patients to post-discharge service providers that best meet their needs.
   - **Data systems and data sharing.** Data systems that capture and report on patient smoking and delivery of stop smoking interventions. They should capture inpatient smoking data, including the requirement to record the 28-day smoking status post-discharge and, where possible, record smoking status at 12 weeks to verify long-term quits. These are all key to measuring the reach and impact of service delivery for both the NHS and LSSS. Data sharing arrangements will enable streamlined data collection and reporting. This includes data sharing agreements. Business intelligence and analytical services departments should be consulted as early as possible. Please refer to the national mandatory **Tobacco Dependence Programme Patient Level Data Collection** (see **Further information** below).
   - **Assign roles for delivering post-discharge follow-up support at a regional and/or ICS level.** This may involve one or more services providing follow-up support for all trusts in the region/ICS. This practice assists with consolidating work and addressing barriers and complexities related to geographic service delivery boundaries.
   - **Governance and quality assurance processes that incorporate patient experience.** Regular quality assurance processes, including quality improvement plans, that are reported to senior team members. These would ideally include both the inpatient and LSSS experience.

2. Referral and specification for LSSS response

- **Seamless support.** There is a need for well-coordinated, efficient pathways that provide **seamless support for people** in the community following discharge.
- **Simple digital referral processes.** Try to make the process of referral through discharge pathways as easy and straightforward as possible, such as by using a one-click electronic referral method.
- **Sufficient detail accompanying referrals to allow for seamless Transfer of Care.** LSSS and trusts should agree to the information that accompanies referrals to ensure LSSS can support Transfer of Care clients in a seamless manner.
- **Rapid Transfer of Care following discharge.** NHS commissioners and LAs should work together with provider organisations to ensure rapid access to post-discharge support from LSSS. This includes contact with the patient within 48 hours of discharge and multiple attempts (three to five recommended) to contact patients, reporting back to the trust for patients that have not been reached.
- **Provision of ongoing supply of stop smoking aids.** Mechanisms should be in place to ensure patients are provided with an ongoing supply of stop smoking aids for 10 to 12 weeks following their quit date. This may require innovative distribution methods for clients that are not initially seen in person.
- **Adaptation of service delivery model to support post-discharge follow-up.** The Standard Treatment Programme (STP) should be adapted to support Transfer of Care, as most patients referred to LSSS will already be engaged in a quit attempt. A tailored, bespoke conversation is recommended at the initial Transfer of Care contact.
- **Flexible service delivery options.** Not all patients discharged from hospital will be mobile or in good health. This is particularly true in the early post-discharge period. LSSS should be prepared to modify service delivery options to ensure ongoing support is delivered. This includes telephone-based support and hybrid service delivery models.
- **Follow-up support.** Support should be provided for at least four weeks post-discharge for patients discharged from acute trusts and 12 weeks for patients discharged from acute mental health trusts.
- **Triage algorithms discussed and in place.** Criteria should be in place for the referral of patients from trusts to the most appropriate community-based provider. This includes efforts to ensure the most qualified provider sees patients from groups at greatest risk of relapse, such as people who are heavily dependent or people with an SMI.
- **Strong working relationships between the trust Tobacco Dependence Team (TDT) and LSSS** providers and leadership.
- **Engaging post-partum women.** NHS trusts operate a maternity tobacco treatment pathway that is led by the trust inpatient maternity team. Where possible, continue engagement with women post-partum, as well as partners and other household members, to avoid relapse.

3. **Outcome measurement**

   - **Assessment of smoking status.** For Transfer of Care clients, the four-week assessment of smoking status will be measured 28 days following discharge from hospital using the Russell Standard (Clinical) (see **Part 4)**. Assessment of 12-week smoking status is also highly recommended to assess longer-term quit rates.
   - **Agreements for outcome assessment.** NHS trusts are required to report on self-reported 28-day post-discharge smoking status, with carbon monoxide (CO)-validated reporting of smoking status recommended. The reporting of 28-day smoking status avoids duplication and confusion among referred clients.

> **Further information**
>
> **Tobacco Dependence Programme Patient Level Data Collection** – click here

4.8 Financial incentives

4.8.1 Commissioning for Quality and Innovation (CQUIN)

The national CQUIN scheme is intended to complement and reinforce existing activity to deliver interventions to people who smoke.

All CQUIN indicators for smoking **are directly linked to CQUIN payments.**

LAs should progress the CQUIN locally by:

- Including it in all NHS Standard Contracts with eligible providers
- Promoting and supporting delivery of the CQUIN to local providers
- Cooperating with local trusts and community services to ensure smooth pathways exist to refer patients between services

See **Annex D** for further information.

4.8.2 Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is an annual reward and incentive programme for all GP practices in England and forms part of GP contracts to improve the quality of care. One of the key principles of QOF is that indicators should, where possible, be based on the best available evidence.

See **Annex E** for further information.

5.0 Delivering interventions

5.1 Principles of stop smoking support

Principles for high quality, effective stop smoking support are outlined below. These principles should guide local service commissioning and delivery.

Individual people (and priority groups) matter:

1. **The person who smokes should be at the centre of everything that we do.** A person-centred approach assesses the needs of people who smoke and is responsive to them. Offering flexible support and minimising barriers to accessing support is essential. This includes individual tailoring of services and consideration of how and where services are delivered.
2. **Seamless support.** The support that a person who smokes receives should be continuous, including where support starts in one setting and continues in another (Transfer of Care).
3. **Enhanced patient-centred communication, family and friend involvement, access to information and shared decision making.** These are increasingly important, as smoking is found in the most deprived communities with lower education levels, lower health literacy and limited access to health services and involvement in care.
4. **A range of support options available to attract and support people who smoke.** Delivering person-centered, tailored interventions requires a range of evidence-based interventions from minimal to specialist support. The cost of these will vary considerably, but they should be judged as a whole, with one offsetting the other.
5. **Ensure access to evidence-based support.** All people interested in quitting should have ready access to evidence-based support, tailored to their needs and preferences.
6. **Young people.** Whilst targeting over 18s, services should work with programmes for children and young people to be as accessible and responsive as possible.

Stop smoking aids:

7. **Promote access to all first choice stop smoking aids.** All first choice stop smoking aids – combination NRT, nicotine vapes and nicotine analogue medications (varenicline [Champix] and cytisine) – should be offered for at least 10 to 12 weeks. Second choice aids should be available for clients who may need them.
8. **Stop smoking aids are provided at sufficient doses and for long enough.** To help with withdrawal symptoms and urges to smoke, increase chances of quitting, and reduce relapse rates, stop smoking aids should be provided at sufficient doses and available to clients for extended periods if this is required.
9. **Direct supply.** To ensure barriers to access and use of stop smoking aids are minimised, direct supply should be employed.

Behavioural support:

10. **Behavioural support is delivered by NCSCT Certified Stop Smoking Practitioners** who have met national and local training requirements. Practitioners delivering specialist support should receive the appropriate training.

11. **Match support to the needs of people who smoke.** All people should have access to evidence-based stop smoking support, with more intensive specialist services for those with greatest need. It is recommended that intensive support be available, including more frequent and extended contact, for pregnant women, people with an SMI, those who are heavily dependent and those who face multiple barriers to quitting.

12. **Treatment models are adapted to address individual physical and mental health needs.** Adapting the intervention delivery (e.g. shorter or longer consultation times), using outreach models in community settings clients are visiting for other reasons, or home or remote service delivery models to best meet the needs of people with physical or mental health needs.

13. **Target priority groups.** Stop smoking support should target and provide outreach to priority groups through co-designed pathways and partnership, working with local organisations within the community.

14. **Cut Down to Stop (CDTS) programmes** should be available to support people not ready to quit in one go. CDTS support should include first choice stop smoking aids (combination NRT, varenicline or cytisine, nicotine vapes) and structured multi-session behavioural support.

Harm reduction:

15. **Temporary abstinence.** When people who smoke are in environments where smoking is not permitted, they should be supported to manage nicotine cravings through the use of licensed nicotine-containing products or a nicotine vape.

16. **Reduction of smoking.** People who smoke and who are not ready, willing, or able to quit now should be advised and supported to use a licensed nicotine-containing product or a nicotine vape to help them reduce their smoking.

Relapse prevention:

17. **Support extended use of stop smoking aids among clients at risk of relapse.** Extended use of a nicotine substitute in the long term to avoid relapse to smoking is good policy. Needs assessments should guide funding for extended use of products. Services may decide to fund for certain clients for a limited time.

18. **Provide access to extended behavioural support for groups at high risk of relapse.** This includes clients who are pregnant or in the post-partum period, people with an SMI, and those who have had multiple failed quit attempts in the past whilst using less intensive support.

5.2 Service models

Stop smoking service models have evolved alongside public service reforms, budgetary constraints and policy developments.

Most stop smoking services are commissioned by LAs, although there are examples of regional commissioning by ICSs. Services may be delivered in-house by LA employees or subcontracted to external providers.

Practice example

Directory of North East and North Cumbria stop smoking services – click here

Whichever service model is used, service provider contracts should include a detailed specification that clearly lays out the criteria for delivery, outcomes and reporting.

Examples of models are outlined in **Table 1**. When deciding which model to use, commissioners need to consider overlaps and synergies between types of support with the impact on access, reach and outcomes.

Table 1: An overview of LSSS commissioning models

Commissioning Model	Pros	Cons
Centralised, specialist A single service that delivers a range across the region.	■ Coordinated approach ■ Greater assurance around consistency of quality	■ Lack of specialist knowledge to reach all priority groups effectively ■ Limited capacity to expand or reach some priority groups
Hub and Spoke A central service provider (the Hub) is funded to deliver the support. They then subcontract other providers such as primary care, community pharmacies and third sector organisations to deliver all or some of the support. The hub will retain delivery of areas such as admin, training, specialist intensive support and marketing resources.	■ Responsive to changes in demand and need ■ Able to employ specialist knowledge and skills where needed ■ Single point of access. ■ Accommodates innovation. Can evolve and innovate quickly	■ Relies heavily on Hub's operational efficiency and leadership ■ Potential dilution of quality by subcontracted providers who are not specialists
Decentralised Support is individually commissioned, with each support option funded separately. Each support model may be delivered by a different provider.	■ Rapid response to targeted groups	■ Uncoordinated approach, leading to gaps in service ■ Possible loss of oversight ■ Unable to respond and move resources to meet changes in demand ■ Multiple points of access may be confusing to users

5.3 Service delivery models

LSSS were built around the principle of a **universal offer of support** that combined pharmacotherapy with behavioural support. Six contacts with weekly support for the first four weeks after setting a quit date is based on the **NCSCT STP** (see **Part 3**). This universal model results in at least three times greater success with quitting when compared to no support.[5]

To maximise reach and efficacy of LSSS, meet the needs of service users and ensure best use of stop smoking budgets, this guidance acknowledges that commissioners may need to provide a range of service delivery models.

Interventions need to be evidence-based and appropriate to need. Evidence suggests that more contact time is associated with higher quit rates. However, a **range of less intensive and more intensive service delivery models may be needed.** The needs of priority groups should be met whilst remaining relevant and accessible to the mainstream smoking population. Within this approach, the scale of intervention is then proportionate to the most disadvantaged. This means providing services in ways that ensure the outcomes are the same.

Support from a specialist stop smoking practitioner (i.e. a person whose main job it is to deliver stop smoking support) results in greater quit rates when compared to non-specialists (e.g. community stop smoking practitioners whose main job is something other than smoking cessation).[4] At the same time, community-based providers help expand the reach of services, in particular those in pharmacy or primary care.

It is recommended that people with an SMI, those who are heavily dependent, and those with complex needs be directed towards specialist support. For people who are not interested or able to participate in such models, having less intensive support delivered by either the LSSS or via trained community partners (e.g. pharmacy or social services staff) will allow for greater reach of stop smoking services.

Importantly, commissioning should ensure service delivery remains evidence-based and in line with the principles for stop smoking support as described in **section 5.1.** This means ensuring access to first choice stop smoking aids and tailored behavioural support delivered by an NCSCT Certified Stop Smoking Practitioner.

Table 2 provides a summary description of service delivery models ranked in a hierarchy of effectiveness. The table describes the efficacy and reach of service delivery models, and considerations for commissioners.

Table 2: Stop smoking interventions ranked based on evidence of effectiveness

Rank	Service delivery model	Description	Evidence grading	Efficacy	Cost	Considerations
1	**Standard Treatment Programme**	Minimum six contacts (weekly or bi-weekly) delivered over 6 to 12 weeks, in person or via telephone or video link, from a trained stop smoking practitioner.	A	300%	+++	Will provide the best quality outcomes for majority of people who smoke. Should always be the first option considered for commissioning stop smoking interventions. The frequency of contact may not appeal to all service users and/or be possible in existing budgets for all clients.
1	**Group-based Standard Treatment Programme**	Weekly or bi-weekly contacts delivered over 6 to 12 weeks in a closed group format by a trained stop smoking practitioner.	A	300%	+++	While effective, coordination of groups can pose logistic challenges for services.
1	**Tailored specialist stop smoking programme**	Weekly or bi-weekly support delivered over 12 to 26 weeks by a trained specialist stop smoking practitioner.	A – B	200 – 300%	++++	Most appropriate for people with an SMI, pregnant women and individuals at high risk of relapse.
2	**Brief support and treatment programme**	Initial session with follow-up contacts at approximately two and four weeks, delivered by either a trained specialist stop smoking practitioner or trained community health or social professional (e.g. pharmacist, GP, nurse, social care worker) alongside the provision of a first choice stop smoking aid.	B	50 – 100%	+	Can be commissioned via GP surgeries, pharmacies or delivered by the LSSS.

Rank	Service delivery model	Description	Evidence grading	Efficacy	Cost	Considerations
2	**Hybrid models**	Combine digital and interpersonal support alongside the provision of a stop smoking aid.	B – C	–	++	Can assist with reducing number of interpersonal contacts.
3	**Cut Down to Stop programme**	6 to 12 contacts delivered to clients who will initially cut down on smoking before stopping completely, along with provision of a first choice stop smoking aid.	B	40 – 80%	+++	Most appropriate for people who will benefit from a longer lead in time, in particular priority groups (e.g. people experiencing homelessness, people with an SMI).
4	**Digital support programme**	Advice, tips and information and remote support from a stop smoking app and/or text messages alongside the provision of a stop smoking aid.	B – C	40 – 80%	+	Digital support alongside pharmacotherapy has less of an evidence base but may be a good option for people who would otherwise not access services.
5	**Self-help and stop smoking aid following brief advice**	Brief advice and self-help alongside the provision of a stop smoking aid.	A	20 – 80%	+	Appropriate for clients who are unable to engage in more intensive models.

Note: Efficacy = increase in quit rate

Note: Swap to Stop interventions will be added as evidence emerges and is assessed

5.4 Targeting priority groups

Matching services to local needs requires commissions designed to engage and support people from priority groups who smoke, as well as diverse groups, either specifically or as part of the wider service offer. Priority groups have been identified nationally and these are described in **Part 1**. Understanding local demographics will help identify additional local priority groups for LSSS.

Where there is a specific requirement for intervention, these groups must be clearly referenced in service specifications and included within service outcomes and key performance indicators.

People who smoke from high prevalence groups are likely to require longer and possibly more intensive support, and this should also be considered in relation to payment schedules and incentivising service activity.

Data submitted by service providers can support commissioners in monitoring access and success rates for priority groups. Commissions should require a minimum throughput of people who smoke setting a quit date from these groups that is at least proportionate to their representation within the local smoking population. Where there are particular issues of inequity, commissions may require an increased level of engagement to ensure that smoking rates are driven down at a rate greater than that expected in the general population.

5.5 Supply of stop smoking aids

A common contribution to relapse is not using stop smoking aids for long enough. Improving access to stop smoking aids through direct supply at no extra cost to clients is a means of improving compliance with treatment. This is particularly true for pregnant women who smoke and for other priority groups. Provision of free pharmacotherapy is highly cost-effective and is one of the key roles of LSSS.[2,12–14] There is also good evidence regarding the cost-effectiveness of providing free nicotine vape starter kits.[15]

Below is guidance for commissioners on methods for the supply of stop smoking aids.

Further information

NCSCT Briefing – Cost effectiveness of smoking cessation pharmacotherapy – click here

5.5.1 Voucher schemes

Voucher schemes enable clients to access **NRT or nicotine vapes** when attending an LSSS without the need for a prescription or payment.

The voucher is normally issued by a stop smoking practitioner after assessing the suitability of the client to use particular stop smoking aids.

NRT products are classified as General Sales List (GSL) medications. This means that a patient group direction (PGD) is not necessary, and they can be supplied by a pharmacy without a prescription, or by qualified and unqualified personnel in various settings under a protocol.

Vouchers used for nicotine vapes would also not require a PGD.

Some areas have applied a prescription equivalent charge for NRT vouchers. The removal of this charge can help improve access. The NHS community pharmacy smoking cessation service does not charge for NRT.

Standard operating procedures (SOPs) and clinical governance processes should be set up and always adhered to, to assure patient safety as well as reducing the risk of fraudulent use of vouchers.

Secure electronic systems are available to digitally transfer vouchers from service provider to pharmacy.

Resources

QuitManager is one digital solution for stop smoking service management, including vouchers – click here

5.5.2 Direct supply

Purchasing and managing their own stocks of NRT and nicotine vapes allows services to supply these directly to clients, by either handing them directly to clients during face-to-face appointments or mailing them to clients' home addresses.

Direct supply increases medication compliance.

SOPs and clinical governance processes should be established to ensure safe storage of medication and products at all times.

The Medicines and Healthcare products Regulatory Agency (MHRA) has issued a clarification on the direct supply of NRT: *'Over the Counter/General Sales List (GSL) medicines can be supplied from a wider range of premises (including online) without the need for a licence. They are suitable for sale and normal use without supervision or advice from a pharmacist or doctor'.* This means that, whilst staff who are not clinically registered can directly supply NRT, they are unable to do so in peoples' homes.

OHID previously issued guidance on this subject, principally that NRT should be stored in a lockable cupboard and that there must be good local governance, including protocols, a SOP, stock control and monitoring.

Further information

NCSCT briefing – Supply of nicotine replacement therapy (NRT) to pregnant women who smoke – click here

5.5.3 Postal systems

Where NRT products are mailed to the home address of clients, systems should be in place to ensure regular review, and the posting as supplies are needed. Products need to be stored in a lockable cupboard in a stop smoking premises. There are rules on what can and can't be sent in the postal system (see **Further information** below).

Further information

Post Office – A guide to what you can and can't send in the post – click here

5.5.4 Primary care prescription

Local electronic systems can be used to request prescriptions for NRT, varenicline, cytisine or bupropion (Zyban) for clients receiving support from a stop smoking practitioner. This includes repeat prescriptions. Local ICBs and GP practices can be engaged to establish effective systems with local community pharmacies.

5.5.5 Procuring nicotine vapes

Whether directly with vape retailers and suppliers or in partnership with local vape retailers, organisations are now successfully navigating standard procurement practices to provide nicotine vapes to clients. Within established procurement practices, there is an option to use vaping products procurement framework solutions developed by OHID for the public sector and take advantage of the associated benefits they provide regarding contract awarding and contract management. The framework enables easy compliance with Article 5.3.

Resources

NCSCT guidance – Advice to services on making vaping products available to clients – click here

Information for LSSS considering providing vape starter kits – click here

5.5.6 Swap to Stop scheme

The Swap to Stop scheme is a world-first national initiative to encourage people who smoke in England to switch from cigarettes to nicotine vapes. One million people will receive free vape starter kits and behavioural support to help them stop completely. There will be a choice of products, strengths and flavours that will allow people who smoke to find the product that works best for them.

This programme includes three routes for delivering vapes alongside behavioural support:

a) direct supply of nicotine vape starter kits to LSSS

b) direct supply to LA-led partnerships

c) digital offer in partnership with NHSE once development is completed

Initial pathfinder expressions of interest were invited by the national team up until November 2023, with an expectation that a second wave of applications will follow. National reporting requirements for the Swap to Stop scheme are described in **Part 4** of this guidance.

Further information

Stopping the Start – click here

5.5.6 Patient group directions (PGDs)

PGDs allow specified healthcare professionals to supply and/or administer medications directly to a client with an identified clinical condition without the need for a prescription from a prescriber. They can be used for varenicline, cytisine and bupropion. PGDs outline who is eligible to provide the medication, what patient criteria must be met, responsibilities of individuals covered under the PGD and necessary training and competency assessments.

