NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

Quality standards

Briefing paper: Smoking: treating dependence

**Quality Standards Advisory Committee meeting**: 27 April 2022

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1. Introduction

This briefing paper presents a structured overview of potential quality improvement areas for smoking: treating dependence. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

Recommendations selected from the key development source are included to help the committee in considering potential statements and measures.

* 1. Development source

The key development source referenced in this briefing paper is:

[Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209](https://www.nice.org.uk/guidance/ng209) (2021).

Review decision made (2020) to update recommendations on stop-smoking interventions (Allen Carr’s Easyway programme for smoking cessation), update scheduled for publication 04 August 2022.

1. Overview
   1. Focus of quality standard

This quality standard will cover support to stop smoking in people aged 12 and over, stopping use of smokeless tobacco and harm reduction approaches if people are not ready to stop smoking in one go. It will merge and replace the existing NICE quality standards for [smoking: supporting people to stop](https://www.nice.org.uk/guidance/qs43) (QS43) and [smoking: harm reduction](https://www.nice.org.uk/guidance/qs92) (QS92)

* 1. Definition

Treatment of tobacco dependence involves services and interventions delivered in a range of settings including NHS primary and secondary care, community settings and local stop-smoking support services. Stop-smoking interventions include behavioural interventions and medicinally licensed products such as varenicline, bupropion and nicotine replacement therapy. Stopping smoking in one go is the best approach but some people may not want, or are not ready, to stop smoking in one go. Harm reduction approaches include:

* cutting down before stopping smoking
* smoking reduction

temporarily not smoking.

These can be achieved with or without the help of 1 or more medicinally licensed nicotine-containing products.

* 1. Prevalence

The [Office for National Statistic’s adult smoking habits in the UK](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2019#main-points) reports that the prevalence of smoking in England has fallen since 2011. In 2011, 19.8% of adults were recorded as current smokers compared to 13.9% in 2019.

Smoking is a cause of preventable illness and premature death. [NHS Digital’s statistics on smoking, England](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking) shows that in 2019 to 2020 the following were all estimated to be attributable to smoking:

* 506,100 (4%) hospital admissions.
* 21% of all admissions for respiratory disease.
* 9% of all admissions for cancers.
* 74,600 (15%) deaths.
* 35% of all deaths from respiratory disease.

25% of all deaths from cancer.

[NHS England’s health matters: tobacco and alcohol CQUIN](https://www.gov.uk/government/publications/health-matters-preventing-ill-health-from-alcohol-and-tobacco/health-matters-preventing-ill-health-from-alcohol-and-tobacco-use) (2019) reports that treatment of smoking-related illness is estimated to cost the NHS £2.6 billion a year and the wider cost to society is around £11 billion a year.

The [Office for National Statistic’s adult smoking habits in the UK](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2019#main-points) (2019) reports that in Great Britain, 53% of people who smoked stated that they intended to quit. [NHS Digital’s statistics on NHS stop smoking services in England](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england) (2020 to 2021) reports that 178,815 people accessed NHS stop-smoking services and set a quit date. 59% of people successfully quit smoking (self-reported). A self-reported quitter is defined as a treated smoker 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.

[Smoking in England’s trends in electronic cigarette use in England](https://smokinginengland.info/graphs/e-cigarettes-latest-trends) (October 2021) shows that 65.3% of users of nicotine replacement therapy are also smokers and 49.9% of e-cigarette users also smoke. This is a household survey that collects monthly data on smoking habits using a representative sample of 1700 to 1800 adults. [Monthly KPI data on harm reduction](https://smokinginengland.info/graphs/monthly-tracking-kpi) (January 2022) shows that 15.5% of cigarette smokers were using e-cigarettes and 5.9% were using nicotine replacement therapies to cut down.

* 1. Health inequalities

There are certain groups in the UK in whom prevalence of smoking is higher than the general population and this results in inequalities in health and life expectancy. Despite a reduction in smoking prevalence in England and the UK overall there has been no reduction in inequalities in recent years. The [Office for National Statistic’s adult smoking habits in the UK](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2019#main-points) (2019) shows:

* 23.4% of those working in routine and manual occupations said they smoked in 2019 which is higher than those in managerial and professional occupations (9.3%).
* The proportion of current smokers was higher among unemployed people (26.8%) compared to those who were employed (14.5%).

