Increasing the impact of stop smoking services: Top 10 best practices

NCSCT

Overview

This document provides checklists of best practice recommendations for **Local Authority Stop Smoking Services.** The checklists have been developed based on the National Centre for Smoking Cessation and Training (NCSCT) maximising the impact of local stop smoking services briefing, which summarises the top 10 actions, based on evidence and best practice, that can be taken to increase the impact of stop smoking services. **Actions specific to targeting and tailoring services to priority groups and people with additional needs are highlighted in blue.** (■)

The checklists aim to assist with service planning and delivery processes, to ensure decisions are based on evidence and to further maximise the impact of services. The recommended practices aim to increase reach, overcome barriers and meet the challenges encountered by people who smoke, particularly those in priority groups.

The recommendations focus on a co-designed, person-centred approach, using a flexible service delivery model designed to promote engagement and be guided by clients' individual needs.

How to use this document

Tobacco leads and service managers can use the checklists to assess service alignment to evidence-based best practice for targeting and tailoring, and identify areas where quality improvement can be focused.

It is understood that not all services will be able to introduce all elements of good practice, and that many elements require budget allocation and changes to commissioning or delivery processes. This tool is however intended to assist services with benchmarking against best practice and as a basis for planning.

Increasing the impact of stop smoking services: top 10 best practices

	Best Practice
Increase reach: Engage more people in services, with a focus on priority groups	
1.	Provide a mix of person-centred, evidence-based service delivery models
2.	Build demand by having a visible presence in the community
3.	Use Cut Down to Stop (CDTS) interventions to engage priority groups and those unable to quit abruptly
4.	Ensure easy, responsive referral pathways with quick response times and referral feedback loops
5.	Maximise opportunities for smoking cessation in settings with direct contact with priority groups
Increase efficacy: Optimise services based on latest evidence to maximise return on investment	
6.	Employ a well-trained, well-led and motivated workforce
7.	Provide access to all first-choice stop smoking aids
8.	Ensure policies, protocols and training support the latest evidence on effective use of first-choice stop smoking aids, including tailoring dose and duration of treatment
9.	Match and tailor the level of behavioural support to the needs of people who smoke
10.	Optimise stop smoking services in inpatient and outpatient services

Increase reach: Engage more people in services, with a focus on priority groups

1.	Provide a mix of person-centred, evidence-based service delivery models	Yes	No	Comments
1.1	An analysis of available data has been undertaken to identify priority groups	☐	☐	
1.2	The local community is involved in co-designing and improving the service	☐	☐	
1.3	Interventions and services are geographically and culturally appropriate to the clients using them	☐	☐	
1.4	Stop smoking support is provided by a standalone stop smoking service and not as part of a multi-component integrated lifestyle service	☐	☐	
1.5	A mix of evidence-based service delivery models are available to meet the needs of clients and expand the reach of the service, including the following:			
	First-choice support options:			
	■ **Standard treatment programme** delivered by a trained stop smoking practitioner (6 – 12 weeks)	☐	☐	
	■ **Group-based standard treatment programme** delivered by a trained stop smoking practitioner (6 – 12 weeks)	☐	☐	
	■ **Tailored stop smoking programme** delivered by a **specialist** stop smoking practitioner (6 – 12 weeks) – Abrupt quit – set a stop date and stop smoking completly from that date. – Cut Down to Stop (CDTS) programme – for those unwilling or unable to stop in one step (abrupt quit)	☐ ☐ ☐	☐ ☐ ☐	
	■ **Hybrid support:** combination of digital and interpersonal support	☐	☐	

	Second-choice support options:			
	■ **Brief support** (1 – 3 sessions) and stop smoking aid	☐	☐	
	■ **Digital support programme** and stop smoking aid	☐	☐	
	Third-choice support option:			
	■ **Self-help** and stop smoking aid following brief advice	☐	☐	
1.6	Extended hours are offered to meet the needs of priority groups (consider early opening, evening and weekends)	☐	☐	
1.7	Behavioural support and treatment can be extended as needed	☐	☐	
1.8	Local indicators for tracking performance of the service have been introduced, are regularly reviewed, and are used for decision making	☐	☐	
1.9	Indicators are in place to monitor reach and efficacy of the service among priority groups and are monitored regularly (quarterly is recommended) – see the **Local Stop Smoking Services and support: commissioning, delivery and monitoring guidance** for how to calculate	☐	☐	
1.10	Clients are involved in evaluating the service on an ongoing basis, and a full service evaluation, which outlines the demonstrable service improvements that have been made, is completed on an annual basis and presented to partners	☐	☐	