Some organisations will have PGDs in place for NRT. NRT is an over-the-counter medication, meaning a PGD is not needed. Organisations should instead have a protocol in place for distribution of NRT.

The individual healthcare professional assigned to the PGD is responsible for assessing that the patient fits the criteria set out in the PGD. The supply and/or administration cannot be delegated.

PGDs may not always be the best way to supply GSL medicines as the PGD has to be followed precisely with little room for professional discretion. They do, however, assure patient safety more rigorously.

PGDs cannot be used for unlicensed medications that require prescriptions.

Further information

NCSCT – Example PGD and NRT voucher protocol – click here

Patient group directions: who can use them – click here

5.6 Financial incentives for pregnant women

As summarised in **Part 1,** financial incentives can increase rates of stopping among pregnant women and are highly cost-effective. The financial incentives scheme will offer pregnant women who smoke up to £400 in vouchers, alongside behavioural support. The scheme will give women who engage with stop smoking support and are smokefree (verified by expired air CO test) an e-voucher. The vouchers will be provided at regular intervals throughout pregnancy. The scheme is based on effective pilots already underway across the country.

Further information

Stopping the Start – click here

ASH – Incentive schemes – click here

5.7 Smoking cessation within integrated health behaviour services

There is a pressing need for advice and support for other health behaviours such as healthy weight, alcohol, diet and physical activity. This has led some LAs to commission lifestyle services and to incorporate stop smoking support into these.

Broadly, two different models for integrating services have emerged and it is important to distinguish between them. One involves an umbrella organisation which directs people to specific treatment programmes, such as stop smoking support with evidence based behavioural support and stop smoking aids. The other provides a more generic multi-behaviour change intervention that may include smoking.

It is essential that commissioning decisions take account of the large body of evidence on the effectiveness and cost-effectiveness of different approaches. **Evidence supports that smoking cessation support is most effective and cost-effective when provided as a single intervention,** rather than as part of multi-component integrated lifestyle interventions.

Resources

NCSCT briefing – Integrated health behaviour (lifestyle) services: a review of the evidence – click here

6.0 Measuring success

LSSS data monitoring systems support accurate recording and reporting of stop smoking service provision and outcomes, and can be used to inform and improve both local commissioning and local provision of services. Increasingly, services have implemented web-based databases that can be modified to record a range of information in addition to the national mandatory fields, such as information about access to high-risk service user groups and their cessation rates.

6.1 The Stop Smoking Services Quarterly Return

The Stop Smoking Services Quarterly Return is used to help monitor and evaluate the national effectiveness and reach of LSSS. It is important that local areas continue to submit quarterly data to NHSE. This data supports research and informs the provision of national support to assist local delivery (see **Part 4**).

NHSE also report on other related data, including **Smoking Status at Time of Delivery (SATOD).**

Further information

Statistics on NHS Stop Smoking Services in England – click here

Statistics on Women's Smoking Status at Time of Delivery: England – click here

Public health lifestyles statistics – click here

6.2 Measures

Historically, four-week quit rates have been the key national measure of success. However, given the drive to support more people who smoke in priority groups with quitting, new and additional local and national measures are appropriate. Other measures, such as 12-week quit status and separate reporting of outcomes for priority population groups, are recommended.

Additional measures should support quality improvement and service evaluation, without driving services to modify or 'game the system' to achieve them.

This list, without claiming to be exhaustive, provides examples of additional measures used by many services:

- Initial 'conversations' with individual people who smoke – virtual and face to face. This could include contact by phone, SMS, email, or online form
- Referrals to service reported by:
  - geographical area
  - demographic group
  - priority group
  - referral source
  - Deprivation Index

- First appointments with stop smoking practitioner
- Quit dates set
- Customer satisfaction surveys
- Staff training
- 12-week and 52-week quit rates

See **Part 4** for more information.

6.3 Rationale for measuring four-week quit status

The key national outcome measure of stop smoking services remains at the four-week quit date. CO-validated smoking status outcomes at four weeks have very stable and predictable relapse rates that allow longer-term success rates to be calculated with a high degree of confidence.

6.4 Longer-term follow-up

Where resources allow, and in addition to the monitoring of four-week quit outcomes, longer-term follow-up data (e.g. at 12 and 52 weeks) may provide a further check on efficacy, especially when considering specific populations or when aiming to add confidence to outcomes of pilot projects. Longer-term follow-up may also provide an opportunity to re-engage those who have relapsed.

In general, however, following service users over longer periods (such as 52 weeks) can become very resource intensive, and the success of this process is often subject to whether contract details and funding allow for it.

6.5 Establishing smoking status: CO monitoring

CO monitoring is an important motivational tool and an evidence-based behaviour change technique. It is also a method of biochemically validating the sometimes unreliable self-reported smoking status.

The recommendation is that services aim for a CO validation rate of 85% of reported four-week quits for clients seen in person or in hybrid models. The 85% refers to actual verification rates and does not just mean that an attempt was made to verify in 85% of cases.

The move to remote support is a challenge to CO monitoring and it is important to take these factors into consideration when designing and commissioning services, including setting a CO verification target. For example, local pharmacies or vape retailers could be contracted and trained to undertake CO readings for both motivation and verification purposes.

Personal *disposable* CO monitors are now available but the additional financial and environmental costs of these need to be considered.

6.6 Transfer of Care

Transfer of Care describes treatment and support initiated by one service provider that is then transferred to a second service provider. Examples of Transfer of Care include inpatients who received support as part of the NHS TDS who are then referred to an LSSS. It can also include individuals who receive stop smoking support while in prison or a treatment centre who are referred to an LSSS upon release/discharge from that setting. Transfer of Care clients are typically engaged in stop smoking treatment at the time they are referred and the LSSS will provide ongoing, complementary support. They will typically not be setting a quit date with the LSSS. The Transfer of Care intervention should consist of a minimum offer of four weeks of support following discharge from hospital or release/discharge from a prison or treatment centre.

Commissioners should be aware that LSSS and the NHS TDS have used different approaches to reporting and measuring outcomes. The NHS DAPB4041 Tobacco Dependence Programme collection was approved by the Data Alliance Partnership Board in January 2022.

Given this data collection was not initially aligned to the Stop Smoking Quarterly Central Return data set, this guidance provides new working definitions to assist in aligning measurements for individuals who are referred from NHS inpatients settings where treatment has been initiated and will continue in LSSS as part of a Transfer of Care (see **Part 4**).

For clients who are part of the Transfer of Care, the CO-validated and/or self-reported quit date will be measured four weeks from date of discharge from hospital or release from prison. This change has been made to align with indicators used by the NHS TDS as well as to better reflect the success of follow-up support provided by LSSS. See **Part 4** for new national indicators for Transfer of Care clients.

NHS trusts are required to report on smoking status four weeks post-discharge and, as described in **section 4,** data sharing agreements will assist with avoiding duplication when individuals are being actively treated by LSSS.

6.7 Measuring impact

People who attempt to stop smoking using a stop smoking aid with no additional behavioural support have a success rate at four weeks of approximately 25% when CO-validated and 35% when self-reported. Therefore, to demonstrate that they are adding value to quit attempts and having an impact upon local smoking rates, services must achieve success rates in excess of these.

6.8 Cost per quitter

Methods used to report on costs are variable and inconsistent. They should not be used as a basis for costing services and the national figure should be treated with caution.

It is important to acknowledge that the cost per quitter may be greater for priority groups and this should be understood as an expected variation. Services who are effective in reaching members of the national priority groups may have a higher cost per quit. It can be valuable for commissioners to calculate both average cost per quit and cost per quit for priority groups.

Case study: Calculating cost per quitter

LA data:

- **Total annual cost of service delivery:**
  Includes all direct costs associated with service delivery
  (i.e. advertising, overhead, staffing, stop smoking aids)
- **Total number of people who report successful four-week quit**

Formula:

$$\text{Cost per quitter} = \frac{\text{Total direct annual cost of service delivery}}{\text{Total number of four-week quits}}$$

6.9 Priority group reach and efficacy

One of the roles of LSSS is to reach national priority groups and quality standards have been established which recommend monitoring of reach among national or locally identified priority groups. It can be useful to calculate the overall number and percent of service users from priority groups.

It can also be useful to calculate quit rates and cost per quit for these priority groups.

Case study: Calculating priority group reach and efficacy

Reach formula:

$$\text{\% of service users from priority groups} = \frac{\text{Number of treated people from priority groups}}{\text{Total number treated people who smoke}}$$

Efficacy formula:

$$\text{\% of four-week quits for priority groups} = \frac{\text{Number of four-week quits for people from priority groups}}{\text{Total number of four-week quits}}$$

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Part 3: Delivering stop smoking services

Summary guidance:
Delivering stop smoking services

- Encourage people to quit smoking and offer multiple simple routes to access evidence-based stop smoking aids and effective support from trained practitioners.
- Effective stop smoking interventions should be available to all, but the scale and intensity of interventions must be proportionate to the most disadvantaged and nationally identified priority groups.
- Local Stop Smoking Service (LSSS) support should reflect latest evidence and best practice and seek to remove barriers to accessing support. Stop smoking practitioners should be trained to national minimum standards.
- Develop strong referral networks with a focus on priority groups. Referral pathways should be simple and responsive to patient and provider needs. The Transfer of Care of patients from hospital to LSSS is critical to maximizing national investment being made via the NHS Tobacco Dependence Programme.
- Provide access to the full range of evidence-based stop smoking aids, including nicotine vapes, combination nicotine replacement therapy (NRT), varenicline (Champix), bupropion (Zyban) and cytisine. Providing stop smoking aids free of charge removes a barrier to accessing them, and increases the likelihood that aids are used properly and for the recommended duration. Some people who smoke will require higher doses of aids over a longer time period.
- Stop smoking support can be delivered in a number of ways and providing a range of service delivery options will meet more peoples' needs. There is a hierarchy of evidence, with some models being more effective than others, and best efforts should be made to match individuals who smoke to the appropriate support to maximise success with quitting.
- People who smoke can benefit from a single stop smoking support intervention, but success with quitting increases with multiple sessions. Some people who smoke will require more intensive behavioural support for a longer duration, including people with severe mental illness (SMI), pregnant women, those who are more heavily dependent and those with complex needs.
- The strongest and most consistent evidence for the effectiveness of stop smoking interventions is for those that involve an abrupt quit attempt. Cut Down to Stop (CDTS) interventions which combine structured behavioural support and stop smoking aids may assist in engaging with, and increasing the rates of stopping among, people who are unable or unwilling to stop abruptly.
- While individual or group face-to-face counselling is most effective, people who receive support via telephone also do well. While there is less evidence for video-based support, it is reasonable to assume that its effectiveness would be comparable to telephone-based models.
- Digital support is recommended as a complement to support from a trained practitioner and/or for people who would not otherwise access stop smoking support.

Aim and objectives of part 3

Aim

To provide guidance on optimal delivery of stop smoking interventions, including practical recommendations for LSSS to maximise reach, effectiveness and cost-effectiveness.

Objectives

This guidance will:

- Outline the principles and practice of Very Brief Advice on Smoking (VBA+)
- Detail optimal referral sources and pathways
- Provide guidance on access to stop smoking aids, including nicotine vaping products
- Describe best practice on training standards and staff development
- Provide guidance on digital, remote and hybrid models of service delivery
- Describe principles of service delivery and essential elements of support
- Outline principles for engaging and tailoring support for priority groups
- Describe best practice in delivery of expanded and optional services (e.g. CDTS, stopping vaping)
- Provide guidance on smokeless and niche tobacco products

Evidence ratings

Recommendations in this delivery section have a rating to show the extent to which they are evidence-based. This is based upon an adapted version of the Scottish Intercollegiate Guidelines Network (SIGN) rating system – see **Part 1** for more detail.[1]

A	The recommendation is supported by good (strong) evidence
B	The recommendation is supported by fair (reasonable) evidence, but there may be minimal inconsistency or uncertainty
C	The recommendation is supported by expert opinion (published) only
I	There is insufficient evidence to make a recommendation
✓	Good practice point (in the opinion of the guidance development group)

1.0 Very Brief Advice on Smoking (VBA)

Evidence rating: A

VBA is a lifesaving intervention which triggers quit attempts. It needs to be delivered opportunistically and repeatedly at every opportunity with people who smoke. It was originally designed to be delivered by general practitioners and involve referral to specialist stop smoking services.[2–5] VBA is recommended by the **National Institute for Health and Care Excellence (NICE)** as evidence-based and cost effective.

There are three elements to VBA:

1. Establish and record smoking status (**ASK**)
2. Advise on how to stop smoking (**ADVISE**)
3 Refer to specialist stop smoking service for support (**ACT**)

VBA is a life-saving public health intervention delivered by individual health and social care practitioners to individuals who smoke.

1.1 VBA+: Tailoring VBA to available local support

VBA is an approach that meets the **Making Every Contact Count (MECC) agenda**[6] and can be easily delivered by all health and social care professionals in **any setting.**

Evidence rating: B

To reflect this widespread adoption of VBA, and the changing access to stop smoking support, the original model was updated in 2021 to **VBA+** (see **Figure 1**).

Importantly, the **principles and merits of identifying people who smoke** (ASK), **advising on the best way of stopping smoking** (ADVISE) and **linking people who smoke to evidence-based stop smoking support** (ACT) **remain the same.**

The updated VBA+ model includes advice on tailoring the referral intervention to improve uptake and engagement with stop smoking services. To inform the ACT component of VBA+ it is important to identify what stop smoking support is available locally so that people interested in quitting can be referred to the best available support.

Clinical story: VBA+ and primary care

In a discussion with a GP who had given up asking his patients about smoking, he said: "I always ask them if they want to stop smoking, and they generally say 'no', even before I tell them how much better they'll feel." I explained that a common mistake is to ask the patient if they want to stop smoking, and that the NCSCT VBA+ model asks the right questions to prompt changes in behaviour – that VBA+ offers patients hope and help. The GP completed the NCSCT online training module and, next time I saw him, said that he had only now realised what he was doing wrong. Instead of asking if they were ready to quit, he now routinely checks smoking status, explains what the best way to quit is (behavioural support and stop smoking aids) and then offers to make a referral. He was happy to admit that this short and simple training package had made a big difference.

Stop smoking service manager, East Midlands

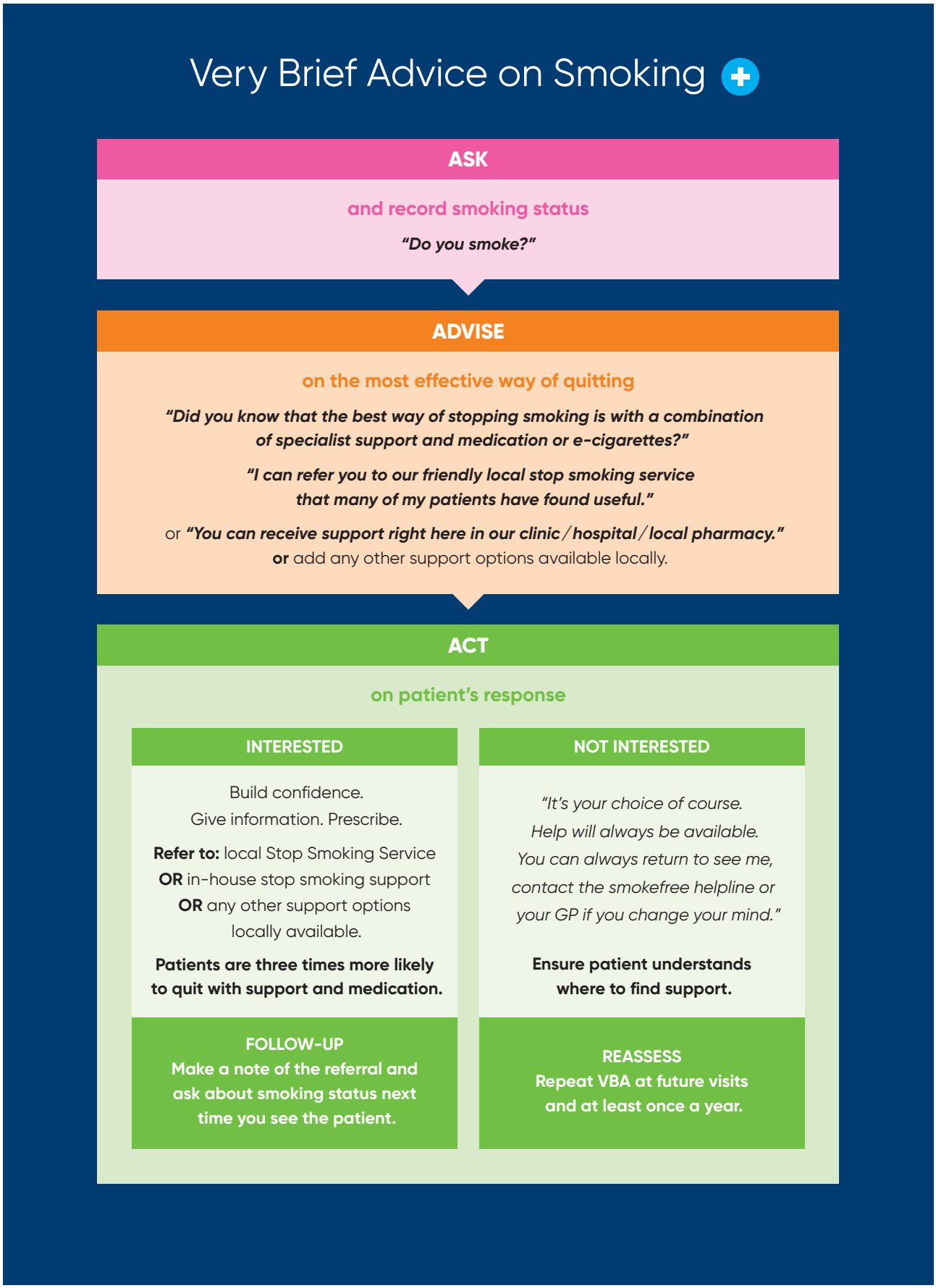
Resources

VBA+ summary – click here

VBA for Ambulance Clinicians – click here

VBA for dental patients – click here

Figure 1: Very Brief Advice on Smoking+



1.2 VBA+ training

All health and social care professionals should be trained in VBA+ and deliver it at every opportunity.[7] Training increases rates of VBA+ delivery.[8]

The NCSCT has an online suite of tailored training modules in VBA+ that allow for specific setting and population factors to be addressed. NCSCT courses are evidence-based and reviewed and updated annually to reflect the latest evidence, practice and policy.

Training

Very Brief Advice on Smoking (VBA+) is focused on general practice but applicable to most clinical and community settings – click here

Very Brief Advice on Smoking for pregnant women is for all health and social care professionals in contact with pregnant women – click here

Secondhand smoke: promoting smokefree homes and cars is for anyone who regularly comes into contact with families – click here

Very Brief Advice on Smoking (VBA+) for Homelessness Services is for those working in homelessness services or in regular contact with people experiencing homelessness – click here

As with any clinical skill, it is important to ensure that training is repeated periodically, with a frequency of every one to three years recommended. All those who have previously completed the NCSCT VBA modules can retake them as a refresher as frequently as they, or their employer, require and receive a new certificate of competence.

NHS VBA+ e-learning modules are available to support staff involved with delivery of the maternity care pathway. In 2024, a bespoke VBA+ e-learning course for acute inpatient and mental health settings will be available to support staff involved in the admission bundle for the NHS Tobacco Dependence Service (TDS).

NHS training

Alcohol and Tobacco Brief interventions – click here

A **Maternity care pathway** online training programme focusing on VBA that includes carbon monoxide (CO) monitoring:

- **Supporting a Smokefree Pregnancy and Smokefree Families** – click here
- **Saving Babies' Lives** – click here
- **Reintroduction of CO Testing** – click here

NHSE-NCSCT Inpatient Acute and Mental Health Admission Team training
Coming soon. Will train staff to deliver VBA+ and support acute management of nicotine withdrawal as part of the NHS Inpatient Tobacco Dependence pathway.

2.0 Referral sources and pathways

Only a small fraction of quit attempts are made with the most effective method of quitting: a combination of stop smoking aids and behavioural support from a trained practitioner. To maximise the success of individual quit attempts an awareness of, and access to, LSSS is needed.

For effective referral of all clients, and notably those in priority groups, it is important to ensure seamless pathways are established and integrated with various local health and social care networks. These include primary and secondary care, mental health and maternity services, and homelessness and social housing groups.