The proportion of current smokers was higher among people who identified as gay or lesbian (22.2%) compared to heterosexual people (15.5%)

Other groups also have a higher prevalence of smoking when compared to the general population:

* The [Office for Health Improvement and Disparities’ local tobacco control profiles](https://fingertips.phe.org.uk/profile/tobacco-control?msclkid=87c0a404b97411ec9cee7a98c42d59f3) report a smoking prevalence of 40.5% in adults with a serious mental illness (2014 to 2015).

[Public Health England and King’s College London’s reducing smoking in prisons: management of tobacco use and nicotine withdrawal](https://www.gov.uk/government/publications/smoking-in-prisons-management-of-tobacco-use-and-nicotine-withdrawal?msclkid=cfb2f1d1b97411ec9e02429b6de9ed00) (2015) reference studies that show around 80% of prisoners smoke.

Smoking related ill health and mortality also varies by geography. [NHS Digital’s statistics on smoking, England](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking) (2017 to 2018) shows that:

* Blackpool and Sunderland recorded estimated smoking attributable hospital admission rates above 2,900 per 100,000 population compared to 721 per 100,000 population in Wokingham.

Manchester’s estimated smoking attributable mortality rate was 482 per 100,000 population compared to 149 per 100,000 population in Harrow.

This geographical variation is largely explained by deprivation as [NHS Digital’s Health Survey for England](https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2018) showed smoking prevalence in the least deprived quintile was 10% compared with 28% in the most deprived quintile in 2018.

[Cancer Research UK’s report on stop smoking inequalities by](https://www.cancerresearchuk.org/sites/default/files/stop_smoking_inequalities_2018.pdf) Smith, Hill and Amos in 2018 comments that smokers from lower socioeconomic backgrounds are more likely to access smoking cessation services but are less likely to be successful in their quit attempt. This is likely due to the additional barriers such as higher levels of dependence, positive or accepting social norms around smoking and difficult or challenging life circumstances.

Equality issues have been assessed further in the [equality impact assessment](https://www.nice.org.uk/guidance/indevelopment/gid-qs10153/documents) for this quality standard.

* 1. Current service delivery

Stop-smoking services offer support to all smokers who want to stop smoking and offer interventions such as behavioural interventions and licensed medicinal products. Services can be based in a variety of settings including primary care, community pharmacy, as part of an integrated lifestyle service or specialist stop-smoking services. Stop-smoking services can also be provided in specialist settings such as in secondary care and maternity services. [Action on Smoking and Health and Cancer Research UK’s stepping up: the response of stop smoking services in England to the COVID-19 pandemic](https://ash.org.uk/wp-content/uploads/2021/01/ASH-CRUK-Stepping-Up-FINAL.pdf) reports that in 2020 (prior to changes due to COVID-19) a specialist stop-smoking service was commissioned by 77% of surveyed local authorities in England (111 local authorities surveyed). Where a specialist service was not commissioned, stop-smoking support was provided by a lifestyle service (17%) or through primary care only (5%). [Action on Smoking and Health and Cancer Research UK’s reaching out: tobacco control and stop smoking services in local authorities in England](https://ash.org.uk/information-and-resources/reports-submissions/reports/reaching-out/) (2022) shows that some local authorities commission a combination of services. It also reports that some stop-smoking support targets high prevalence populations or other target groups whilst other services are universal and available to all smokers.

[The NHS Long Term Plan](https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/smoking/) (2019) includes actions for the NHS to achieve a smoke free society, for example the offer of NHS-funded tobacco treatment services for all people admitted to hospital, a smoke-free pregnancy pathway and universal smoking cessation offer as part of specialist mental health services. The [Department of Health and Social Care’s smoke free generation: tobacco control plan for England](https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england) (2017) details the Government’s ambitions to create the first smoke free generation, a smoke free pregnancy for all and parity of esteem for those with mental health conditions. There will be an updated tobacco control plan published in 2022.

1. Summary of suggestions
   1. Responses

In total 12 registered stakeholders responded to the 2-week engagement exercise.