2.	Build demand by having a visible presence in the community	Yes	No	Comments
2.1	Marketing and promotion of services:			
	■ There is an evidence-based marketing/communications plan to promote the service that is regularly reviewed and refreshed	☐	☐	
	■ There is a strong web presence for the service that is monitored and evaluated	☐	☐	
	■ There are promotional materials for the service that are regularly updated and widely disseminated	☐	☐	
2.2	There is active partnership and promotion with key referral sources in the community	☐	☐	
2.3	Direct-to-public communication campaigns are utilised to trigger quit attempts and raise awareness about available support	☐	☐	
	■ There is a local, evidence-based communication campaign to promote stopping or reducing smoking that is sufficiently extensive, and communication plans are evaluated	☐	☐	
	■ Communication campaigns are targeted, tailored and tested with priority groups to ensure messages resonate	☐	☐	
	■ Communications use messages focused on hope (stopping smoking is possible) and help (how to stop smoking – with support and treatment)	☐	☐	
2.4	The barriers and enablers to accessing services and needs of priority groups have been identified – and processes put in place to overcome them – which are reflected in the service offer and communications	☐	☐	

3.	Use Cut Down to Stop (CDTS) interventions to engage priority groups and those unable to quit abruptly	Yes	No	Comments
3.1	A structured CDTS support programme is available to:			
	■ people in priority groups (e.g. people with severe mental illness)	☐	☐	
	■ anyone unable to stop abruptly (the core offer)	☐	☐	
3.2	The following stop smoking aids are available to clients taking part in the CDTS programme:	☐	☐	
	■ Combination NRT (always including a faster-acting NRT)	☐	☐	
	■ Nicotine vapes	☐	☐	
	■ Varenicline	☐	☐	
	■ Combined use of NRT, nicotine vapes and/or varenicline	☐	☐	
3.3	Stop smoking practitioners have received training in delivering a multi-session, structured CDTS programme according to the NCSCT competency framework	☐	☐	
3.4	CDTS outcomes are monitored by population group	☐	☐	

4.	Ensure easy, responsive referral pathways with quick response times and referral feedback loops	Yes	No	Comments
4.1	The service has a single point of access that receives referrals via telephone, email and webform	☐	☐	
4.2	Electronic referral systems that support the principles for effective referrals, and allow for analysis and reporting to commissioners and referrers, are operational	☐	☐	
4.3	Electronic referral pathways are in place via:			
	■ primary care	☐	☐	
	■ secondary care	☐	☐	
	■ mental health services (inpatient and outpatient)	☐	☐	
	■ drug and alcohol services	☐	☐	
	■ maternity services	☐	☐	
	■ social housing groups	☐	☐	
	■ homelessness support organisations	☐	☐	
	■ lung health checks	☐	☐	
	■ other health and social care and voluntary organisations that work with locally identified priority groups	☐	☐	

4.4	Organisations engaging with priority groups have been mapped, and referral pathways are in place and being used	☐	☐	
4.5	Referring staff are trained in delivering Very Brief Advice on Smoking (VBA+), which is ideally tailored to their setting and/or population they work with	☐	☐	
4.6	Referrals are responded to within two working days	☐	☐	
4.7	Staff contacting people referred to the service have received training in techniques for effective communication with people who smoke	☐	☐	
4.8	Referral numbers and outcomes can be reported back to referrers, including:			
	■ statistical data for the general population and by priority group, to demonstrate how the service is contributing to reducing health inequalities	☐	☐	
	■ quotes from clients	☐	☐	
	■ recognition of the top referring team/person	☐	☐	
4.9	Local strategies and service plans incorporate stop smoking and tobacco control measures, especially where strategies relate to priority groups (maternity services, housing strategy, integrated care board [ICB] strategies)	☐	☐	
4.10	There is a named individual within the service who is the link person for referring organisations	☐	☐	
4.11	There is a proactive tobacco control alliance in place	☐	☐	

5.	Maximise opportunities for smoking cessation in settings with direct contact with priority groups	Yes	No	Comments
5.1	Stop smoking services are available in the highest prevalence areas, communities and settings	☐	☐	
5.2	Stop smoking support is embedded in key settings with direct contact with people who smoke, including:			
	■ targeted outreach programmes for priority groups	☐	☐	
	■ trained stop smoking practitioners embedded in priority group settings	☐	☐	
5.3	It is a priority to forge strong working relationships with local organisations and staff to support engagement with those in priority groups who smoke	☐	☐	
5.4	Incentives are offered to people in priority groups who smoke	☐	☐	
5.5	All health and social care staff in the below settings are trained in delivering VBA+, tailored to the setting in which they work, and training is refreshed every one to three years	☐	☐	
	■ Acute medical trusts (transfer of care)	☐	☐	
	■ Mental health trusts (transfer of care)	☐	☐	
	■ Emergency departments	☐	☐	
	■ Community mental health services	☐	☐	

	■ Primary care	☐	☐	
	■ Lung health check services	☐	☐	
	■ Drug and alcohol services	☐	☐	
	■ Social housing	☐	☐	
	■ Homelessness services	☐	☐	
	■ Judicial services	☐	☐	
	■ Other priority settings	☐	☐	
5.6	There is a way of tracking the training delivered to health and social care staff, with a flag to repeat training every one to three years	☐	☐	
5.7	Seamless referral pathways are in place to link patients upon discharge from hospital/treatment centres to appropriate stop smoking support (transfer of care)	☐	☐	
	■ Tailored support is offered within 48 hours to patients discharged from hospital who are making a quit attempt, with continued supply of stop smoking aids	☐	☐	
	■ Brief interventions are offered to patients who are ambivalent or not ready to stop	☐	☐	