Principles for maximising effective referrals:

- Have a visible presence in the community and ensure that this presence is regularly reviewed and refreshed
- Implement a targeted outreach programme for priority groups
- Co-design referral pathways with people who smoke and ensure that they are person-centred
- Set minimum response times and quality standards for responding to referrals
- Ensure staff receive training in VBA+ that is ideally tailored to their setting and complete refresher training periodically
- Develop simple electronic referral systems that support the principles for effective referrals and allow for analysis and reporting to commissioners and referrers

Best practice examples

Stop Smoking London – click here

Fresh and Balance – click here

Breathe – click here

2.1 Self-referral

Self-referral should be the **primary referral pathway.** A physical presence in the local community with targeted outreach is crucial to increasing accessibility and engagement. People who smoke who are motivated to self-refer to LSSS should always find it easy to identify and access support that meets their needs.

Best practices include:

- A **single point** of access to all support services with a dedicated helpline, as well as digital access. Information should be shared across social media.
- The provision of information in the most prevalent **non-English languages locally** and in **British Sign Language (BSL).** Some (mainly older) non-English speakers do not read or write their first language, so images and key words only may be relevant. Engaging with the local community to understand their needs and co-produce appropriate resources is vital.
- **Co-designing services** with people who smoke and with service users to actively identify and remove barriers to access.[9]
- Supply of **posters, leaflets and cards for healthcare professionals** to hand out and display to promote and maintain the profile of LSSS. These need to be regularly refreshed and re-distributed.
- **Website content,** and any information from helpline staff, should include advice and motivation to all people who smoke to quit. Information supplied should help them make an informed decision and encourage them into the most effective and appropriate support available. Staff may benefit from a script to ask relevant questions to triage clients to the support that meets their needs. (See section on communication and marketing in **Part 2**).
- All communications and referral processes should be **person-centred** and tailored to the local community. This includes using language that will resonate and engage members of priority groups.

Client story: ensuring people who smoke can identify with your service

Pete is a 48-year-old factory shift worker who had smoked since he was a young teenager. He had never been to a stop smoking service. When he was at a community event, a stop smoking adviser asked him how he felt about his smoking. He said he was keen to stop due to the cost, but he had tried several times to quit and it was just too difficult. When invited to attend the service he said:

"People like me don't quit with services like yours".

He added that he did not want to sit around with other people in a group, holding hands in a circle whilst being told off like a naughty schoolboy. Plus, the appointments never fitted with his work patterns.

The adviser explained that staff understood how hard it was to quit smoking and that they never judged people who smoke. Plus, there was definitely no hand holding required! She went on to explain that most people attended one-to-one sessions in person or by phone, with flexible appointments to fit in with shift work.

Pete decided to attend a mix of face-to-face and telephone support. He was so chuffed with quitting that he helped set up a clinic in his workplace.

2.2 Primary care

Staff in general practice and primary care teams have regular contact with large numbers of people who smoke and they are a key setting for delivery of VBA+ and for generating referrals to LSSS.

The number of quit attempts triggered by GPs has declined in the last decade[10] but this trend need not continue and **good working relationships** with primary care providers is important for improving training in VBA+ and increasing rates of referrals by identifying and removing barriers.

Multi-component interventions to address barriers and increase uptake of VBA+ in primary care are most effective.[12–14] Best practice includes:

- **GP surgery pathways** should be developed, with named responsibility for delivering each element of VBA+.
- **Training.** Primary care staff should have the skills to deliver VBA+ and to provide accurate information to patients on the benefits of smoking cessation and the value of stop smoking aids and support. Training primary care providers increases delivery of VBA+ and results in more patient referrals.[8,11] Refresher training and performance coaching increases rates of delivery.[12]
- **Champions.** As seen in other areas of quality improvement, having a **smoking cessation champion** within each primary care setting can significantly improve rates of VBA+ delivery and rates of referral to LSSS.[13–15]
- **Electronic prompts and referral tools.** Automated medical record prompts and simple electronic referral tools can increase delivery of VBA+.[16–18]
- **Patient engagement, including carbon monoxide (CO) testing.** Offering CO monitoring alongside VBA+ and facilitating access to free or low-cost stop smoking aids can increase patient motivation to quit.[16]
- **Co-location of services:** There has been success with co-location of stop smoking support in GP surgeries. General practices may also be commissioned to deliver stop smoking support to patients by a trained member of the primary care team.
- There is some limited evidence that **proactive outreach** to patients identified as people who smoke in clinic medical records can serve to increase uptake.[16] As smoking status and referral are Quality and Outcomes Framework (QOF) indicators, people who smoke can also be identified through practice data searches for bulk messaging.

2.3 Community pharmacy

Community pharmacies are frequently people's first point of contact with health services. They play a key healthcare role in many areas of higher deprivation where there are greater numbers of people who smoke. Healthy Living Pharmacies are taking a bigger role in supporting the health of local communities. Working with local community pharmacies to encourage and support delivery of VBA+ can serve to prompt quit attempts. Community pharmacy champions and electronic referral to LSSS may serve to enhance referral rates.

A number of community pharmacies provide smoking cessation support, enabling them to identify and support clients in-house. Community pharmacies may also play an independent **CO monitoring** role to support remote delivery of support.

To support the introduction of the NHS Long Term Plan (LTP), the NHS Community Pharmacy Smoking Cessation Service (SCS) was introduced in 2022 to allow referrals from the NHS TDS.

Further information

Healthy Living Pharmacies – click here

Community pharmacy advanced service specification: NHS Smoking Cessation Service (SCS) – click here

Resources

Standard Treatment Programme for NHS Community Pharmacy Smoking Cessation Service

– click here

2.4 Maternity services

The **NHS TDS** for pregnant women is now delivered within maternity services. The integration of stop smoking support into maternity services is part of the NHS LTP and the **Saving Babies' Lives Care Bundle.**

Identifying pregnant women who smoke includes asking about current and past smoking status and CO monitoring. Opt out referral pathways, which are effective for engaging with pregnant women who smoke and improve quit rates, should be followed.[19,20] Support is offered for women who self-report smoking, have quit in the last two weeks, have a CO reading of 4ppm or more or have previously been referred, but have not engaged with services.

Whilst most pregnant women will receive support via standalone NHS maternity services, some women may choose to self-refer, or will be referred, to LSSS.

LSSS may wish to **partner with NHS maternity services** to support women who return to smoking in the post-partum period where risk of relapse is high (64 to 87%). Some LSSS are commissioned to provide support within the NHS maternity care pathway.

Partners of pregnant women who smoke are a critical group whose smoking status is intrinsically linked with the outcomes of a pregnant woman who smokes.[21] Support for partners who smoke should be planned and managed seamlessly between NHS maternity services and LSSS.

Health visiting services have an important role to play in supporting parents to stay smokefree through pregnancy and to protect future pregnancies through relapse prevention. They should also promote a smokefree environment for the family. **Training and support for health visiting teams** should be offered as part of a whole systems approach.

See below for a full list of training resources for maternity care. See **section 7.3** for further information on treatment delivery for pregnant and post-partum women.

Further information

Saving babies' lives version three: a care bundle for reducing perinatal mortality – click here

Training

Very Brief Advice on smoking for pregnant women is for all health and social care professionals in contact with pregnant women – click here

Secondhand smoke: promoting smokefree homes and cars is for anyone who regularly comes into contact with families – click here

NHS training

A **Maternity care pathway** online training programme focusing on VBA that includes CO monitoring:

- **Supporting a Smokefree Pregnancy and Smokefree Families** – click here
- **Saving Babies' Lives** – click here
- **Reintroduction of CO Testing –** click here

Client story: smokefree family

Kevin and Chloe both smoked. Chloe had quit smoking during her first pregnancy but relapsed soon after the birth. Their two-year-old daughter, Lily, had asthma. They had tried to smoke outside but in the winter it was harder. When Chloe was at work, other family smoked when looking after Lily and Kevin and Chloe found it hard to ask them not to do this. Money was tight and they struggled to pay their rent some months.

During their daughter's review, the health visitor talked about their smoking and offered to do a CO screening for both parents. The results shocked them both.

The health visitor talked about the risks of smoking around Lily and during any future pregnancies. She discussed how they could make their home smokefree and talk about this with their family and friends. They were both keen to quit smoking but worried that it would be too stressful. The health visitor discussed the local support available, how quitting actually helped relieve stress and that the stop smoking adviser could help them find ways to manage any cravings. They also worked out together how much money they could save. They accepted a referral to the stop smoking service. The health visitor also referred them to a community group for support with finances and housing.

Three months later, Kevin and Chloe (and Chloe's mother) had quit smoking and, with a new garden shelter in place, their home was completely smokefree. Lily had reduced her asthma medication and was thriving. They were happier about their finances and housing situation and were looking forward to having a second child.

2.5 Repeat service users

Evidence rating: ✓

People who smoke often need several attempts before stopping successfully. Anyone who has made a previous, unsuccessful quit attempt should therefore be offered VBA+ on how to stop smoking (see page 94). As the majority of successful quit attempts are unplanned or spontaneous, people who smoke should also be enabled to stop whenever they want to (see Treatment episode, page 174).

Quit attempts should draw on experiences from previous attempts to stop and should bear in mind factors that contributed to previous relapses (e.g. high nicotine dependence). Groups with higher rates of smoking, such as those with mental illness, are more likely to be repeat service users, and specific provision should be made to encourage their re-engagement with stop smoking support.

The evidence for relapse prevention interventions isn't strong and careful consideration should be given to investing in this. There are a number of evidence-based behaviour change techniques that are supported by evidence however (see **Further information** below).

Further information

Cochrane Review: Relapse prevention interventions for smoking cessation – click here

2.6 NHS Tobacco Dependence Service (TDS) pathways

Smoking tobacco is linked to over 500,000 hospital admissions each year and an estimated 20% of all hospital admissions are for people who smoke.[22,23]

Further information

NCSCT Secondary care factsheets – click here

The NHS TDS requires that:

- Every patient admitted to hospital overnight is systematically screened for smoking status
- Every person who smokes is referred for opt-out discussion with a dedicated Tobacco Dependence Advisor (TDA)
- Patients should have a personalised plan to support quitting whilst in contact with NHS services and after discharge
- Patients should receive a two-week supply of NRT
- Patients should receive an offer of referral for post-discharge stop smoking support for four to 12 weeks, including the ongoing provision of stop smoking aids

Staff training should be commensurate with their role in the tobacco dependence pathway.

In 2024, the **Standard Treatment Plan for Inpatient Tobacco Dependence,** structured around the three Tobacco Dependence Treatment Care Bundles, was published (see **Table 1**).

Because patients referred from acute inpatient or acute mental health trusts will have received specialist tobacco dependency support and stop smoking aids (most commonly combination NRT) during their inpatient admission, post-discharge follow-up should be viewed as a **Transfer of Care.** Referral pathways need to be in place to allow LSSS to deliver support following discharge from hospital.

A simple, automated support pathway that enables a seamless Transfer of Care from hospital to community-based stop smoking support is a key part of the pathway. Consideration should be given to limited mobility and other barriers to participation in services for patients who may be recovering following discharge from hospital. This should include a modified service delivery model that includes early telephone contact following discharge, assessment of risk of relapse, and person-centred stop smoking support. Information on support received and stop smoking aids used should be shared to ensure continuity of support. See **section 7.4** for further information on best practices for **Transfer of Care.**

Resources

Standard Treatment Plan for Inpatient Tobacco Dependence – coming soon

Table 1: Overview of the NHS Inpatient Tobacco Dependency Treatment Delivery Care Bundles

Bundle	Responsible Team	Care Bundle Details
Admission Care Bundle	**Admitting Team** (Target for completion: Within two hours of admission)	**Brief advice and acute management of tobacco withdrawal** **IDENTIFY** – Identify tobacco use status. Any patient that actively smokes or has stopped within the **last two weeks** should be identified as meeting criteria for treatment **ADVISE** – Provide brief advice on importance of smokefree admission, role of NRT, and available treatment and support **TREAT** – Initiate combination NRT using rapid NRT prescribing protocol. Consider use of a nicotine vape or nicotine analogue medications where appropriate **REFER** – Inform patient they will be referred to the in-house Tobacco Dependence Team and complete referral using local pathway **RECORD** – Tobacco dependence diagnosis is recorded in patient medical record, ideally in the admission **diagnosis list and disease management plan**
Inpatient Care Bundle	**Tobacco Dependence Team (TDT)** (Target for completion: Within 24 hours of admission)	**Initial assessment and treatment plan** ■ Complete assessment ■ Titrate/tailor or change medications as needed ■ Provide personalised behavioural support
	Tobacco Dependence Team (TDT) (Based on patient need and length of stay)	**Follow-up consultations (whilst in hospital)** ■ Titration of medications ■ Provide behavioural support
	Tobacco Dependence Team (TDT)	**Discharge planning and referral to community support** ■ Provide referral for ongoing support and to continue 12 week course of medication ■ Provide supply of combination NRT/other aids (minimum recommended supply is 2 weeks) ■ Ensure tobacco treatment plan is included in discharge summary and incorporates: behavioural support provided, treatment provided, and details of referral to community stop smoking support
Post-Discharge Care Bundle	**Tobacco Dependence Team (TDT) or Community Stop Smoking Service (Transfer of Care)** (Target for completion: four weeks, post-discharge)	**7 – 14 day post-discharge telephone contact** ■ Check smoking status, ongoing use of treatment, check engagement with community-based tobacco dependence support, liaise with community support if appropriate. **Four week follow-up contact and outcome assessment** ■ Document smoking status, ongoing use of treatment, check engagement with community-based tobacco dependence support, liaise with community support if appropriate.

2.7 Private and independent sector hospitals

Identify and engage with local independent sector secondary care hospitals to ensure access to appropriate services is available to all patients.

2.8 NHS outpatient, diagnostic, pre-surgical and emergency departments

A large number of people who smoke will attend various NHS departments. Not all will end up admitted overnight and so will not be eligible for the NHS TDS. Contact and engagement with these departments is essential to support all hospital staff with training in VBA+ and to implement seamless referral pathways.

2.8.1 Pre-surgical teams

Patients who smoke experience twice the rate of post-surgical complications as people who do not smoke and 38% increased risk of mortality.[24,25] Quitting before surgery has greatest benefits when people stop smoking four to eight weeks prior to surgery.[24,26] Establishing working relationships with pre-surgical teams can assist with engaging people awaiting surgery in support. This can include establishment of a pre-surgical VBA+ pathway (with clear roles and responsibilities), training pre-surgical team members in VBA+, electronic referral systems and rapid access to support.

2.9 Major conditions (speciality care)

Stopping smoking is a key strategy for preventing and managing all major smoking-related diseases including stroke, cancer, diabetes and heart and respiratory conditions. Stopping smoking can significantly improve treatment outcomes and working with specialists in the outpatient setting and community surgeries can be effective in increasing referrals.

2.9.1 Targeted Lung Health Checks

The NHS England (NHSE) Targeted Lung Health Check (TLHC) runs in areas with high rates of lung cancer. People over 55 and under 75 years of age and who are recorded as 'ever smokers' are invited to an appointment where their risk of lung cancer is calculated. Those above the risk threshold are eligible for a free scan and people who currently smoke should be referred to LSSS for support.

Having **effective referral pathways** and supporting **training for all staff** delivering TLHCs can assist with increasing rates of referral among this high-risk population.

A pilot programme, in which the NHS Community Pharmacy SCS receives referrals for stop smoking support from the TLHC programme, is also underway.

Further information

Targeted Lung Health Checks – click here

NHS SCS Pilot – Support for TLHC screening – click here

Training

Communicating with high-risk individuals about lung cancer screening online training module – click here

2.10 Mental health services

People with mental illness, including SMI, are a priority group for LSSS due to high smoking prevalence and the established benefits to physical and mental health associated with quitting.[27,28] There are established best practices for mental health services (see **section 7.2**) that can increase engagement.

The following practices are recommended:

- Assume that people with SMI want to stop smoking. Offer hope and help by delivering VBA+ systematically and opportunistically to patients.
- Pathways should be in place for delivering VBA+ with referral to specialist tobacco treatment support in all mental health settings. The procedures for delivering VBA+ need to be defined in the treatment pathway, reflected in clinical records systems and assessed in quality assurance checks.
- VBA+ should be repeated frequently, including at all medical reviews, Care Programme Approach meetings and annual health checks.
- Implement a process to ensure smoking status, provision of VBA+ and outcome of referral is recorded in patient records.
- Ensure clear pathways to specialist tobacco treatment support are in place (see examples below) and reviewed regularly to ensure they remain appropriate and are being used.

2.10.1 NHS Physical Health Checks for people with SMI

The NHS Physical Health Checks for People with SMI programme offers opportunities for collaboration with LSSS. Primary care is responsible for undertaking checks for patients with SMI who are not in contact with secondary mental health services. Smoking assessment and the delivery of VBA+ is key to the physical assessment and referral of patients who smoke to LSSS is a unique opportunity.

2.10.2 NHS inpatient mental health Tobacco Dependence Service (TDS)

The NHS inpatient mental health TDS seeks to identify and support people hospitalised for acute mental illness with treatment in the inpatient setting and refer patients to community-based stop smoking support upon discharge from hospital (see **section 2.5**).

2.10.3 Community mental health services

Having **strong working relationships** with community mental health services and inpatient mental health trusts means effective referral pathways and support with training staff, both of which can increase rates of referral.

2.11 Allied and other healthcare professionals (including dentists)

Work in partnership with dentists, optometrists, podiatrists, ambulance services and other healthcare professionals to support delivery of VBA+ and referral of patients who smoke. Dental teams are in an ideal position to identify and refer people who smoke or use smokeless tobacco products.

Resources

VBA for Ambulance Clinicians – click here

VBA for dental patients – click here

2.12 Judicial and prison settings

Smoking rates among prisoners on admission are estimated to be around 80%, meaning 200,000 people who smoke are imprisoned each year. With the exception of outdoor areas in open prisons, prisons in England, Wales and Scotland have been smokefree since 2018.

All prisons are expected to meet the minimum offer for stop smoking services and supporting those in custody. As part of the minimum offer, healthcare and prison staff should receive evidence-based training to support people who smoke to quit. NRT should be on prescription and nicotine vapes available to purchase. Working relationships with local prison staff can facilitate access to **post-release stop smoking support** and help reduce rates of relapse back to smoking

Resources

Minimum offer for stop smoking services and support in custody – click here

2.13 Homelessness services

Smoking rates are incredibly high among adults experiencing homelessness, but at least 50% of those who smoke want to quit. Barriers faced by this group include access to information about quitting and support, peer group pressure, and use of smoking to relieve boredom and/or stress.[29–31] Poor mental health, a higher use of alcohol and illicit drugs, along with the challenges of being homeless make effective smoking cessation support harder to access and quitting harder to sustain.[32]

Currently, only a small proportion of homelessness service users receive an intervention about their smoking or receive a referral to LSSS.[33] Good practice includes training homelessness staff in VBA+, having regular offers of stop smoking support embedded in routine health reviews, outreach visits from LSSS and offering harm reduction support.[33]

Training

Very Brief Advice on Smoking (VBA+) for Homelessness Services is for those working in homelessness services or in regular contact with people experiencing homelessness – click here

2.14 Community third sector and outreach providers

Third sector providers are critical to effective engagement with local priority groups of people who smoke. They will have reach into, and credibility with, these priority groups and their experience and expertise should be valued. Working in partnership with, and communicating through, these providers can help remove barriers to accessing support and increase motivation to quit.

2.15 Workplaces

Working with local employers, especially those with higher numbers of routine and manual (R/M) workers, to promote quitting at work can be a success for the employer as well as for individual staff. Improved productivity, reduced absenteeism and social responsibility are valuable to the business.

Further information

British Heart Foundation – Health at Work Quit Smoking booklet – click here

2.15.1 NHS staff offer

As part of the NHS LTP, NHS staff who smoke will be supported with stopping. The NHS staff offer includes access to stop smoking aids and support from a trained stop smoking practitioner. Several LSSS have partnered with NHS trusts to support the offer. This has involved trusts promoting the offer, referring staff to LSSS, and LSSS providing the specialist support and shared outcome data.

NHSE will launch a digital tobacco dependency treatment service in 2024. Initially offered to all NHS staff who smoke, this service will be evaluated and refined in its first year and, if successful, will be rolled out to the general population.