* 11 stakeholders suggested areas
* 1 stakeholder had no comments

5 specialist committee members suggested areas

The responses have been summarised in table 1 for further consideration by the committee.

Table 1 Summary of suggested quality improvement areas

| Area for improvement | Stakeholders |
| --- | --- |
| **Identifying people who smoke** | BAMEHC, BTOG/RCP/NHSE&I, BTS, SCM |
| **Stop-smoking advice** | BTS, CTAG, DUK, PAGB, SCM |
| **Access to stop-smoking support** | BAMEHC, BTOG/RCP/NHSE&I, BTS, CTAG, KCH, SCM |
| **Stop-smoking interventions** | ACE, CTAG, DUK, PAGB, SCM |
| **Harm-reduction approach** | BTOG/RCP/NHSE&I, CTAG, DUK, PAGB, SCM |
| **Support to stop smoking in pregnancy** | BEDSCI, PAGB, SCM |
| **Additional areas**   * Awareness in the population * School-based interventions * Emerging from COVID-19 * Innovation in stop-smoking pharmacotherapy | * SCM * BAMEHC, PAGB, SCM * SCM * SCM |

Abbreviations:

* ACE, Allen Carr’s Easyway
* BAMEHC, BAME Health Collaborative
* BEDSCI, Bedfont Scientific Ltd
* BTOG/RCP/NHSE&I, British Thoracic Oncology Group/Royal College of Physicians/NHS England’s National Speciality Adviser for tobacco addiction.
* BTS, British Thoracic Society. The RCP endorses the response submitted by the BTS.
* CTAG, Cochrane Tobacco Addiction Group
* DUK, Diabetes UK
* KCH, Kings College Hospital
* PAGB, PAGB the consumer health organisation
* SCM, Specialist committee member

Full details of all the suggestions provided are given in appendix 1 for information. See appendix 2 for additional stakeholder suggestions discussed by the committee during the prioritisation meeting.

1. Suggested improvement areas

Section 4 presents a summary of the suggested improvement areas, with provisional recommendations that may support statement development and information on current UK practice.

* 1. Identifying people who smoke

Stakeholders commented that it is important that people are asked if they smoke at every contact with a healthcare professional and highlighted this as an area for quality improvement. Stakeholders specifically noted this as a quality improvement area in secondary care. Stakeholders also suggested that people should be asked if they are willing to discuss smoking so that this can be revisited in further discussion if they are not ready to quit or can be offered harm reduction approaches. Stakeholders suggested that people should also be asked if they have considered smoking so that they can be given advice on the importance of not smoking and referral or follow-up as needed. Smoking status should be recorded electronically and be updated so that smoking status can be tracked, for example relapse after previous quit attempt. Electronic recording allows transfer of information across services.

#### Selected recommendations

[NICE’s guideline on tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209) (NG209):

**Recommendations on identifying and quantifying people’s smoking.**

These recommendations are for health and social care professionals and those providing stop-smoking support or advice.

1.11.1 At every opportunity, ask people if they smoke or have recently stopped smoking.

1.11.5 If someone does not want, or is not ready, to stop smoking in one go:

* find out about the person's smoking behaviour and level of nicotine dependence by asking how many cigarettes they smoke – and how soon after waking
* make sure they understand that stopping smoking reduces the risks of developing smoking-related illnesses or worsening conditions affected by smoking
* ask them to think about adopting a harm-reduction approach (see the section on supporting people who do not want, or are not ready, to stop smoking in one go)
* encourage them to seek help to stop smoking completely in the future
* leave the offer of help open and offer support again the next time they are in contact.

1.11.6 Record smoking status and all actions, discussions and decisions related to advice, referrals or interventions about stopping smoking.

#### Current quality statements

[NICE’s quality standard on smoking: supporting people to stop](https://www.nice.org.uk/guidance/qs43) (QS43):

Statement 1 People are asked if they smoke by their healthcare practitioner, and those who smoke are offered advice on how to stop.