Increase efficacy: Optimise services based on latest evidence to maximise return on investment

6.	Employ a well-trained, well-led and motivated workforce	Yes	No	Comments
6.1	The service employs a core team of:			
	■ specialist stop smoking practitioners that provide intensive support to the most complex clients	☐	☐	
	■ community-based staff who provide less intensive stop smoking support as an adjunct to their day job (e.g. social prescribers, food bank workers, health trainers/champions)	☐	☐	
6.2	All practitioners complete the NCSCT online practitioner training and assessment and complete a two-day virtual/face-to-face course that meets the NCSCT Training Standard	☐	☐	
6.3	Practitioners delivering specialist stop smoking support receive additional appropriate training for tailoring support to populations with additional needs	☐	☐	
6.4	The workforce is diverse and is reflective of the communities served	☐	☐	
6.5	A programme of shadowing and mentoring is available to new staff and as needed for experienced staff	☐	☐	
6.6	Staff have access to debriefing support from a manager or peer	☐	☐	
6.7	Staff have access to monthly clinical supervision with an experienced Tobacco Dependence Advisor / Smoking Cessation Specialist.	☐	☐	

6.8	Staff have access to continued professional development (CPD) opportunities at least annually	☐	☐	
6.9	An annual performance review is conducted and training plan developed	☐	☐	
6.10	Staff have the equipment required to fulfil their role	☐	☐	
6.11	Wellbeing support is in place for staff and staff are aware of how this is accessed	☐	☐	

7.	**Provide access to all first-choice stop smoking aids**	**Yes**	**No**	**Comments**
7.1	All first-choice stop smoking aids are available for 10 – 12 weeks:			
	■ Combination NRT	☐	☐	
	■ Nicotine vapes	☐	☐	
	■ Varenicline (PGD, primary care, other)	☐	☐	
	■ Cytisine (PGD, primary care, other)	☐	☐	
7.2	Processes and protocols allow for the direct supply of the below stop smoking aids at appointments:			
	■ Combination NRT	☐	☐	
	■ Nicotine vapes	☐	☐	

8.	**Ensure policies, protocols and training support the latest evidence on effective use of first-choice stop smoking aids, including tailoring dose and duration of treatment**	**Yes**	**No**	**Comments**
	Protocols allow for:			
8.1	Tailored dosing of NRT that includes higher dosing for clients more dependent on tobacco	☐	☐	
8.2	Extended use of stop smoking aids (beyond 10 – 12 weeks) for clients who meet criteria	☐	☐	
8.2	Combined use of two stop smoking aids for clients who meet criteria	☐	☐	

9.	Match and tailor the level of behavioural support to the needs of people who smoke	Yes	No	Comments
9.1	People with severe mental illness (SMI), pregnant women and their partners, people who are highly dependent on tobacco or at high risk of relapse, those with complex needs (including people who use substances and those experiencing homelessness) are directed towards specialist support	☐	☐	
9.2	Clients receive consistent care from one practitioner	☐	☐	
9.3	For pregnant women, support is continued throughout pregnancy and into the post-partum period	☐	☐	
9.4	Pathways are in place to notify prescribers of clients who are prescribed medications affected by smoking	☐	☐	

10.	Optimise stop smoking services in inpatient and outpatient services	Yes	No	Comments
10.1	Pathways are in place for delivering VBA+, with referral to specialist tobacco dependence treatment support in all inpatient and outpatient hospital settings	☐	☐	
10.2	Staff have been trained in VBA+ and have strong working relationships with Local Authority Stop Smoking Services	☐	☐	
10.3	Specialised teams of tobacco dependence/stop smoking practitioners are embedded in community and inpatient services and have sufficient time to meet local needs	☐	☐	

10.4	Tobacco dependence/stop smoking practitioners working with people from priority groups complete specialised training	☐	☐	
10.5	Facilitate direct access to NRT, nicotine vapes or nicotine analogues prior to quitting, and for extended periods after quitting to prevent relapse	☐	☐	
10.6	Protocols and policies ensure that people from priority groups receive an appropriate amount of nicotine replacement, given they are typically more tobacco dependent and likely to require a higher dose than people who smoke in the general population	☐	☐	
10.7	Offering quitting in one step (abrupt quit) is the first-choice option, with flexibility to offer CDTS for those not interested, or able, to stop in one step	☐	☐	
10.8	Flexible service delivery models that are designed to support engagement of people from priority groups (including flexible appointment times and venues, more frequent contacts and tailored duration of support) are offered	☐	☐	
10.9	Protocols allow for breaks in quit attempts and easy routes back into treatment	☐	☐	
10.10	Pathways are in place to notify prescribers of clients prescribed medications affected by smoking	☐	☐	