2.16 Social housing

High rates of smoking are found amongst social housing residents, resulting in them being disproportionately affected by significant health and economic inequalities. While there are a number of pilot projects involving social housing associations and public health teams, practice remains inconsistent.

Further information

Action on Smoking and Health (ASH) – Smoking and social housing – click here

3.0 Service delivery

3.1 Behavioural support

Evidence rating: A

Structured behavioural support programmes are most commonly provided in-person, individually or in groups. When provided by trained practitioners they deliver evidence-based behaviour change techniques (BCTs) that increase quitting success rates by:

- Helping clients to avoid or deal with urges to smoke and to manage withdrawal symptoms
- Maximising motivation to remain abstinent and achieve the goal of permanent cessation
- Boosting self-confidence
- Maximising self-control
- Optimising the use of stop smoking aids

3.2 Behaviour change techniques (BCTs)

BCTs are specific elements of the behavioural support programme that add value to quit attempts.[34] They are the things that you say and do with people who smoke that improve chances of quitting (see **Figure 2**).

BCTs included in a structured support programme include:

- Establishing and building rapport
- Ensuring that clients have a realistic expectation of stop smoking aids, use them properly and are aware of any potential side effects
- Informing clients of what to expect in terms of withdrawal symptoms and urges to smoke
- Helping clients to identify how to change their routine to avoid smoking cues
- Using CO monitoring as a motivational tool
- Stressing the importance of the 'not-a-puff' rule and gaining commitment from the client to this
- Supporting the client through their quit attempt

Training

NCSCT Online training and assessment programme – click here

Further information

University College London – Centre for Behaviour Change – click here

Figure 2: BCTs with most evidence of effectiveness:[34]

- Building rapport
- Setting a quit date
- Enforcing the 'not-a-puff' rule
- Addressing tobacco withdrawal and urges to smoke
- Advising on effective use of stop smoking aids
- Advising on changing routines and addressing smoking triggers, high-risk situations
- Increasing self-regulation
- Increasing self-efficacy (confidence)
- Rewarding abstinence and incentivising goals
- Tailoring treatment to client needs
- Addressing being around people who smoke and fostering social support
- Relapse prevention
- Extending treatment

3.3 The NCSCT Training Standard

The competences (knowledge and skills) necessary to deliver identified evidence-based BCTs have been converted into learning objectives which form the NCSCT Training Standard for stop smoking practitioners.

A comprehensive, validated and effective training and assessment programme including all BCTs is provided by the NCSCT on behalf of OHID. The Standard Treatment Programme (STP) complements the online training provided by the NCSCT and acts as a guide to stop smoking practitioners' interactions with people who smoke.

All specialist and community stop smoking practitioners should be trained to the NCSCT Standard and should be NCSCT certified.

NHS-NCSCT have published a competency framework for inpatient tobacco dependence treatment which is tailored to the knowledge and competencies required in inpatient settings.

Resources

NCSCT Training Standard: Learning Outcomes for Training Stop Smoking Practitioners – click here

Standard Treatment Programme – click here

Training

NCSCT Online training and assessment programme – click here

Further information

NHSE competency frameworks for inpatient tobacco dependency treatment – click here

3.4 Principles of behavioural support

These principles for high-quality, effective stop smoking support should guide all aspects of service delivery.

1. **The person who smokes is at the centre.** A person-centred approach assesses the needs of people who smoke and is responsive to them. Offering flexible support and minimising barriers to access (e.g. consideration of how and where services are delivered) is essential, including individual tailoring of services.
2. **Seamless support.** The support that a person who smokes receives should be continuous, including where support starts in one setting and continues in another (Transfer of Care).
3. **Enhanced person-centred communication skills, family and friend involvement, access to information and shared decision-making.** These are increasingly important as smoking is found in the most deprived communities with lower education levels, lower health literacy, and limited access to health services and involvement in care.
4. **A range of support options available to attract and support people who smoke.** Delivering person-centred, tailored interventions requires a range of evidence-based interventions from minimal to specialist support. The cost of these will vary considerably, but they should be judged as a whole, with one offsetting the other.
5. **Ensure access to evidence-based support.** All people interested in quitting should have access to evidence-based support tailored to their needs and preferences. Depending on resources, you will prioritise what can be offered and to whom more intensive specialist services are offered. Individuals with greatest need should receive more intensive support.
6. **Treatment models adapted to address individual physical and mental health needs.** Adapting service delivery (e.g. variable consultation times and durations), using outreach in community settings, or home or remote service delivery models to best meet the needs of people with physical or mental health needs.
7. **Target priority groups.** Target and provide outreach to priority groups to maximise service access.

8. **Behavioural support delivered by NCSCT Certified Stop Smoking Practitioners** who have met national and local training requirements. Practitioners delivering specialist support should receive the appropriate training.
9. **Support extended use of stop smoking aids among those at risk of relapse.** Clients who feel they need to continue to use a nicotine substitute long-term to avoid relapse to smoking should be encouraged and supported to do so.
10. **Provide access to extended behavioural support for those at high risk of relapse.** This includes pregnant women and those in the post-partum period, people with SMI, and those who have had multiple failed quit attempts in the past whilst using less intensive support.

3.5 Service delivery models

Stop smoking interventions can be delivered in a number of ways and providing a range of service delivery options will meet more peoples' needs. There is a hierarchy of evidence, with some models being more effective than others. **Table 2** contains pragmatic definitions of the intervention types commonly delivered by services.

All interventions share common features, such as the provision of behavioural support, a structured approach and the offer of stop smoking aids.

Some people who smoke can benefit from a minimal stop smoking intervention, but success with quitting increases with multiple sessions, usually at least six weekly appointments. Whilst the most intensive treatment models are the most effective, they may not appeal to the people who need them most.

Best effort should be made to match individuals to the appropriate locally-available model of support to maximise success with quitting. It is recommended that people with SMI, pregnant women, those who are more heavily dependent and those with complex needs be directed towards more intensive specialist support.

Table 2: Stop smoking service delivery models ranked based on evidence of effectiveness

Rank*	Service delivery model	Description	Considerations
1 Evidence = A	**Standard Treatment Programme**	Minimum six contacts (usually weekly) delivered over 6 to 12 weeks in person or via telephone or video link from a trained stop smoking practitioner.	Will provide the best quality outcomes for majority of people who smoke. The frequency of contact may not appeal to all services users and/or be possible in existing budgets for all clients.
1 Evidence = A	**Group-based Standard Treatment Programme**	Weekly or bi-weekly contacts delivered over 6 to 12 weeks in a closed group format by a trained stop smoking practitioner.	While effective, coordination of groups can pose logistic challenges for services.
1 Evidence = A–B**	**Tailored specialist stop smoking programme**	Weekly or bi-weekly support delivered over 12 to 26 weeks by a trained specialist stop smoking practitioner.	Most appropriate for people with SMI, pregnant women and individuals at high risk of relapse.
2 Evidence = B	**Brief support and treatment programme**	Initial session with follow-up contacts at two and four weeks delivered by either a specialist stop smoking practitioner or community stop smoking practitioner, alongside the provision of a first choice stop smoking aid.	May assist with expanding reach of stop smoking services to people who are unable or unwilling to engage in more intensive forms of support.
2 Evidence = B – C	**Hybrid models**	Combine digital and inter-personal support alongside the provision of a stop smoking aid.	Can assist with reducing number of inter-personal contacts.
3 Evidence = B	**Cut Down to Stop programme**	6 to 12 contacts delivered to clients who will initially cut down on smoking before stopping completely, along with provision of a first choice stop smoking aid.	Most appropriate for people who will benefit from a longer lead in time, in particular priority groups (e.g. people experiencing homelessness, people with SMI).
4 Evidence = B – C	**Digital support programme**	Advice, tips and information and remote support from a stop smoking app and/or text messages alongside the provision of a stop smoking aid.	Digital support alongside pharmacotherapy has less of an evidence base but may be a good option for people who would otherwise not access services.
5 Evidence = A	**Self-help and stop smoking aid following brief advice**	Brief advice and self-help alongside the provision of a stop smoking aid.	Appropriate for clients who are unable to engage in more intensive models.

* Service delivery models have been ranked based on a hierarchy of evidence regarding their efficacy in supporting people who smoke with stopping.

** The evidence rating for tailored specialist support would have received a ranking of A if based solely on evidence regarding intensity of behavioural support. The A – B ranking reflects the fact that tailored specialist support is recommended for populations which have multiple barriers where available evidence is good, but not as strong as for general population of people who smoke.

3.5.1 Standard Treatment Programme (in-person or remote)

Evidence rating: A

LSSS were originally built around the principle of a universal offer that combined pharmacotherapy with behavioural support, consisting of six contacts with weekly support for the first four weeks after setting a quit date. This internationally-acclaimed model results in at least three times greater success with quitting compared with quitting cold turkey.

The **STP** describes the components of an evidence-based, structured, individual, face-to-face smoking cessation intervention and acts as a clinical guide.

All LSSS should provide a minimum of weekly sessions for at least four weeks following the quit date. LSSS should provide support beyond four weeks, or include additional sessions within the four-week time window, dependent upon the needs of their individual clients.

A standard intervention would typically include a total minimum potential client contact time of 1 hour 50 minutes, from the pre-quit preparation appointment through to the four-week post-quit appointment (see **Table 3**). The initial pre-quit session is likely to be the longest, and a minimum of 30 minutes should be allocated to it, although slightly less time may be required if a client has used the service before.

Table 3: Overview of minimum behavioural support sessions for Standard Treatment Programme

Session	Timeframe	Duration
Session 1:	Pre-quit assessment (one or two weeks prior to quit date)	30 – 45 minutes
Session 2:	Quit date	20 minutes
Session 3:	1 week post-quit date	15 minutes
Session 4:	2 weeks post-quit date	15 minutes
Session 5:	3 weeks post-quit date	5 minutes
Session 6:	4 weeks post-quit date	15 minutes
	Total	1 hour 50 minutes

Note: Further sessions may be provided as needed and clients will need to be able to access the full course of their chosen stop smoking aid beyond the end of the STP.

The STP should, as a minimum, include:

- Building rapport and boosting motivation throughout
- Assessing and confirming current readiness and ability to quit
- Informing clients about the treatment programme
- Assessing current smoking behaviour
- Assessing past history of quit attempts
- Explaining how tobacco dependence develops and assessing level of nicotine dependence
- Using diagnostic criteria such as the Heaviness of Smoking Index or the Fagerström Test for Cigarette Dependence
- Measuring carbon monoxide
- Explaining the importance of abrupt cessation and the 'not-a-puff' rule
- Discussing withdrawal symptoms and cravings/urges to smoke and how to deal with them
- Discussing stop smoking aids; confirming choice, correct usage and sufficient supply
- Discussing the client's smoking contacts and how the client can get support to quit
- Setting a quit date
- Discussing any potential high-risk situations in the coming week
- Advising on changing routine
- Prompting commitment from client (confirm the importance of the 'not-a-puff' rule)
- Discussing future preparations and plans
- Relapse prevention
- Providing a summary to the client

Resources

Standard Treatment Programme – click here

Standard Treatment Programme for Pregnant Women – click here

3.5.2 Remote service delivery (telephone and video-based)

Evidence rating:

Telephone: A

Video-based: C

LSSS used proactive telephone support, in addition to in-person, face-to-face sessions effectively for many years before the COVID-19 pandemic. The pandemic rapidly moved all sessions to telephone and video platforms. Since then, remote and hybrid models have evolved to meet client and service needs.

Provision of behavioural support via telephone can be effective in helping people to stop smoking. There is good evidence that delivering the STP by telephone, particularly when combined with stop smoking aids, increases both compliance with aids and short and long-term smoking abstinence. As is the case with face-to-face support, we know that multiple contacts improve effectiveness.

Video-based communication (video chats) may also be helpful in delivering behavioural support remotely. Available evidence, of which there is very little, has shown it to be comparable to telephone support. Video has the added advantage of supporting non-verbal communication. For video conferencing, client access to, and knowledge of, video conferencing software and technology must also be considered.

Remote consultations via telephone or video should be **arranged for a set day and time** using a similar contact schedule as used for face-to-face support: before their quit date, on their quit date and weekly for at least four weeks post-quit date. It is important to ensure that the client knows that this is an appointment time, specifically set aside for them, to encourage them to answer calls and engage in the behavioural support being delivered.

Access to stop smoking aids should also continue to be available to clients (see **section 5**). Service policies that apply to face-to-face consultations (e.g. safeguarding, record keeping etc.) would also apply to remote consultations.

Further information

NCSCT guidance – Remote consultations – click here

3.5.3 Group-based Standard Treatment Programme

Evidence rating A

Group-based interventions should be at least an hour in length and may need to be considerably longer depending upon the size of the group, offering a minimum total of six hours contact time with group members over a six-week treatment period.

Once the person who smokes has set a quit date and agrees to take part in the behavioural support programme, it is important that they are offered and encouraged to attend weekly support sessions that include CO monitoring and advice on correct and continued use of stop smoking aids. Whilst venues and appointment times can be flexible, the client must be advised to attend regularly to get the maximum benefit.

3.5.4 Tailored specialist stop smoking programme

Evidence rating: A B

Intensive (longer and more frequent sessions) and/or extended support (for 12 weeks post-quit and longer) may increase rates of quitting, especially in some high-priority populations. Tailored specialist stop smoking programmes are most appropriate for people with SMI, pregnant women and individuals with multiple needs and/or at high risk of relapse. Stop smoking practitioners should be trained in how to tailor treatment to these clients.

Specialist support should be tailored to the needs of clients and typically involve weekly or bi-weekly support, delivered over 12 – 26 weeks. Through adapting and tailoring service delivery and treatment content based on best practices, barriers to stopping smoking for the priority group targeted can be addressed (see **section 7**).

Resources

NCSCT briefing – Smoking cessation and smokefree policies:
Good practice for mental health services – click here

NCSCT briefing – Smoking Cessation and Mental Health:
A briefing for front-line staff – click here

Smoking Cessation Intervention for People with Severe Mental Ill Health:
SCIMITAR+ Trial – click here

NCSCT briefing – Stopping smoking in pregnancy:
A briefing for maternity care providers – click here

3.5.5 Brief support and treatment programme

Evidence rating: B

Brief support and treatment programmes typically include between one and three contacts in total. These sessions, typically an initial appointment with follow-up contacts at two and four weeks with specialist or community stop smoking practitioners, also include the provision of first choice stop smoking aids. Whilst brief support ranks lower than structured multi-session support (the STP) for effectiveness, the availability of less intensive intervention models may assist with expanding the reach of services to people unable or unwilling to engage in more intensive forms of support.

3.5.6 Cut Down to Stop (CDTS) programme

Evidence rating	
Cut Down to Stop without a stop smoking aid	I
Cut Down to Stop with NRT	B
Cut Down to Stop with varenicline	B

A structured CDTS programme involves behavioural support from a trained practitioner and the provision of stop smoking aids to set progressive smoking reduction goals, with a view to stopping completely over a specified period. CDTS programmes can be tailored locally to meet client needs but typically consist of six to 12 contacts and ideally continue for at least four weeks following stopping completely. See **section 6.2** for further information.

Further information

Cochrane Review – Smoking reduction interventions for smoking cessation – click here

Resources

CDTS client workbook – coming soon

Training

NCSCT training on CDTS – coming soon

3.5.7 Digital support

3.5.7.1 Text messaging

Evidence review: A B

Automated text message-based stop smoking interventions result in greater quit rates than minimal stop smoking support. Incorporating text messaging into support from a trained stop smoking practitioner may support improved outcomes. Client consent and opt out ability must be ensured.

3.5.7.2 Digital applications (apps)

Evidence rating: B C

Digital interventions should be designed to deliver evidence-based BCTs to maximise their effect.[35,36] There is data to suggest that interventions that are personalised and interactive are more effective.[36] There is also limited evidence that the addition of digital interventions to in-person support can increase success with stopping smoking.[37]

The use of first choice stop smoking aids alongside digital stop smoking support increases effectiveness compared to digital support alone.[38] This is consistent with evidence regarding efficacy of stop smoking medications when used alongside behavioural support.[39,40]

An almost exhaustive range of apps offering stop smoking support are available. These vary from ones with minimal functions and effectiveness (e.g. that count how many cigarettes have not been smoked and how much money saved) to highly complex and more effective apps that combine access to real-life NCSCT Certified Stop Smoking Practitioners and stop smoking aids.

If app content does not contradict or conflict with the STP, including facilitating use of stop smoking aids, client preference can direct choice.

> ***"We see using apps as a complementary tool which is part of our service. It makes sense to our advisors, and it makes sense to our clients, that we should be recommending apps."***
>
> **Christopher Keoghan,** Stop Smoking Specialist, Yorkshire Smokefree Service

The Organisation for the Review of Care and Health Apps (ORCHA) provides an independent review of digital health apps on its website.

Further information

Organisation for the Review of Care and Health Apps (ORCHA) – click here

3.5.7.2.1 NHS Quit Smoking app

The NHS Quit Smoking app is free and designed for those who want to stop smoking. The app provides a four-week quit programme consisting of practical support, encouragement and tailored advice. The support offered is evidence-based but not live. Users can track their progress, see how their health is improving, how much money they have saved and receive virtual badges to mark progress. Information on how to access the app, plus other NHS stop smoking resources, is available at Better Health.

Further information

NHS Quit Smoking app | App Store (iOS) – click here | Google Play (Android) – click here

3.5.7.2.2 Smoke Free app

The Smoke Free app is a comprehensive digital solution for people wanting to stop smoking. In some areas of the country is it provided free for users by the LA or the local NHS trust. In the spring of 2024, it will be available to certain groups via a new national stop smoking self-referral hub. It can also be purchased by individuals for as long as they need it.

The app adheres closely to the NCSCT STP and all the advisors are NCSCT Certified Stop Smoking Practitioners. Live support is available 24 hours a day, every day of the year, and users can speak to an advisor as often as they like. The app also provides automated features such as daily stop smoking tasks, an AI QuitCoach, progress indicators such as time since the last cigarette, health improvements gained and money saved. Badges are earned for achievements and the app is fully vape friendly and able to give advice on vaping.

The effectiveness of the app has been demonstrated in trials and success rates compare well with face-to-face services, both in terms of quitting success and cost per quit. The app team can arrange on-boarding calls with new users and follow-up calls to establish outcomes. If required, the app can supply NRT and nicotine vapes to users, delivered directly to their home.

Further information

Smoke Free app – click here

Conflict of interest

NCSCT Chief Executive Dr Andy McEwen is a friend and ex-colleague of the Smoke Free app CEO Dr David Crane. NCSCT Clinical Consultant Lou Ross also works as the Business Development Manager for Smoke Free. The NCSCT has no commercial conflict of interest to declare in relation to Smoke Free.

3.5.8 Hybrid models

Evidence rating: B C

Hybrid models of stop smoking support combine in-person and remote models. Services typically conduct the first session in-person and then move to remote support.

4.0 Behaviour support programme

4.1 Assessing nicotine dependence

Assessing dependence on nicotine can help predict the severity of withdrawal symptoms that individuals may experience and indicate the type and dose of medication and level of behavioural support needed.

Evidence rating: A

Cigarette consumption alone is not a good indicator of dependence as it does not account for the different ways and intensity with which people smoke cigarettes.

The Fagerström Test for Cigarette Dependence (FTCD)[41] provides a quantitative measure of dependence. It consists of six questions and a maximum score of 10; the higher the score, the more tobacco dependent clients are.

Resources

Fagerström Test for Cigarette Dependence (FTCD) – click here

The Heaviness of Smoking Index (HSI) uses the two most important indicators from the FTCD: 'How soon after you wake do you smoke your first cigarette?' and 'How many cigarettes per day do you usually smoke?'[42–44] Many services use this measure.

Heaviness of Smoking Index (HSI)

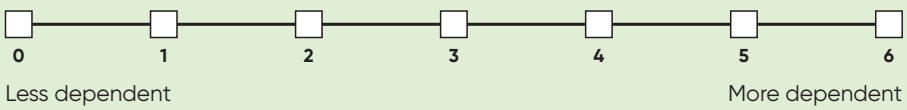
1. **On the days that you smoke, how soon after you wake up do you have your first cigarette?**

   ☐ Within 5 minutes (3 points)
   ☐ 6 – 30 minutes (2 points)
   ☐ 31 – 60 minutes (1 point)
   ☐ After 60 minutes (0 points)

2. **How many cigarettes do you typically smoke per day?**

   ☐ 10 or fewer (0 points)
   ☐ 11 – 20 (1 point)
   ☐ 21 – 30 (2 points)
   ☐ 31 or more (3 points)

Scoring



4.2 Biochemical markers of smoking status

Biochemical markers of smoking status confirm self-reported quit rates. The process also has an important role to play in expanding the quit attempt to involve others and can be motivational.

4.2.1 Carbon monoxide (CO) monitoring

Evidence rating: A

The most cost-effective and least invasive method is to measure the amount of CO in expired air.

CO monitoring:

- Provides a visible marker of the harm of smoking and benefits of cessation
- Is a measure to track progress and increases the likelihood of quitting
- Can detect CO poisoning
- Is a service quality indicator (under 10 parts per million (ppm) confirms self-reported quit)
- Is non-invasive and tolerated by most clients
- Is a valuable motivational tool

There is a national expectation that a minimum of 85% of self-reported four-week quitters who make an in-person face-to-face or hybrid quit attempt undertake (and not just attempt) expired CO validation.

Best practice:

- Staff should be trained in CO monitoring at different time points (including using it as a motivational tool) and in the importance of verifying self-reported smoking status at the four-week post-quit point.
- All stop smoking practitioners must have access to a functioning CO monitor at every in-person face-to-face consultation.
- Systems should be in place to ensure that CO monitors are calibrated according to the manufacturer's instructions.
- LSSS require a written protocol for CO monitoring use that also details infection control and management issues. The protocol should clearly state when monitors need calibrating, who should do it and how it should be done.
- If clients do not attend their appointment, they should be followed up by telephone, text or email (three times, at different times of day) and asked and encouraged to attend for CO verification.
- CO monitoring may be offered to clients at community pharmacies and other health centres to support remote support models.
- Services could also investigate the options for disposable CO monitors for use with remote access clients. These have not been found to be widely successful or cost-effective to date.

4.2.2 Carbon monoxide monitoring in pregnancy

Women who self-report smoking and/or who have a CO reading of 4 ppm or more should be referred for specialist support.

4.2.3 Carbon monoxide poisoning

Clients may occasionally exhibit abnormally high expired CO levels (70 ppm or more) which could be due to very heavy smoking or other causes, such as leaking car exhausts or faulty gas appliances. Advice should be given about possible CO poisoning and attending accident and emergency.

Length of exposure is important, and it is probably best to assess symptoms rather than rely on fluctuating CO levels.

Further information

NHS – Carbon monoxide poisoning – click here

Resources

National Gas Helpline – 0800 111 999

4.2.4 Cotinine testing

Evidence rating: A

Cotinine is a metabolite of nicotine produced when nicotine is broken down in the body and can be detected in the blood, urine or saliva. Whilst CO monitoring is currently the most cost-effective method of validating four-week quits, specific projects or groups may require more specific monitoring using either urinary or salivary cotinine samples, such as clinical studies, for example.

However, cotinine testing does not allow instant feedback for clients as samples need to be laboratory tested, meaning it cannot be used as a motivational tool. In addition, the test cannot differentiate between nicotine from tobacco and nicotine from NRT or a vape and can therefore be unreliable as a marker of smokefree status where NRT or a vape is being used.

5.0 Stop smoking aids

5.1 Principles of stop smoking aid access

These principles should guide all aspects of making stop smoking aids available:

1. **Support access to all first choice stop smoking aids.** Stop smoking aids should be ranked according to their level of effectiveness.[7] First choice stop smoking aids are recommended options for all people who smoke, unless contraindicated.
2. **Ensure stop smoking aids are provided at sufficient doses and for long enough.** Stop smoking aids should be offered for at least 10 to 12 weeks. To manage withdrawal symptoms and urges to smoke, increase chances of quitting and reduce relapse rates, stop smoking aids should be provided at sufficient doses and available to clients for extended periods if required.
3. **Direct supply.** To improve compliance and increase quit rates, direct supply of stop smoking aids at no or minimal cost should be employed.

5.1.1 Higher doses of stop smoking aids

Evidence rating: A

People who are more tobacco dependent generally benefit from higher doses of NRT and nicotine vapes,[45] or the use of nicotine analogue medications, to effectively manage withdrawal symptoms and urges to smoke. Client response – their experience of withdrawal symptoms and urges to smoke – can be used to guide treatment.

Research has shown that a higher dose of NRT patch (42/44 mg, i.e. two patches) is more effective in managing withdrawal symptoms in those who are highly tobacco dependent compared to a single NRT patch (21/25 mg).[46–47] Use of a second patch may serve as a more feasible method for achieving a higher nicotine dose given it does not require frequent administration, as is the case with the faster-acting products. High-dose NRT has been found to be well tolerated and safe among people who are more tobacco dependent.[46,48,49] While most people who smoke will not require a second patch, having flexibility within protocols to offer high-dose combination NRT to clients who are more dependent may serve to increase four-week quit rates in this population and, above all, is a safe practice.

Resources

NCSCT briefing – Combination NRT – click here

5.1.2 Extended use of stop smoking aids

Evidence rating: A

Some people who smoke, specifically people who are more dependent upon tobacco, may benefit from the use of stop smoking aids for extended periods of time (three to 12 months). This is safe practice and recommended as a relapse prevention strategy.[7,50]

5.2 First choice stop smoking aids

There are three first choice stop smoking aids that are shown to significantly increase long-term quit rates:[7,51]

- **Combination NRT:** nicotine patch plus faster-acting second nicotine product
- **Nicotine vapes:** vaping device using nicotine-containing e-liquid
- **Nicotine analogue medications:** varenicline and cytisine

Resources

Stop smoking aids quick reference sheet – click here

Training

Stop smoking medications online training module – click here

Further information

Stop smoking aids resources and information – click here

5.2.1 Combination nicotine replacement therapy (NRT)

Evidence rating: A

Combination NRT (nicotine patch plus a faster-acting NRT product) gives superior relief of withdrawal symptoms and urges to smoke and increases quit rates compared to single-form NRT.[45,51]

The patch provides a steady supply of nicotine throughout the day (helping with withdrawal symptoms and background urges to smoke) and the faster-acting NRT product can be used in high-risk situations or in response to 'breakthrough' urges to smoke.

Most NRT products have specific techniques of use that maximise nicotine delivery, and hence effectiveness, and minimise side effects. **Staff should receive appropriate training in stop smoking aids and the BCTs that support their use.**

Guidance on individualised dosing of NRT:

- It is important for clients to be encouraged to use sufficient NRT. Failing to use enough for long enough is a common reason for relapse.
- The initial dose of NRT can be guided by level of dependence through use of the HSI (number of cigarettes per day and time to first cigarette in the morning).
- Experience of withdrawal symptoms and urges to smoke can be used to adjust the initial dose.
- Both the dose of NRT patch and the dose and frequency of the faster-acting NRT can be adjusted as needed to address withdrawal symptoms and urges to smoke.

NRT can be gradually reduced (a step-down approach) over the final weeks of use or the dose maintained until stopping. NRT is typically used for eight to 12 weeks, but some clients may benefit from use for extended periods of time, from three to 12 months. This is safe practice and recommended if there is a risk of relapse to smoking.[7]

NRT can be used by adolescents aged 12 and over, pregnant women, people with cardiovascular disease and surgical patients.

Further information

NCSCT briefing – Combination NRT – click here

5.2.1.1 NRT use by pregnant women

Evidence rating: B

NRT is safe and effective in supporting pregnant women to quit smoking.[52,53] Combination NRT can be used for pregnant women who smoke and might be particularly helpful to those who are more dependent or are struggling with withdrawal symptoms and/or urges to smoke.[54] It is recommended that pregnant women use a 16-hour patch or remove the 24-hour patch overnight to avoid an extended delivery of nicotine to the fetus.

5.2.1.2 NRT use by cardiac patients

Evidence rating: A

Combination NRT can be safely used in cardiac patients.[55,56] High-quality research examining the use of NRT in cardiac patients has found no evidence of a significant increase in adverse cardiac outcomes or other ill effects.[55,56]

The majority of research has included patients with a stable heart condition (i.e. recent heart attack, heart surgery). There have been only a small number of studies examining the use of NRT among patients with acute coronary syndromes, which are defined as recent myocardial infarction (heart attack) and/or unstable angina. Studies show no adverse effects of NRT use in people with acute coronary syndromes.[57–58]

5.2.1.3 Surgical patients

There is no known risk of NRT use among surgical patients nor strong evidence to suggest that NRT impacts healing or cardiovascular complications, except for facial-cranial surgery for which there is minimal research to guide practice.[59,60] A risk-benefit assessment of the limited adverse effects, if any, of NRT use versus the well-established risk of continued smoking should guide decision-making.

5.2.1.4 Supply of NRT

See **Part 2, section 5.5** for guidance on supply of NRT.

5.2.2 Nicotine vapes (electronic cigarettes)

Evidence rating: A

Nicotine vapes are the most popular stop smoking aid in England, being used in approximately 35% of quit attempts.[10]

While vaping is not risk-free, in the short- and medium-term, vaping poses a small fraction of the risks of smoking.

Nicotine vapes are generally more effective than NRT in aiding smoking cessation, with similar effectiveness to varenicline in clinical trials.[51,61,62]

Provide advice on vaping that includes:

- Vapes provide nicotine in a far less harmful form than smoking tobacco; the harm from smoking is not caused by nicotine.
- Some people find vaping helpful for quitting, cutting down the amount of tobacco smoked and/or managing temporary abstinence from smoking.
- There is a wide range of vapes and people may need to try various types, flavours and nicotine strengths before they find something suitable for them.
- Although some health risks from vaping may yet emerge, these are likely, at worst, to be a small fraction of the risks of smoking. This is because vapour does not contain the products of tobacco combustion (burning) that cause lung and heart disease, and cancer.

Services should routinely offer vaping starter packs (see **Part 2, section 5.5.5**).

Principles of use:

- People attempting to quit should use a vape with nicotine-containing e-liquid. It is recommended that all clients use nicotine-containing vapes and that sufficient nicotine is used to manage cravings and withdrawal.
- Those who are more dependent may initially benefit from vaping 20 mg/ml nicotine e-liquid alongside an NRT patch, using the vape as their faster-acting nicotine product.
- Experience can guide how much nicotine is required; the aim should be to use sufficient nicotine to significantly reduce or eliminate withdrawal symptoms and urges to smoke.
- Use regularly throughout the day and when cravings occur. Clients should be advised to use their vape as often as they need to, in order to manage urges to smoke.
- Multi-session behavioural support provided by trained stop smoking practitioners will improve the chances of successfully stopping smoking, whether or not people use vapes. Encourage clients to familiarise themselves with the use of their vape before setting a quit date.
- The action of vaping is different to smoking, which generally involves taking a deep lungful of smoke from a cigarette. Clients new to vaping should inhale gently, drawing the vapour into the mouth and then inhaling into the lungs. Practice is often needed and clients shouldn't be put off by this.

- More frequent and consistent vaping ('grazing on nicotine') is typically needed to get sufficient nicotine, compared to smoking a cigarette every couple of hours ('bingeing on nicotine').
- Clients will need to recognise when atomisers need replacing. Simply drinking water can help avoid the dry mouth that can be experienced.
- Clients should be advised to always take their fully charged vape with them when they go out, to avoid the risk of smoking when they haven't got their vape to hand.
- Advise clients not to leave their vape to charge overnight.
- Clients should be told that the benefits of vaping are greatest when they stop smoking tobacco completely.
- Some service users have vaped whilst using varenicline to quit smoking. There have been supply issues with varenicline since 2021 and with bupropion between 2022 and 2023, but use of vapes with varenicline, bupropion and cytisine should not be seen as problematic.

The most common **side effects of vaping** tend to be a dry mouth and tickly cough as the vapour can have a drying effect on the mouth and throat. These can generally be remedied by drinking more water.

Further information

Information for specialist stop-smoking services that are considering providing e-cigarette starter packs: recommendations from the Trial of Ecigarettes (TEC) – click here

Resources

NCSCT briefing – Vaping: a guide for health and social care professionals – click here

NCSCT briefing – Incorporating nicotine vaping products into Stop Smoking Services – click here

Training

Vaping: a guide for healthcare professionals online training module – click here

5.2.3 Varenicline

Licenced varenicline is not currently available in the UK. When supply of licenced varenicline recommences, we will include more information in this section and inform the field.

Evidence rating: A

Varenicline is a first choice stop smoking medication that is twice as effective as single-form NRT and has been shown to be slightly more effective than combination NRT.[63]

Varenicline is a prescription-only medicine that reduces nicotine withdrawal symptoms and urges to smoke and blocks some of the rewarding effects of smoking.

Varenicline is typically taken for 12 weeks. It has been shown to be safe and effective to extend treatment to 26 or 52 weeks for relapse prevention in clients who may benefit, or as part of a CDTS intervention.[64,65]

Further information

NCSCT briefing – Guidance on alternatives to Champix – click here

NCSCT publications – Unlicensed varenicline – click here

Resources

Varenicline summary of product characteristics – click here

5.2.4 Cytisine

Evidence rating: A

Cytisine was approved for use as a prescription-only stop smoking aid in the UK in January 2024. Cytisine is an effective treatment that works in a similar way to varenicline, reducing urges to smoke by attaching to some of the same neuronal receptors in the brain that nicotine does. Its side effects (gastric symptoms and sleep disturbance) are like those found with varenicline, but less common.

One pack of Cytisine contains 100 tablets which is a complete treatment course (25 days). Using it for up to 12 weeks is probably more effective and it appears to be roughly as effective as varenicline when taken for the same duration (12 weeks). Even with 25 days' dosing, evidence suggests that it is as effective as NRT.

Cytisine is swallowed as a tablet with water according to the following schedule, with the quit date no later than the fifth day of treatment:

Days of treatment	Recommended dosing	Maximum daily dose
From the 1st to the 3rd day	1 tablet every 2 hours	6 tablets
From the 4th to the 12th day	1 tablet every 2.5 hours	5 tablets
From the 13th to the 16th day	1 tablet every 3 hours	4 tablets
From the 17th to the 20th day	1 tablet every 5 hours	3 tablets
From the 21st to the 25th day	1–2 tablets a day	2 tablets

Cytisine is not licensed for people under 18, over 65 or for pregnant or breastfeeding women. Neither is it recommended for people with unstable angina, a recent myocardial infarction, clinically significant arrhythmias or who have had a recent stroke.

Incorporating cytisine into the STP will maximise clients' chances of quitting successfully.

Further information

Cytisine summary of product characteristics and dosing guide – click here

NICE – 2024 exceptional surveillance of tobacco: preventing uptake, promoting quitting and treating dependence – click here

Resources

NCSCT briefing – Cytisine – click here

5.3 Second choice stop smoking aids

As a rule, use of first choice stop smoking aids should be promoted to all people who smoke making a quit attempt. There may be occasions, however, such as first choice aids being contraindicated or client choice, when use of second choice aids is appropriate.

5.3.1 Bupropion

Evidence rating: A

Bupropion can almost double the chances of long-term abstinence, but it is less effective than first choice stop smoking aids and about as effective as single-dose NRT.[66] Bupropion is not licensed for use in pregnancy or when breastfeeding.

Although a safe medication, bupropion does have a relatively serious side-effect profile and a number of contraindications and cautions. Given its side effect profile it is a second choice stop smoking aid.

Further information

Bupropion summary of product characteristics – click here

5.3.2 Single-form NRT

Evidence rating: A

Single NRT products typically deliver approximately half the nicotine people would get from smoking one pack of cigarettes per day. Single NRT products increase rates of quitting but are not as effective as first choice stop smoking aids.[45]

There are seven different types of NRT: patch (16-hour and 24-hour), gum, lozenge (including mini-lozenge), microtab, nasal spray, mouth spray and inhalator.

There is no evidence to suggest that one type of NRT is significantly more effective in practice than another. Product selection should be guided by client preference.

Training

Stop smoking medications online training module – click here

Resources

Stop smoking aids quick reference sheet – click here

Further information

Nicotine gum – click here

Nicotine patches – click here

Nicotine inhalator – click here

Nicotine nasal spray – click here

Nicotine mouth spray – click here

Nicotine microtabs – click here

Nicotine lozenges – click here

5.4 Effect of stopping smoking on medications

Tobacco (not nicotine) stimulates a liver enzyme responsible for metabolising some drugs, which means that some medications are eliminated from the body quicker by people who smoke than by people who don't smoke. There are a small number of medicines that may need increased monitoring or dose adjustment when a person stops smoking.

For clients taking medication with a clinically significant interaction, the prescriber should be informed that the client is making a quit attempt and that the dose may need to be monitored and, in some cases, adjusted. This is particularly important for clients taking clozapine, where the risk of toxic effects following cessation requires careful monitoring and dose adjustment. Quit status should be regularly reassessed so that, if the client relapses, prescribers can readjust the dose.

Further information

Specialist Pharmacy Service – Considering drug interactions with smoking – click here

NICE – Which drugs are affected by stopping smoking? – click here

5.5 Tobacco-free niche nicotine products

Evidence rating: I

Tobacco-free nicotine pouches are products placed between the lip and gum, from where nicotine is absorbed. They entered the market in the UK in 2019, as an alternative to tobacco smoking. They have not been extensively studied.[67] Oral nicotine pouches are regulated under the General Product Safety Regulations (GPSR). They are not currently recommended as a stop smoking aid due to lack of research on safety and efficacy.[67]

Resources

NCSCT briefing – Nicotine pouches – coming soon

Further information

Tobacco-free Nicotine Pouch Use in Great Britain: A Representative Population Survey 2020-2021 – click here

Committee on Toxicology statement on the bioavailability of nicotine from the use of oral nicotine pouches and the assessment of the potential toxicological risk to users – click here

6.0 Methods of quitting

6.1 Abrupt quit

Evidence rating: A

Abrupt quitting involves setting a quit date and planning complete abstinence after that date.

Most services employ the abrupt quit approach that requires clients to set a quit date (often at the second appointment) with a trained practitioner and commit to the 'not-a-puff' rule.

Further information

NCSCT Standard Treatment Programme – click here

NCSCT briefing: The 'Not-a-Puff' Rule – click here

6.2 Cut Down to Stop (CDTS)

Evidence rating	
Cut Down to Stop without a stop smoking aid	I
Cut Down to Stop with NRT	B
Cut Down to Stop with varenicline	B

Some people who smoke will not be ready to commit to quitting abruptly and may like to try an alternative method such as CDTS.

- Structured CDTS programmes involves setting progressive smoking reduction goals, with the view to stopping completely, over a specified period of time.
- CDTS support should include both first choice stop smoking aids (NRT, varenicline, nicotine vapes) and structured multi-session behavioural support from a trained practitioner.

CDTS allows people who smoke to experience the value of stop smoking aids, make progressive steps towards quitting over several weeks, and get some initial success with smoking reduction that serves to increase their confidence in their ability to stop completely.

The STP and BCTs can be adapted to support CDTS (see **Figure 3**).

CDTS is not recommended for women who are pregnant due to the significant risk of tobacco use to mother and fetus.

Figure 3: Adapting BCTs for CDTS interventions

BCTs used at initial contact:

- Inform clients about the CDTS treatment programme
- Assess current smoking routines and associated barriers
- Explain tobacco addiction and what to expect in terms of withdrawal and craving
- Explain and conduct CO monitoring
- Agree to reduction plan and weekly targets
- Discuss the use of stop smoking aids as part of their CDTS
- Identify smoking routines and triggers and support problem solving
- Elicit commitment to reduction targets
- Summarise the CDTS plan

BCTs used at follow-up contacts:

- Assess progress
- Assess cravings and withdrawal symptoms, and use of NRT or nicotine vape
- Conduct CO monitoring
- Identify challenges experienced in the last week and plan for dealing with these
- Agree on weekly reduction goal
- Advise on use of NRT or nicotine vape
- Review plan for achieving reduction goal
- Elicit commitment to reduction targets
- Summarise the CDTS plan

Resources

CDTS client workbook – coming soon

7.0 Priority groups

Tailoring service access and delivery to the needs of priority groups will increase the quantity and quality of behavioural support delivered, improve stop smoking aid compliance and result in more quits.

Evidence rating: A

Principles for tailoring service delivery and treatment to priority groups:

- Be client led and client focused, and ensure genuine informed choice
- Co-produce support programmes and communication materials
- Put the support where the people are and offer a wide range of support options
- Work collaboratively with others who support priority populations

7.1 Low income households and people experiencing socio-economic disadvantage

People living in low income households smoke at higher rates and data has consistently shown they are less likely to succeed in quitting than people from wealthier households.[10,68] People from lower socio-economic groups experience greater barriers to quitting, including being more heavily dependent on smoking, higher rates of smoking amongst those they associate closely with and higher levels of stress related to deprivation and disadvantage.[68] Evaluations of LSSS have found that there has been success in engaging people from low socio-economic groups and, although people from these groups had lower quit rates, this was offset by increased service reach.[69,70]

Lower income people who smoke are less likely to continue with the full course of treatment or complete the stop smoking support programme. The analysis of LSSS concluded that Interventions that offer tailored and targeted support have the potential to improve quit outcomes among people experiencing socio-economic disadvantage.[69]

Reducing the availability of illegal tobacco has been linked to lower rates of smoking among socially deprived groups.

Best practices for tailoring services include:

- Ensure an equity-oriented approach to LSSS delivery that targets people in lower socio-economic groups.
- Provide barrier-free, cost-free access to stop smoking aids and stop smoking support.
- Flexible support programmes that offer more intensive and longer support.
- Consider outreach into settings such as workplaces, housing associations and debt advice services.
- Work with police and other local partners to reduce access to illegal tobacco.
- Ensure LSSS communication and promotional activities, including the design and dissemination of targeted communication campaigns, feature people from lower socio-economic groups.

- Use of peer facilitators and buddies to encourage engagement with services.
- Address language and communication barriers.
- Offer a CDTS option.
- Add text messaging and digital support to the main behavioural support programme.

Further information

ASH – Smoking: low income households – click here

7.2 People with severe mental illness (SMI)

Although just as likely to want to stop smoking as people who do not have SMI, this client group typically face significant barriers and challenges to quitting smoking.[28] SMI clients need, and deserve, high-quality, evidence-based support tailored to their individual needs to give them the best possible chance of quitting smoking.[28]

Evidence rating: B

This client group require flexibility and time. Attempting to fit them into rigid pre-existing treatment protocols will be unlikely to meet their needs.

The recommendations focus on a person-centered approach using a flexible service delivery model designed to promote engagement of people with SMI, guided by the client's individual needs.

First choice stop smoking aids are effective for people with a mental illness,[71] including people with SMI.[63,72] Given people with SMI are typically more nicotine dependent, the amount of NRT required is likely to be higher than that needed for people who smoke in the general population.

Best practices for tailoring services include:

- Offer quitting in one step (abrupt quit) as the first choice option, with flexibility to offer CDTS for those not interested, or able, to stop in one step.
- Facilitate access to NRT, nicotine vapes or other stop smoking aids prior to quitting and for extended periods after quitting to prevent relapse.
- Provide person-centred support that is tailored to the individual, including flexible appointment venue, more frequent contacts and tailored duration of support.
- Address common barriers to quitting and facilitate alternative activities.
- Offer support with quitting to family/caregivers.
- Be ready for setbacks and build these into the treatment plan.
- Ensure good communication with the care team and those performing the mental health medication review.

Resources

NCSCT briefing – Principles and best practices for stop smoking support in people with SMI – coming soon

Client story: quitting while dealing with a mental health condition

Julian is 41 years old and volunteers in a research team. He was diagnosed with schizophrenia at 18. Smoking was an additional thing he had to deal with alongside his mental health condition.

He said that smoking "took over all parts" of his life and "was difficult to give up".

When discussing quitting smoking with his advisor, he discussed when he would give up, what it would be like and "worked on visualising being smokefree".

He described his advisor as listening carefully, asking the right questions to get to know what was important to him and what his motivators and barriers were.

After quitting, Julian said that being smokefree meant "one less complication to my health conundrum. It was a really valuable experience that gave me more confidence. I was helped to feel positive about quitting smoking. I felt quite exalted that I had managed it!"

7.3 Pregnant women

Evidence rating: A

Best practices for tailoring services include:

- Delivery of support by stop smoking practitioners trained in working with pregnant women who smoke.
- Rapid, flexible behaviour support programme (including home visits and outreach) that continues for as long as it is needed.
- Access to, and support with use of, free combination NRT or nicotine vapes.
- Use of CO monitoring as a motivational tool.
- Offer support, and access to stop smoking aids, to partners and significant family members to create a social norm and motivate the pregnant client to attempt and maintain a quit attempt.

7.3.1 Behavioural support

Evidence rating: A

Behavioural support is effective in supporting pregnant women with stopping smoking.[73] There is good evidence for tailoring stop smoking support for pregnant and post-partum women and existing best practice.[79–82]

The NCSCT STP for Pregnant Women is a key resource for adapting support (see **Resources** below). The STP for Pregnant Women differs from that used for other groups in that there is a greater urgency during pregnancy to support women unable to quit on their own. Pregnant women may require a more flexible approach and longer periods of support than the general population. As such, the timing and number of sessions can be adapted to the individual needs of the pregnant woman. Support should be provided as early as possible. Continued support throughout the pregnancy, up to the date of delivery, is recommended, as relapse is common and often occurs late into pregnancy.

Understanding barriers and challenges to quitting allows service providers to develop and shape their interventions. High levels of stress or having a mental illness have been shown to affect success with stopping in pregnancy and should be taken into consideration.[74] One of the key barriers to quitting is having a partner who smokes and to a lesser extent other family members, especially if the woman is living in a household with other people who smoke.[75,74] Offering support to partners and family members is best practice. Additionally, having the support of partners or other significant people has been shown to be important.[76]

Rates of post-partum relapse are very high and planning for supporting women with remaining smokefree in the post-partum period, through behavioural support and use of stop smoking aids, should be addressed before the baby's arrival.

7.3.2 Financial incentives for pregnant women

Evidence rating: A

Financial incentive schemes to support pregnant women with smoking cessation have been found to be highly effective in increasing quit rates.[73,77,78] Incentive schemes that include validation of remaining smokefree are highly cost-effective and show improved engagement with services. They result in better pregnancy outcomes, with pregnant women two and a half times more likely to stop smoking.[77,78] A variety of incentive models have been examined, including incentives to encourage recruitment to stop smoking support, to reward compliance with contacts, and to reward stop smoking achievement at predefined timeframes, usually contingent on a biochemically-confirmed cessation.[77,78] A variety of rewards have been used, including cash payments, vouchers exchangeable for goods (excluding alcohol and cigarettes) or leisure activities, and promotional items.[77,78] More research is needed to provide guidance on the difference between the various financial incentives.

The newly announced financial incentives scheme for pregnant women will support the availability of a national incentive programme for pregnant women who smoke. This section will be updated to include further details once guidance is made available.

7.3.3 NRT use in pregnancy

Evidence rating: B

NRT is safe and effective in supporting pregnant women to quit smoking and there is no evidence that using NRT during pregnancy is harmful to mother or fetus.[52,53] NRT can be recommended for any pregnant woman who is unable to stop smoking on her own and those at risk of relapse. Combination NRT can be used for pregnant women who smoke and might be particularly helpful to those who are more dependent or who are struggling with withdrawal symptoms and/or urges to smoke.[54] Combination NRT may be important because pregnant women have increased nicotine metabolism. It is recommended that pregnant women use a 16-hour patch or remove the 24-hour patch overnight to avoid an extended delivery of nicotine to the fetus.

Using NRT for as long as necessary to prevent relapse is important. Pregnant women should be reassured about, and informed on, the safety of NRT and its correct use in pregnancy, as there tend to be concerns and issues with treatment compliance that can undermine success with stopping.[79] Clear, consistent messages about the safety of NRT use from healthcare professionals and stop smoking practitioners is best practice.[79]

7.3.4 Vaping during pregnancy

Evidence rating: B

Available evidence, primarily from a large UK trial, indicates nicotine vapes are an effective aid for those who are pregnant and wanting to quit smoking, especially for those who do not wish to access formal support or use NRT.[80]

While limited research exists on the safety of vaping during pregnancy, a recent study found that regular use of nicotine vapes or nicotine patches by pregnant women was not associated with any adverse outcomes.[81] Vaping nicotine has a similar safety profile to NRT and is more effective in preventing low birth weight and more effective in helping pregnant women quit than NRT.[81]

While licensed NRT products such as nicotine patches, gum and inhalers are the recommended option, if a pregnant woman chooses to use a vape, and if that helps them to quit smoking and stay smokefree, they should be supported to do so.

To maximise health benefits and reduce the risks caused by smoking tobacco, the best outcome is for pregnant women to switch completely from tobacco to vaping.

7.3.5 Nicotine analogues during pregnancy

Nicotine analogues (varenicline and cytisine) are not recommended for use in pregnant and post-partum women.

Client Story: quitting whilst pregnant

Lorna is 34 years old and is on her fifth pregnancy. She has had two miscarriages and two babies born prematurely. Her CO test at booking was 20ppm. She tells her midwife she has cut down from 20-a-day to 10-a-day. Her midwife referred her to the maternity in-house stop smoking service.

Lorna tells her advisor that she has a lot of stress in her life, as her husband is unemployed and he also smokes. She states smoking helps to relieve her stress.

The advisor asks her if she understands why we worry about women who smoke in pregnancy. Lorna says she knows it must affect the baby's growth but doesn't really know why. The advisor then explains simply about how CO reduces oxygen in her red blood cells that help her baby to grow and develop. She carries out another CO reading (18 ppm), this time showing Lorna the difference in the amount of CO in her red blood cells compared to the higher CO reading in the baby. This information upsets Lorna, but she is relieved to know that CO can be eliminated from her blood, and therefore her baby's, in under 24 hours. Lorna is also relieved to know that, as she is early in pregnancy (11 weeks), if she quits smoking now her baby will be born at the same gestation and weight as a woman who has never smoked.

The advisor takes time to explain how cutting down on the amount she smokes is not a safe option, that stress is a withdrawal symptom of nicotine addiction and that, with support and NRT every day, stopping smoking will become easier. Support through a local community group is also offered.

Lorna mentions that her partner smokes. An offer of support for him to quit is made. The advisor reassures Lorna about the safety of using NRT in pregnancy and she chooses to use a 16-hour patch in combination with nicotine mouth spray, to quickly alleviate her withdrawal symptoms, especially as she smokes soon after waking. The advisor explains how important it is to use her NRT correctly and as often as 'on the hour, every hour' during the day. She explains the importance of seeing Lorna on a weekly basis.

Lorna was seen weekly up to her four-week post-quit date session, and then regularly until her delivery. She had one lapse on week one but, after discussion, it was found she needed to increase her mouth spray use. Her husband also came on board after two weeks and successfully quit too. With intensive support throughout her pregnancy, they both remained quit and celebrated the safe arrival at term of a 3.5 kg healthy baby girl.

Further information

Saving babies' lives version three: a care bundle for reducing perinatal mortality – click here

NCSCT briefing – Smoking cessation interventions involving significant others – click here

ASH briefing – Evidence into Practice: Supporting smokefree pregnancies through incentive schemes – click here

Resources

Standard Treatment Programme for Pregnant Women – click here

NCSCT briefing – Stopping smoking in pregnancy: A briefing for maternity care providers – click here

Training

Pregnancy and the Post-Partum Period Specialty Module – click here

Very Brief Advice on smoking for pregnant women is for all health and social care professionals in contact with pregnant women – click here

Secondhand smoke: promoting smokefree homes and cars is for anyone who regularly comes into contact with families – click here

NHS training

A **Maternity care pathway** online training programme focusing on VBA that includes CO monitoring:

- **Supporting a Smokefree Pregnancy and Smokefree Families** – click here
- **Saving Babies' Lives** – click here
- **Reintroduction of CO Testing** – click here

7.4 NHS Tobacco Dependence Service (TDS) Transfer of Care

Evidence rating: A

The NHS tobacco treatment pathway includes Transfer of Care for stop smoking support following discharge from hospital. The pathway recommends patients discharged from acute trusts be followed for a **minimum of 28 days post-discharge** and patients discharged from an acute mental health trust for up to **12 weeks post-discharge.** Ongoing support should include both behavioural support and continued supply of stop smoking aids.

Transfer of Care recognises that quit dates will not be set with LSSS as the quit attempt is initiated in hospital. This guidance includes new advice and working definitions to support LSSS with monitoring of Transfer of Care (see **Part 4**). For clients who are part of the Transfer of Care, the self-reported and CO-validated quit date will be measured from date of discharge from hospital. Importantly, reporting the 28-day outcome for Transfer of Care clients back to the referring NHS trust is necessary as this is a mandatory performance indicator for trust tobacco dependence treatment programmes.

Best practices for well-coordinated, efficient pathways providing **seamless support for people** in the community following discharge from their contact with the NHS include:

- **Simple digital referral processes,** such as a one-click electronic referral method.
- **Referral criteria** agreed, so that patients are seen by the most appropriate community-based service. This includes efforts to ensure specialist qualified providers see patient groups at greatest risk of relapse or with specific needs (e.g. pregnant women and partners, people who are heavily dependent and people with SMI).
- **Sufficient detail to allow for seamless Transfer of Care.** LSSS and trusts should agree to the minimum information that accompanies referrals to ensure LSSS practitioners can meet individual care needs.
- NHS commissioners and LAs need to ensure that provider organisations give **rapid access** to follow-up support from LSSS. This includes contact with patients within 48 hours of discharge, multiple attempts to contact patients (at least three to five attempts at different times of day) and reporting back to trusts about patients who have not been reached.
- **Provision of ongoing supply of stop smoking aids.** Mechanisms should be in place to ensure patients are provided with ongoing supply of medication for 10–12 weeks (from the initiation of treatment in hospital). This may require innovative distribution methods for patients that are not initially seen in person.
- **Adaption of service delivery model to support post-discharge follow-up.** The STP should be adapted to support patients who have already initiated a quit attempt.
- **Flexible service delivery options.** Not all patients discharged from hospital will be mobile or in good health and this is particularly true in the early post-discharge period. LSSS should be prepared to modify service delivery options to ensure ongoing support, including offering remote support and hybrid service delivery models.

- **Follow-up support** for at least four weeks post-discharge for patients discharged from acute trusts and 12 weeks for patients discharged from acute mental health trusts.
- Development of **strong working relationships between NHS TDS and LSSS** commissioners, managers and providers.
- **Engaging post-partum women.** NHS trusts operate a maternity tobacco treatment pathway that is led by the trust inpatient maternity team. Where possible, continue engagement with post-partum women, as well as partners and other household members, to avoid relapse.

7.5 People with substance misuse disorders and co-addictions

A proportion of people who receive support from LSSS will also use other substances, including alcohol. Their use of other substances can have a direct effect on their ability to quit smoking. As such, it is important for clients to be asked about current and past substance use as this will have implications for their quit plan.

Evidence rating: B

There has been limited research looking at best practices for treating tobacco dependence in people with alcohol or substance abuse.[82] Research indicates that stopping smoking at the same time as undergoing treatment for alcohol and other drug dependence does not undermine drug treatment and may result in increased rates of smoking cessation.[88-91] Evidence suggests the use of stop smoking aids improves outcomes and that clients may require more intensive treatment for a longer period of time.[82,83–84]

It is important that LSSS develop a policy regarding the collection, storage and confidentiality of information on substance use, so that both practitioners and clients can feel confident in having discussions about it.

It is also important that communication and coordination of care takes place with services that clients are engaged with.

Resources

NCSCT guidance – Service policy guidance on cannabis use – click here

NCSCT briefing – Smoking cessation and cannabis use – click here

7.6 Populations with multiple or complex needs

People with multiple or complex needs include those experiencing homelessness, those with contact with the criminal justice system, ethnic minorities, travellers, and members of the LGBTQ+ community.[85]

Best practices for tailoring services include:

- Ensure support is visible – put it where the people are.
- Prioritise smoking cessation alongside other addiction and support services.
- Train key workers in VBA+.
- Partner with local organisations who work with populations with multiple or complex needs to promote and support outreach.
- Embed LSSS into settings which have good working relationships with, and/or deliver services to, people with multiple or complex needs.
- Train staff in working with local populations with multiple or complex needs, including on how to adapt treatment.
- Ensure services can be provided in languages spoken by residents in your area and provide translation services where required.

Call for evidence and good practice on interventions for people with multiple or complex needs
We are looking for examples of evidence and good practice to include in future versions of this guidance. Please contact the NCSCT if you have a good practice to share.

7.6.1 People experiencing homelessness

Evidence rating: B

Many people experiencing homelessness face substantial barriers to quitting and one of the main issues is not being offered, or having access to, evidence-based support. This is compounded by issues of stress related to their housing situation, stigma, boredom, hunger, chronic pain and anxiety. Smoking is dangerous for all people but, because people who are experiencing homelessness have very low or no incomes, they often engage in more risky smoking practices, such as smoking discarded cigarettes, sharing cigarettes and begging for cigarettes, which increase their vulnerability. People experiencing homelessness who smoke tend to smoke a greater number of cigarettes per day relative to the general population of people who smoke.

To reduce these risks, good practice includes having regular offers of stop smoking support embedded in routine health reviews, outreach visits from LSSS and offering harm reduction support.[33]

LSSS can work with homelessness services to create a supportive environment for people who smoke to understand how to improve their health and the benefits of stopping. Stop smoking support can be embedded into these settings, including outreach and onsite support from practitioners trained in working with people experiencing homelessness.

Although there is no reason to believe that stop smoking treatment works any differently for people experiencing homelessness than the general population, best practice identifies the need to use tailored approaches given the daily challenges they face.[33,86] CDTS interventions have been identified as particularly useful for people experiencing homelessness.

There is some evidence to suggest a modest benefit of more intensive behavioural smoking cessation interventions when compared to less intensive interventions.[86] However, further research is needed.

Vaping has been found to be popular and should be encouraged and facilitated by frontline staff as a substitute for smoking tobacco. NRT can also be used.

Further information

Room to Breathe – click here

ASH – Smoking: People experiencing homelessness – click here

Training

Very Brief Advice on Smoking (VBA+) for Homelessness Services is for those working in homelessness service or in regular contact with people experiencing homelessness – **click here**

7.6.2 LGBTQ+ communities

Evidence rating: B C

LSSS policies, communications and services should embrace members of the LGBTQ+ community and use inclusive language that avoids assumption about gender or sexual orientation. Services should use the Sexual Orientation Monitoring Information Standard as part of local data collection for monitoring and needs assessments. Communication materials and messages should include representation of the LGBTQ+ community and ideally use tailored and targeted messages.

Evaluations suggest rates of successful quitting among LGBTQ+ people who quit with support are comparable to heterosexual people. The majority of research has been conducted among gay men, with less research available for other LGBTQ+ people.[87] Gender-specific interventions have been identified as a preference and have been associated with greater satisfaction and uptake.[93–95] There is some evidence that such interventions result in higher quit rates, although results have been mixed and more research is needed to understand the effect of tailoring interventions on improving quit rates.[88,89]

There is also some evidence that group support may have greater effectiveness.[91] Needs assessments and systematic reviews have attempted to identify best practice for tailoring treatment to LQBTQ+ clients. This has included holding group sessions in LGBTQ+ spaces, discussing social justice, discussing LGBTQ+-specific triggers, boosting motivation/self-efficacy and addressing social support.[87,91] Partnering with LGBTQ+ organisations, and co-designing and co-locating services in health and community services that work with the LGBTQ+ community, are good practice.[92]

Further information

ASH – LGBT evidence into practice briefing – click here

The Greater Manchester Health and Social Care Partnership's 'You Can' campaign – click here and here

7.7 Children and young people

Experimentation is part and parcel of adolescence and thankfully most young people do not progress on to regular smoking (or regular vaping). For those that do, smoking remains a chronic condition and so anything that can be done to prevent the uptake of smoking will obviously have great individual and public health benefits.

Evidence rating: I

There is limited evidence on cessation interventions with adolescents, either in school or in community settings.[93] There is good reason to believe that many of the BCTs that form the basis of the STP would be effective for young people, but their effectiveness has not been directly assessed with adolescents who smoke. There is some evidence that group-based stop smoking support may be more effective than individual, mixed delivery, online or text messaging support in increasing rates of quitting.[94] There is evidence to suggest that delivering interventions in the school setting may engage more adolescents who smoke in treatment.[94,95] There is also evidence to show that supporting adults who smoke to quit will help reduce the rate of smoking uptake among young people.[94]

In 2022–23, 1,055 people under 18 years of age who smoked set a quit date with LSSS, with a self-reported quit rate of 47.0%, 12% of which were CO-validated.[70] The relatively low reach of services likely reflects the intentional focus of services on adults. While quit rates among adolescents are lower than those of adult clients, they remain good.

The key issues of smoking cessation with young people, especially when delivered by school nurses or other healthcare professionals, are:

- intent to stop smoking – is this genuine, or is the quit attempt being driven by adults who think they should stop?
- confidentiality – are the school and parents/carers informed about the quit attempt?
- use of stop smoking aids, including vapes.

This guidance recommends training staff who work in youth services (with whom young people already have a relationship and whose organisations are credible to them) in smoking cessation and encouraging signposting to, and raising awareness of, this service. VBA+ to prompt a quit attempt may be effective with young people but we simply don't know, nor who it is most effectively delivered by.

Further information

ASH – Young people and smoking – click here

What are the main sources of smoking cessation support used by adolescent smokers in England? A cross-sectional study – click here

8.0 Smokeless tobacco products

Smokeless tobacco covers a wide range of tobacco-containing products that are not smoked but rather chewed, inhaled or placed in the mouth. The use of smokeless tobacco products is more prevalent amongst certain populations and priority groups. A local needs analysis will determine whether there is a need for services to support cessation of these products.

8.1 Harms associated smokeless tobacco products

Smokeless tobacco poses a significant risk to oral and general health. Smokeless tobacco use increases the risk for periodontal diseases, oral lesions and is a risk factor for oropharyngeal cancers.[96–102] Evidence also suggests a strong association between some smokeless tobacco products and increased risk of ischaemic heart disease, stroke and adverse perinatal outcomes.[96–98] Some smokeless tobacco products contain more than 30 carcinogens, including tobacco-specific nitrosamines.[96,102]

Resources

NCSCT briefing – Smokeless tobacco products – coming soon

Further information

ASH – Evidence into Practice: Smokeless Tobacco products – click here

Call for evidence and good practice on smokeless tobacco interventions
We are looking for examples of evidence and good practice to include in future versions of this guidance. Please contact the NCSCT if you have a good practice to share.

8.2 Oral tobacco products (chewing)

This traditionally refers to any type of product containing fermented or liquified tobacco that is designed to be chewed or placed in the mouth. They are typically used in England by people of South Asian origin and include paan masala, gutka and tobacco-containing betel quid.

8.3 Nasal tobacco products

Nasal tobacco (snuff) is a semi-moist tobacco product consumed via the nose. This category also includes snus and naswar, which can be consumed orally.

8.4 Oral tobacco products (non-chewing)

These are tobacco products used orally, but not intended to be inhaled or chewed. They are sold in sachets, in powder or particulate form. This type of smokeless tobacco is currently banned for sale under the Tobacco and Related Products Regulations legislation.

8.5 Waterpipes

Waterpipe smoking is a broad term given to a device whereby smoke (usually sourced from a tobacco mixture) is passed through water prior to inhalation. Waterpipes are also known as hookah, shisha, narghile, goza and hubble bubble.

Many people wrongly perceive waterpipe smoking as less harmful than smoking because of the perception that water filters out the harmful substances in the smoke. Like cigarette smoke, waterpipe smoke contains metals, CO and cancer-causing chemicals.[103] Waterpipe use can lead to many of the same ill health effects as cigarette smoking, including increased risk of cancer, heart disease, respiratory problems and gum disease.[103–104] Some shisha mixes do not contain tobacco but are still harmful because of the smoke.[103]

A recent review of interventions to support waterpipe users with stopping found some evidence that behavioural interventions can be effective and limited evidence regarding the effectiveness of stop smoking aids.[105]

Further information

NCSCT briefing – Waterpipe tobacco smoking – click here

8.6 Heated tobacco products

These devices, also referred to as heat-not-burn products, heat a small plug of tobacco (often contained in a pod or stick that looks like a very small cigarette) to below 300°C, producing an inhalable vapour. These devices are sometimes confused with vapes.

Because these devices heat rather than burn tobacco, they are likely to produce fewer toxicants than traditional cigarette smoking. However, they still use tobacco and how less harmful they are than cigarettes is still unclear.[106–107]

These devices are manufactured almost exclusively by the tobacco industry. At the moment there is very little independent evidence about the safety or effectiveness of heated tobacco products.[106–107]

It is likely that heated tobacco products will be attractive to some people who like the taste of real tobacco and do not find other consumer products such as nicotine vapes appealing.

While heated tobacco products have been available in the UK since 2016, they are not as popular as other devices, with less than 1% of 'vapers' using one of these devices in 2022 – 23.[10]

Further information

Evidence review of e-cigarettes and heated tobacco products 2018: executive summary – click here

8.7 Stopping use of smokeless tobacco

Principles:

- Assess local need and be prepared to provide support with stopping the use of smokeless tobacco where need may be significant.
- Stop smoking practitioners should have a working knowledge of smokeless tobacco products.
- Support may be provided within an existing service or as a standalone service.
- Work in partnership with existing voluntary and community organisations to raise awareness of, and inform people on, the harms of these products.
- Use local names for products and provide support in languages used locally.

All health professionals should ask about smokeless tobacco when screening for tobacco use by asking: "Do you smoke or use any other form of tobacco?". Healthcare professionals should inform smokeless tobacco users about the health risks of non-combustible tobacco use in any form and refer patients to LSSS for support with stopping.

LSSS should offer support for people who use smokeless tobacco, including waterpipe smoking, in their treatment protocols. As with cigarettes, support for quitting smokeless tobacco includes the combination of behavioural support from a trained stop smoking practitioner and use of stop smoking aids to address withdrawal symptoms and urges to use tobacco. There is some evidence that NRT (in particular the lozenge) and varenicline increase rates of quitting smokeless tobacco, although the quality of this research is limited.[108] The STP can be adapted for use with people who are attempting to stop using smokeless tobacco.

Further information

NICE – Stopping use of smokeless tobacco – click here

9.0 Stopping vaping

Nicotine vape use is sometimes likened to smoking and there are enquiries about why we do not have Stop Vaping Services. The reason is that, based on current evidence, it would not be a cost-effective health improvement intervention.

Further information

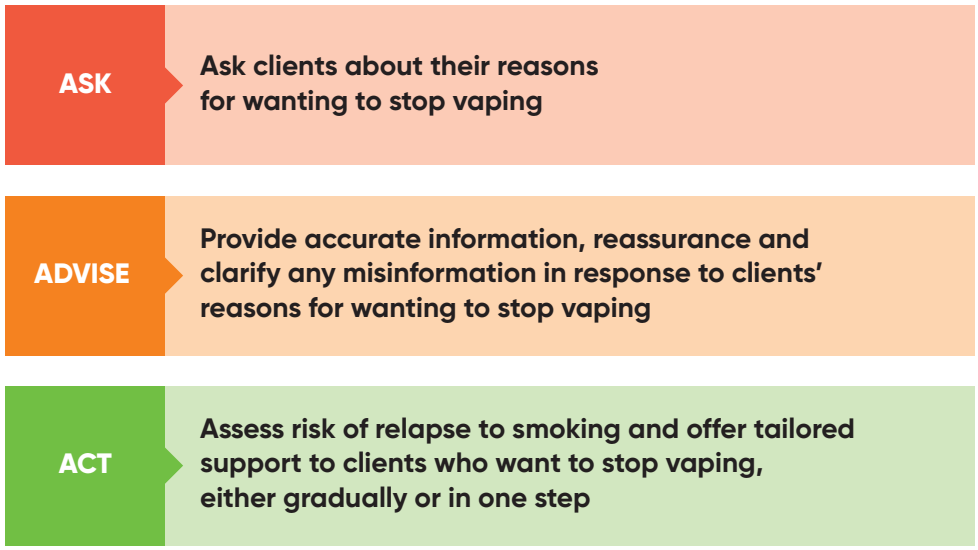
NCSCT briefing – Why do we not have Stop Vaping Services? – click here

When supporting clients who want to stop vaping, our priority should always be to ensure that they do not return to smoking cigarettes. NICE recommends that people should use vapes for as long as they help prevent them going back to smoking.

It is important to assess why clients want to stop vaping, their risk of relapse, and to plan and prepare appropriately for stopping vaping, either gradually or in one step.

When working with clients who want to stop vaping, it can be useful to organise support using the ASK, ADVISE, ACT model (see **Figure 4**).

Figure 4: ASK, ADVISE, ACT for support with stopping vaping



Resources

NCSCT briefing – Supporting clients who want to stop vaping – click here

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Part 4: Monitoring stop smoking services

Summary guidance:
Monitoring stop smoking services

- Monitoring and evaluation of service data provides an opportunity to assess the reach, effectiveness, and cost-effectiveness of smoking cessation interventions at a local and national level.
- Monitoring can help shape service specifications and business cases to support service funding.
- NHS England (NHSE, formerly NHS Digital) quarterly monitoring of stop smoking service delivery costs and outcomes helps evaluate the effectiveness of stop smoking services and informs local and national quality improvement.
- Inclusion criteria exist for who can be included in Local Stop Smoking Service (LSSS) quarterly returns. New Swap to Stop scheme indicators are available.
- There is a new 'Transfer of Care' category to allow for the inclusion of clients referred from the NHS Tobacco Dependence Service (TDS). This will assist with removing potential barriers for LSSS in providing support to patients following discharge from hospital and aligning measurement between LSSS and the NHS.
- Additional local data monitoring is recommended for effective service evaluation. Monitoring data includes activity related to local priority groups and contact response times.
- Quality assurance intelligence is recommended for ongoing service development and quality improvement, enabling a focus on areas including training, partnership engaging and customer satisfaction.

Aim and objectives of part 4

Aim

To provide guidance on monitoring, evaluating and quality assuring local stop smoking services.

Objectives

This guidance will:

- Highlight the requirements of the Stop Smoking Services Quarterly Return.
- Provide guidance on data definitions for quality and consistency.
- Highlight supplementary local data collection that monitors reach, access and outcomes of services.
- Provide guidance on local quality assurance procedures, including marketing and communication, and workforce diversity and inclusion.

1.0 Local Stop Smoking Service quarterly returns

1.1 Overview

The **Stop Smoking Services Quarterly Return** is an Office of Health Improvement and Disparities (OHID) central return used to monitor the delivery and effectiveness of LSSS.

The return is submitted by local authorities (LAs) to NHSE via the Strategic Data Collection System (SDCS).

The purpose of the national data set is to help monitor and evaluate the effectiveness and reach of stop smoking services. It is designed to provide consistent information on people who have sought and received quitting help from an evidence-based service.

The national data set is not a mechanism for counting all people who have stopped smoking in a locality, nor is it a prevalence measure. For this reason, it should not include quits that don't result from structured stop smoking interventions delivered by trained practitioners, defined by the Russell Standard (Clinical) (see **Annex A: Definitions**).[1,2]

This routine data collection has been invaluable in supporting the national tracking of LSSS success and has frequently informed further research into smoking cessation. It has also helped local areas benchmark their activity and, through the process of data submission, identify providers who may require additional support.

1.2 Data submission and requirements

- The submission is mandated as part of section 31 of the 'Creating a Smokefree Generation' grant agreement.
- Returns are made using an Excel spreadsheet downloaded from the SDCS for each reporting quarter.
- At the end of the monitoring period (one quarter plus six weeks), local areas have a further four weeks (five weeks in quarter 4) to submit data. This means that, at the end of the quarter, there is a total of 10 weeks to submit returns for quarters 1, 2 and 3 and 11 weeks for quarter 4.
- Launch and submissions dates are on the NHS England stop smoking services collection website (see further information below).
- Revisions of previous quarters (to allow for late data) are permitted in the case of quarters 1, 2 and 3 but not in the case of quarter 4. Under this system, however, more time is available for submission of quarter 4 data than for any other quarter. Late data from quarter 4 may not be carried into quarter 1 of the next reporting year.
- For the first 3 quarters of the year, NHSE produces three sets of tables at local, regional and national levels, accompanied by a summary describing the key results. Within the quarter 4 annual report all provisional figures from previous quarters are confirmed and figures are deemed final.
- Local commissioners are also asked to calculate and report on the proportion of the overall integrated service budget allocated to spend on smoking. Total expenditure on delivery is also submitted, with pharmacotherapy (all stop smoking aids) reported separately. This allows a cost per quitter to be calculated both with and without pharmacotherapies.

1.2.1 Capturing monitoring information

Most services have invested in web-based information systems to help streamline data collection and to analyse service performance. Such systems are of great benefit to commissioners and have proved a highly worthwhile investment. It is important that commissioners have access to anonymised provider data to inform current and future commissioning, and access to data should be agreed as part of the contractual process with providers.

To facilitate annual service audits by service providers and comply with clinical governance, all providers should maintain adequate client records which include all client contacts, medications used and outcomes. It is also important that service providers return data on all clients treated, not just on successful outcomes, so that success rates may be accurately calculated.

It is further recommended that service providers or practitioners that repeatedly submit incorrect or incomplete data receive refresher training in the approved definitions and procedures. Any data that they submit should be subject to regular spot checks until the service lead is satisfied that the correct procedures and definitions are being used.

The submission of partial or incorrect data is an important quality assurance issue and contracts should not be renewed with providers who are not able to submit accurate, timely data submissions.

1.2.2 Exception reporting

Before submitting quarterly data, it is recommended that service leads and/or commissioners examine the data so that, if they find outlying data, they can carry out an exception reporting procedure.

Specifically, self-reported four-week quit rates would be expected to be between 35% and 70%. If the overall results from a provider (or those for a specific intervention type/setting) fall outside this range, then an area may wish to conduct further checks.

The procedure outlined below is the exception reporting process previously recommended, and it is offered here as an example:

Step 1: The service provider or practitioner is contacted and asked to confirm that all the standard data definitions (see **Annex A: Definitions**) have been followed. If this is not the case, then the total number of successful four-week quits should be recalculated using the approved definitions and the data re-entered onto the service database.

Step 2: If the service provider or practitioner asserts that the approved definitions have been used, a random sample of 10% of people reported to be treated should be checked and verified by the service provider concerned. Such quality assurance measures could be carried out by telephone, or face to face if possible.

This should establish whether the clients meet the criteria for self-reported or carbon monoxide (CO)-verified four-week quits and whether they have received an approved intervention of the required content and duration.

If the quality assurance checks indicate that recorded quits are unreliable, all cases received from this provider may then need to be re-verified using the approved definitions and the total number of four-week quits should be re-entered onto the service database. If, after the required checks have been carried out, the results are still outside the expected range, a further review into the causes may be required.

Further information

NHS Digital Stop Smoking Services Data Collection and Sets – click here

Official Statistics on NHS Stop Smoking Services in England – click here

LSSS additional funding support allocations and methodology – click here

LSSS data collection service access – click here

1.3 Definitions and data quality

1.3.1 Definitions

To maintain the quality, consistency and usefulness of the data collected, it is important that services abide by the strict criteria on who can be included in monitoring returns and the four-week quit status of clients. These criteria need to be applied consistently. Clear definitions are provided in **Annex A: Definitions.**

NEW in LSSS data template: Gender definition.

Clients who do not feel they can identify themselves as being either male or female are defined as being of indeterminate sex.

The approach for recording of clients of indeterminate sex is under review, awaiting recommendations from the Equalities Act review. This will inform decisions regarding systems for capturing data of this nature. Until this is resolved, it is asked that you continue to collect and maintain this data locally on a voluntary basis but exclude it from national returns. This information may be requested on an informal basis at some point in the future.

1.3.2 Swap to Stop

As part of the national Swap to Stop scheme, services will need to report on client numbers within this scheme.

Indicators to be reported on in the quarterly LSSS data submission are:

- Total number provided with a vape as part of national Swap to Stop scheme
- Number who set a quit date and attended multiple support sessions as part of national Swap to Stop scheme
- Number who set a quit date, attended multiple support sessions and successfully quit as part of national Swap to Stop scheme
- Number who did not engage with multi-sessional support and/or did not set a quit date but who had successfully quit as part of national Swap to Stop scheme

1.3.3 NHS Transfer of Care to LSSS

Clients who have transferred into LSSS via referral from the NHS TDS are considered a 'Transfer of Care' and can be included in this return.

Transfer of Care is considered a distinct intervention with a specific definition. It was introduced in 2024-25 because most hospital inpatients being referred to LSSS have begun a period of smoking abstinence in hospital and will not be setting a quit date with the LSSS.

The lack of alignment between metrics used within LSSS and the NHS TDS has been identified as a potential barrier to delivering follow-up of patients referred from NHS inpatient settings. This has prompted changes to national reporting to ensure any barriers to service delivery are addressed and is consistent with national efforts to support integrated service delivery.

Updated guidance and definitions for Transfer of Care clients who have been referred to LSSS from NHS trusts should be used from 2024 – 25 onwards. New data definitions allow for Transfer of Care clients referred from the NHS TDS to be included in the national data set, provided they receive their first treatment episode within 14 days of their discharge from hospital. Treatment may be delivered in person, by telephone or real-time video. See **Annex F** for details on the indicators and definitions supporting Transfer of Care from NHS trusts to LSSS. See **Part 2** for principles for post-discharge follow-up.

Outcome measurement

- **Assessment of Smoking Status.** For Transfer of Care clients, the assessment of four-week quits will be measured **28 days following discharge from hospital** based on the Russell Standard (Clinical).[1] Assessment of 12-week smoking status is also highly recommended to assess longer-term quit rates.
- **Agreements for Outcome Assessment.** NHS trusts are required to report on self-reported 28-day post-discharge smoking status, with CO-validated reporting of smoking status recommended. The reporting of 28-day smoking status avoids duplication and confusion among referred clients.

2.0 Local data collection and monitoring

In addition to national data collection, supplemental data should be collected locally to monitor service reach, access and outcomes.

Suggestions for Key Performance Indicators (KPIs) and additional data collection are suggested in **Table 1** below.

Table 1: Indicators for local data collection

Outcome measure	Data
Referrals	1. Number of referrals 2. How referrals received 3. Organisation, department or team referrals received from
Contact response time for referrals:	Percentage of clients contacted within 24 hours (one working day) of referral if pregnant and 48 hours (two working days) for other referrals. 1. Date and time referral received 2. Date and time first contact attempt with client 3. Number of contact attempts made 4. When contact made with client (if achieved) 5. How contacts made, e.g. telephone, online, text, email
Contact for clients lost to follow up	The number of contact attempts made to each client.
Priority group access and outcomes	The number of referrals, number of people who accept the service, set quit dates and achieve four- and 12-week quit outcomes by identified service user priority groups.
Immediate households of pregnant people who smoke	The number of referrals, number of people who accept the service, set quit dates, achieve four- and 12-week quit outcomes by partners, parents and others living in the same household as a pregnant person who smokes.
Cut Down to Stop (CDTS)	How many service users are supported via CDTS and outcomes achieved at 4, 12, 24 and 36 weeks.
Transfer of Care from the NHS TDS	The number of referrals, number of people accessing the service, set quit dates and achieve four- and 12-week quit outcomes for clients transferred from NHS TDS.
Six- and 12-month follow up	Follow up service users who achieved a 12-week quit at six and 12 months and report quit outcomes, specifically: ■ **% and number who remained quit at point of contact** ■ **% and number who relapsed at point of contact** ■ **% and number contacted overall** Target 10% of annual total of service users achieving a 12-week quit.
Shisha and smokeless tobacco products (*if in service specification*)	How many service users using shisha and/or smokeless tobacco (e.g. betel quid and gutka) that are supported to quit at four and 12 weeks by priority group and ethnicity.

3.0 Local quality assurance

In addition to exception reporting, it is recommended that services have quality assurance procedures in place. These should include an element of independent auditing to complement internal checks.

Minimum quality assurance requirements should be clear in service specifications and service provider contracts and form part of the service quality performance reports (see **Table 2**).

Table 2: Recommended quality assurance indicators

Indicator	Measure
Client satisfaction	Numbers of compliments and complaints. Details of service user feedback.
Exception reports	Where four-week success rates fall outside a 35% – 70% range, it is recommended that an exception reporting procedure is adopted to check adherence to the intervention principles.
Clinical audit	Two clinical audits (agreed with the commissioner) to be completed each year. For example, a comparison of quit outcomes for different stop smoking aids.
Case studies	Provide a minimum of six service user case studies per year.
Partner organisations	Provide a list of all partner organisations, number of staff trained in VBA and referrals received.
Holistic support and onward referral	The number of holistic assessments of service users' needs taking place and the number of onward referrals to other services such as debt advice, employment agencies, food banks, community organisations, job centres and housing support organisations to address the barriers that are impacting on people's lives and ability to quit.
Training delivered both inside and outside provider organisation	Report NCSCT certified (or equivalent) training to support quit attempts: 1. Total numbers/proportions of staff trained 2. Numbers of new and re-certified staff 3. Level of training delivered (e.g. VBA+ or Practitioner) 4. NCSCT module certificates 5. Other staff training, specifying course topic 6. Organisations they work for
Workforce wellbeing, equality, diversity and inclusion	Staff vacancies. Staff diversity and inclusion and health and wellbeing, reporting number staff by protected characteristics, languages spoken, number of complaints and concerns and staff on long-term sick leave.

3.1 Marketing and communications

Where marketing and communications are the responsibility of the service provider, they should develop and provide an annual communications plan that outlines how they will promote the service to the relevant priority high prevalence groups.

Provide quarterly reports on service promotion and community events attended or delivered.

3.2 Client satisfaction

Service user involvement and feedback is a highly useful quality assurance measure. Reports on co-design of service and engagement of clients in service improvement and development is recommended.

Resources

An example client satisfaction questionnaire:

Stop Smoking Service Client Satisfaction Questionnaire (full) – click here

Stop Smoking Service Client Satisfaction Questionnaire (brief) – click here

Part 4: References

1. West R, Hajek P, Stead, et al. Outcome criteria in smoking cessation trials: proposal for a common standard. *Addiction* 2005;100(3):299–303. doi: 10.1111/j.1360-0443.2004.00995.x

2. West, R. Assessing smoking cessation performance in NHS Stop Smoking Services: The Russell Standard (Clinical). 2005. Available from: https://www.ncsct.co.uk/publications/The-Russell-Standard

Annex A:
Definitions

NEW definitions have either been added to this revised guidance or are updates to the previous definition list.

NEW 14-day rule for Transfer of Care

The 14-day rule allows patients or prisoners to be included in national data returns (as Transfer of Care) who are referred to Local Stop Smoking Service (LSSS) and have their first treatment episode with the LSSS within 14 days of their discharge from hospital setting or release from prison. Treatment episodes may be delivered either in-person or remotely, recognising the need to be patient-centred.

Note: This definition is an update of the 2019 version to support Transfer of Care to LSSS. Previously, the 14-day rule required the first intervention to be delivered within 14 days of the last day the client smoked. This was serving as a barrier to clients who would benefit from support from LSSS.

Note: For clients who are part of the Transfer of Care, the CO-validated quit date will be measured from date of discharge from hospital or release from prison or treatment centre (see Transfer of Care below).

Abrupt quit

An abrupt quit involves setting a quit date after which the individual commits to not smoking.

NEW CO-verified four-week quitter

A treated person who smokes who reports not smoking for at least days 15 to 28 of a quit attempt, and whose carbon monoxide (CO) reading is assessed 28 days from their quit date (-3 or +14 days) and is less than 10 ppm. The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell Standard).

Clients whose follow-up date falls outside this time span may not be counted for the purposes of quarterly data submissions to NHS England (NHSE). CO verification should be conducted face to face and carried out in at least 85% of self-reported, in-person, four-week quitters.

Note: For clients who are part of the Transfer of Care the CO validated quit date will be measured from date of discharge from hospital or release from prison or treatment centre (see Transfer of Care below).

NEW Core20PLUS5

This is a country-wide approach used by NHSE. It seeks to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the Core20PLUS5 – and identifies five focus clinical areas requiring accelerated improvement. Smoking cessation positively impacts on all five areas.

NEW Cut Down to Stop (CDTS)

Cut Down to Stop (CDTS) refers to a structured programme of support with reducing smoking and then stopping. CDTS support is distinct from harm reduction or reducing smoking in that it includes: 1) structured multi-session support, 2) setting progressive reduction goals with the ultimate goal of stopping completely over a defined period of time, and 3) the offer of a first choice stop smoking aid (NRT, cytisine, varenicline, nicotine vape).

NEW Digital support

Digital support refers to stop smoking support that is delivered via a digital platform such as text messages, smartphone applications, or computer systems.

NEW Harm reduction

Harm reduction involves interventions that reduce the harm of tobacco use to health. It includes strategies such as smoking reduction and the use of products with reduced harm to health when compared to combustible tobacco.

Lost to follow-up (LTFU)

A treated person who smokes who cannot be contacted face to face, via telephone, email, letter or text following three attempts to contact them at different times of day, at four weeks from their quit date (or within 25 to 42 days of the quit date). The four-week outcome for this client is unknown and should therefore be recorded as LTFU on the monitoring form.

NEW Inpatient Tobacco Dependence Service (TDS) / Team (TDT)

The team within NHS trust hospitals that support patients with the provision of tobacco dependence treatment.

NEW Inpatient Tobacco Dependence Advisor (TDA)

Refers to NHS staff who deliver tobacco dependence treatment as part of the NHS tobacco dependence pathway in NHS hospitals.

NEW Non-treated person who smokes

A person who smokes who receives no support or is given Very Brief Advice and/or supplied with leaflets, helpline cards or pharmacotherapy only, and who does not set a quit date or consent to treatment. Examples may include people who smoke who are seen at health fairs or community events, during a GP consultation or during a hospital stay where a quit date is not set and a quit attempt is not made. **This does not include inpatients in secondary care who smoke who must abstain from smoking whilst in a care environment.**

NEW Priority groups

The high-risk groups which are nationally defined in *Part 1: Essential information for providing Local Stop Smoking Services* or are locally identified.

NEW Person-centred

An approach that focuses on the needs of each person to provide tailored, evidence-based support.

Quit date (QD)

The date a person who smokes plans to stop smoking completely with support from a stop smoking practitioner as part of an assisted quit attempt.

Renewed quit attempts

A quit attempt that takes place immediately following the end of one treatment episode. A new treatment episode should be commenced in the database/service records.

NEW Remote support

Support delivered using inter-personal communication in which the practitioner and client are at a distance. This includes support delivered using telephone or real-time video link.

Routine and manual (R/M)

A person who smokes whose self-reported occupational grouping is of a routine and manual (R/M) worker as defined by the National Statistics Socio-economic Classification.

Self-reported four-week quitter (SR4WQ)

A treated person who smokes who reports not smoking for at least days 15 to 28 of a quit attempt and is followed up 28 days from their quit date (-3 or +14 days). The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell Standard).

Note: This does not include Transfer of Care clients (see below).

Self-reported four-week quitter: Transfer of Care (SR4WQToC)

A person who reports not smoking 28 days following their discharge from hospital or release from prison or treatment centre.

NEW Severe mental illness (SMI)

Refers to people with a diagnosis of bipolar disorder, psychotic disorders such as schizophrenia, personality disorder or a major depressive disorder.

Smoked product

Any product that contains tobacco and produces smoke is a smoked product, including cigarettes (hand-rolled or tailor-made), cigars and pipes (including waterpipes). Waterpipes include shisha, hookah, narghile and hubble-bubble pipes.

Smoker (Person who smokes)

A person who smokes a smoked product. In adulthood this is defined in terms of daily use, whereas in adolescence (i.e. for those aged 16 or under) it is defined in terms of weekly use.

Spontaneous quitters

These are people who smoke who have already stopped smoking when they first come to the attention of the service. They can only be counted as having been 'treated', and included in the national data return, if they had quit 48 hours or less before attending the first session of a structured, multi-session, treatment plan. Where this is the case, their spontaneous quit date should be recorded as their actual quit date.

Examples of such quitters include people who have started using nicotine vapes (as an alternative to smoking) and have not smoked for up to 48 hours, or pregnant women who smoke but stopped prior to approaching their local stop smoking service provider. Whilst it is recognised that offering as many people who smoke as possible support to quit and maintain abstinence is desirable, local commissioners will need to balance the needs of their smoking population against available service resources.

People who have stopped smoking for more than 48 hours before attending a service should not be included in the national data submission but may be counted as having been 'treated' for local accounting purposes (e.g. to justify resources used or analyse performance). It is recommended that this is only recorded if they have quit within 14 days prior to coming to the attention of the service and have attended the first session of a structured, multi-session, treatment plan within 14 days of their spontaneous quit date (which should then be recorded as their quit date).

Note: People who smoke who have been treated within the NHS Tobacco Dependence Service are not included as spontaneous quitters. See Transfer of Care for more information.

Stop smoking

Preferred term to denote client-facing communications relating to smoking cessation activity.

NEW Stop smoking aids

This term refers to the broader category of approved stop smoking treatments that assist with quit attempts, such as combination NRT, prescription medications (e.g. cytisine, varenicline and bupropion) and nicotine vapes.

Stop smoking applications (apps)

Smartphone applications that are designed to provide stop smoking support to people who smoke.

NEW Stop smoking practitioner

An NCSCT Certified Stop Smoking Practitioner who is employed by a service which is, either directly or indirectly, commissioned to provide stop smoking support.

Stop smoking service provider

A local authority stop smoking service provider is defined as a locally or nationally managed and coordinated service commissioned to provide accessible, evidence-based, and cost-effective clinical services to support people who smoke that want to stop. Service delivery should be in accordance with the quality principles for clinical and financial management contained within this guidance.

Time between treatment episodes

When a client has not managed to stop smoking, there is no definitive period of time required between the end of a treatment episode and the start of another. The stop smoking practitioner should use discretion and professional judgement when considering whether a client is ready to receive support to immediately attempt to stop again. If this is the case, the client must start a new treatment episode – i.e. attend one session of a structured, multi-session intervention, consent to treatment and set a quit date with a stop smoking practitioner – to be counted as a new data entry on the quarterly return.

NEW Transfer of Care

Transfer of Care describes treatment and support that is initiated by one service provider and then transferred to a second service provider. Inpatients who receive support as part of the NHS Tobacco Dependence Service (TDS) and are then referred to a Local Stop Smoking Service (LSSS) are one example. It can also include individuals who receive stop smoking support while in prison or a treatment centre, who are then referred to LSSS upon release/discharge from that setting. Transfer of Care clients are typically engaged in stop smoking treatment at the time they are referred and the LSSS will provide ongoing, complementary support. The Transfer of Care intervention should consist of a minimum offer of four weeks of support following discharge. Four-week quit rates will be measured from the time of discharge from hospital or release from prison or treatment centre.

Note: This change has been made to align with indicators used by the NHS TDS as well as to better reflect the success of follow-up support provided by LSSS.

NEW Treated person who smokes (previously labelled as 'treated smoker' which is still the term used for LSSS Quarterly Monitoring)

A person who:

1. Has attended at least one session of a structured, multi-session intervention, delivered by a stop smoking practitioner, on or prior to the quit date, who consents to treatment and sets a quit date with a stop smoking practitioner.

   Or,

2. Has attended at least one session of support from the Local Stop Smoking Service following Transfer of Care from the NHS Tobacco Dependence Service. The intervention should consist of a minimum offer of four weeks of support following discharge from hospital.

   Or,

3. Has committed to a Swap to Stop programme. People who attend a first session but do not consent to treatment or set a quit date should not be counted.

Treatment episode

At the point of attending one session of a structured, multi-session intervention, consenting to treatment, and setting a quit date with a stop smoking practitioner, a client becomes a treated person who smokes, and the treatment episode begins. The treatment episode ends when:

1. A client has been completely abstinent for at least the two weeks prior to the four-week follow-up.

   Or,

2. A client is lost to follow-up at the four-week point.

   Or,

3. When a four-week follow-up reveals that a client has lapsed during the two weeks immediately prior to the follow-up and is therefore recorded as a non-quitter.

Good practice dictates that if the client wishes to continue treatment after a lapse, treatment should be continued if it seems appropriate, but the client will not count as a four-week quitter for the purposes of that treatment episode.

Annex B:
Checklist for effective commissioning

Question	Action required	When / Who
Intelligence Led: Local prevalence, need and demand		
Is there sufficient tobacco control **commissioning capacity and expertise?**		
Is there a **local tobacco control strategy or alliance** with cross-sector input?		
Does the **local needs assessment** include a comprehensive section on tobacco control that addresses smoking-related harm and health inequalities, and acknowledges the impact of tobacco control activity across the Public Health Outcomes Framework and NHS Outcomes Framework?		
Is there a shared understanding of the local level of smoking prevalence, and service need, based on a range of local and national data across a range of public services?		
Has a **Joint Strategic Needs Assessment (JSNA)** been completed or recently updated?		
Is local data on tobacco control interventions provided within hospitals, primary health care and other settings collected and analysed to **inform the needs assessment?**		
Do commissioners own and analyse local stop smoking service treatment data to assess quality, including specific breakdown by gender, age, postcode, condition, route of referral and treatment outcome, so that treatment provision can be aligned with need?		
Does the needs assessment incorporate a methodology such as asset-based community development to consider the availability and potential for development of existing community support networks and other local assets?		
Has **an Equity Impact Assessment** been completed and shared?		
Is data available and regularly examined regarding the **impact of tobacco control and stop smoking interventions** on hospital admissions, length of stay and social care activity?		
Does **analysis of tobacco-related hospital admissions** inform the targeting of local interventions?		

Question	Action required	When / Who
Intelligence Led: Local provision of stop smoking services		
Has a **CLeaR local tobacco control assessment** been completed along with appropriate Deep Dives?		
Has an **analysis of the gaps** in access, reach and outcomes of the current service been undertaken?		
Is there equity of access to current stop smoking services for national and local priority populations (such as routine and manual workforce, people living in social housing or experiencing homelessness, people with mental illness, people with smoking related illness, prison populations and lesbian, gay, bisexual, transgender, queer (LGBTQ) people)?		
Has support provided been weighted in terms of deprivation and does this include priority groups?		
How are the **needs of priority groups met?**		
Person-centred support:		
Is the local community involved in **co-designing support**?		
Are interventions and services **geographically and culturally appropriate** to the people for whom they are designed? How do you know?		
Are **barriers** to accessing stop smoking services identified and removed?		
Is **marketing and communication** of support offer accessible and attractive to all people who smoke?		
Will the **service model** meet demand and needs whilst being responsive to changes?		
Is there a patient-centred pathway in place for **Transfer of Care** between the NHS Tobacco Dependence Service and Local Stop Smoking Services?		

Question	Action required	When / Who
Evidence-based support:		
Do interventions commissioned for tobacco control and tackling smoking-related harm take an **evidence-based approach** based on NICE NG209 and latest 2024 National Centre for Smoking Cessation and Training (NCSCT) guidance?		
Is there systematic provision of VBA and routine referral written into providers contracts and supported by appropriate training and established referral pathways and systems?		
Are all of the Health and Social Care workforce receiving training on the VBA model and routinely referring people who smoke to either inhouse or local stop smoking support?		
Are **formalised electronic referral systems** in place to facilitate timely and efficient referral as well as supporting identification of areas where referral rates could be improved?		
Are a mix of evidence-based **service delivery models** available to meet the needs of clients and expand reach of services?		
Is easy access to low-cost **first choice stop smoking aids** (combination NRT, varenicline, cytisine and nicotine vapes) available to patients via the Local Stop Smoking Service?		
Are policies in place to allow for extended treatment for patients at risk of relapse?		

Question	Action required	When / Who
Quality outcomes and indicators:		
Do **contracts for commissioned services specify performance indicators** and are these regularly measured, monitored, evaluated, and reviewed towards key service outcomes?		
Do performance indicators promote service design to meet quality standards and reduce the risk of gaming?		
Is **formal system-wide evaluation of the range of tobacco control support** featured in the commissioning strategy?		
Have a **wide range of measures of success been included within the contracts** to reflect the three roles of LSSS and of commissioning targets?		
How do overarching outcomes **fit within the Quality and Outcomes Framework?**		
How are outcomes **verified** as part of quality assurance monitoring?		
Are providers required to undergo an **independent audit** and review as well as conducting **internal quality assurance checks?**		
Are the consequences of failure to achieve outcomes clear?		
Are client satisfaction indicators included and monitored?		

Are the following in service specification scope?	Y/N	Action
Is the **service model** clear?		
Aims of service?		
Objectives of service?		
Funding and delivery of marketing and communication?		
Transfer of Undertakings (Protection of Employment) (**TUPE**)?		
What data, IT infrastructure and telecoms is required, how will these be implemented, and what their maintenance plan is?		
Supply and maintenance of CO monitors and ongoing supply of consumables?		
Practitioners trained to **NCSCT Standards?**		
Is **harm reduction support** included in support provision?		
Are all **first choice stop smoking aids** available to all clients?		
How will stop smoking aids be provided to **remove barriers** to clients?		
Are **service review and auditing practices** clearly defined?		

Annex C:
Communications and marketing resources

NICE – NG209: Recommendations on promoting quitting – click here

Better Health – Smokefree Resource centre – click here

Smokefree Action Coalition – Campaign resources –click here

Fresh and Balance – Media communications and education – click here

Action on Smoking and Health – Evidence into Practice:
Motivating quitting through behaviour change communications –click here

NHS Better Health – Quit smoking – click here

Annex D:
Commissioning for Quality and Innovation (CQUIN)

The national CQUIN scheme is intended to complement and reinforce existing activity to deliver interventions to people who smoke.

The CQUIN applies to community, mental health and acute providers. It covers adult inpatients (patients aged 18 years and over who are admitted for at least one night) only and excludes maternity admissions.

CQUIN indicators for smoking:

1. Percentage of eligible adult patients admitted and screened for smoking status; results recorded in patient's record.
2. Percentage of patients who have been recorded as smoking that are given brief advice, including an offer of NRT.

Local authorities should progress the CQUIN locally by:

- Including it in all NHS Standard Contracts with eligible providers.
- Promoting and supporting delivery of the CQUIN to local providers.
- Cooperating with local trusts and community services to ensure smooth pathways exist to refer patients between services.

It is not recommended that service providers are remunerated for referrals beyond what is provided through established reward and incentive programmes such as the Quality and Outcomes Framework (QOF).

Further information

NHS England – CCG CQUIN 2019/20 Indicators Specifications – click here

Annex E:
Quality and Outcomes Framework (QOF)

The QOF is an annual reward and incentive programme for all GP practices in England and forms part of GP contracts to improve the quality of care. One of the key principles of QOF is that indicators should, where possible, be based on the best available research evidence. They are re-evaluated annually, and indicators and codes may change.

The following indicators relating to smoking are currently part of QOF:

AST008	The percentage of patients with asthma on the register aged 19 years or under, in whom there is a record of either personal smoking status or exposure to secondhand smoke in the preceding 12 months.
SMOK002	The percentage of patients with any, or any combination of, the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder, or other psychoses whose notes record smoking status in the preceding 12 months.
SMOK004	The percentage of patients aged 15 or over who are recorded as currently smoking who have a record of an offer of support and treatment within the preceding 24 months.
SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder, or other psychoses who are recorded as currently smoking who have a record of an offer of support and treatment within the preceding 12 months.

Further information

NHS England – Quality and Outcomes Framework Guidance for 2023/24 – click here

Annex F:
National indicators alignment to support Transfer of Care from hospital to Local Stop Smoking Services

The following working definitions should be used for Transfer of Care from NHS trusts to Local Stop Smoking Services (LSSS).

Indicator	Definition
Transfer of Care	Transfer of Care describes treatment and support that is initiated by one service provider and then transferred to a second service provider. Inpatients who receive support as part of the NHS Tobacco Dependence Service (TDS) and are then referred to LSSS are treated as Transfer of Care clients.
Transfer of Care date (replaces quit date)	Hospital discharge date (replaces quit date for clients referred from the NHS TDS programme).
Transfer of Care referrals	Number of patients referred to LSSS from NHS trusts as part of Transfer of Care. This indicator will be used to track total number of referrals from hospital (denominator).
Treated person who smokes: Transfer of Care	Has attended at least one session of support from the LSSS following Transfer of Care from the NHS TDS. The intervention should consist of a minimum offer of four weeks of support following discharge from hospital and continued supply of stop smoking aids.
14-day rule for Transfer of Care	The 14-day rule allows patients to be included in national data returns (as Transfer of Care) who are referred to LSSS and have their first treatment episode within 14 days of their discharge from hospital. Treatment episodes may be delivered either in-person or remotely, recognising the need to be patient-centred.
Self-reported four week quitter: Transfer of Care (SR4WQToC)	A treated person who smokes who reports not smoking 28 days (-3 or +14 days) following their discharge from hospital.
CO-verified four week quitter: Transfer of Care (CO4WQToC)	A treated person who smokes who reports not smoking and whose carbon monoxide (CO) reading is assessed 28 days following discharge from hospital (-3 or +14 days) and is lesss than 10 ppm.

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