#### Current UK practice

The Quality and Outcomes Framework (QOF) indicator SMOK001 is reported by [NHS Digital’s indicators no longer in QOF](https://digital.nhs.uk/data-and-information/publications/statistical/gp-contract-services/2019-20) (INLIQ). This reports the percentage of patients aged 15 and over whose notes record smoking status in the preceding 24 months. Data from 2019 to 2020 shows a mean intervention rate of 74.2% for general practice (median 74.8%, interquartile range 7.6%). General practice performance ranges from 28.2% intervention to 99.3% intervention rate. [NHS Digital’s INLIQ business rules v37.0](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/quality-and-outcomes-framework-qof/quality-and-outcome-framework-qof-business-rules/inliq-indicators-no-longer-in-qof-business-rules) lists the field name and code clusters used to calculate numerators and denominators and this includes smoker, current smoker, never smoked and ex-smoker codes, suggesting this can be recorded electronically in patient records in general practice.

The [British Thoracic Society’s national smoking cessation audit report](https://www.brit-thoracic.org.uk/quality-improvement/clinical-audit/national-smoking-cessation-audit-2021/) (2019) reports smoking cessation activity in NHS acute hospitals across the UK. Part 1 of the report audits whether patients were asked “do you smoke?” and if this was appropriately recorded. 125 institutions submitted 13647 patients records. Smoking status was recorded in 77% of medical records. 86% of standardised medical proformas had a dedicated space to document smoking status but it is not clear if this is electronic or paper.

No published studies on current practice were highlighted for identifying people who smoke in other settings such as community pharmacy.

### Resource impact

These recommendations are not included in the resource impact report for tobacco: preventing uptake, promoting quitting and treating dependence (NG209). They were not identified as areas of the guideline that would be likely to have a significant resource impact (>£1m in England each year).

### Issues for consideration

**For discussion:**

* What is the priority for improvement? Stakeholders suggested:
  + Identifying people who smoke.
  + Recording of smoking status.
* What is the key action that will lead to improvement?
* Could we focus on a specific audience or setting?
  + Some stakeholder comments focussed on secondary care.
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Stop-smoking advice

Stakeholders suggested that the provision of brief advice is an area for quality improvement. They suggested that face-to-face brief advice should be offered in all clinical settings and noted that provision of brief advice that includes information on how to quit increases the chance of people quitting. Stakeholders also noted that that all healthcare professionals should provide very brief advice at every opportunity, including community pharmacists, dentists, GPs and stop-smoking advisers. Stakeholders highlighted a need for mandatory training on giving very brief advice and specifically highlighted this for secondary care staff. Stakeholders also suggested that the specific advice that is given is an area for quality improvement. They noted that the connections between complications such as cardiovascular disease and the risk of developing type 2 diabetes and smoking should be made clear in discussion with people to encourage them to stop smoking or reduce the amount they smoke, and people should be made aware of the harms of passive smoking from both cigarettes and e-cigarettes.

#### Selected recommendations

[NICE’s guideline on tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209) (NG209):

**Recommendation on using medicinally licensed nicotine-containing products (raising awareness).**

This recommendation is for people working in public health, and others with tobacco control and providing advice about harm-reduction as part of their remit.

1.8.1 Raise public awareness of the harm caused by smoking and secondhand smoke. Make it clear thar smoking causes a range of disease and conditions inlcuding cancer, chronic obstructive pulmonary disease and cardiovascular disease.

**Recommendations on identifying and quantifying people’s smoking.**

These recommendations are for health and social care professionals and those providing stop-smoking support or advice.

1.11.2 If they smoke, advise them to stop smoking in a way that is sensitive to their preferences and needs, and advise them that stopping smoking in one go is the best approach. Explain how stop-smoking support can help.

1.11.3 Discuss any stop-smoking aids the person has used before, including personally purchased nicotine-containing products.

1.11.4 Offer advice on using nicotine-containing products on general sale, including over-the-counter nicotine replacement therapy (NRT) and nicotine-containing e-cigarettes.

1.11.5 If someone does not want, or is not ready, to stop smoking in one go:

* find out about the person’s smoking behaviour and level of nicotine dependence by asking how many cigarettes they smoke – and how soon after waking
* make sure they understand that stopping smoking reduces the risks of developing smoking-related illness or worsening conditions affected by smoking
* ask them to think about adopting a harm-reduction approach
* encourage them to seek help to stop smoking in the future

leave the offer of help open and offer support again the next time they are in contact.

**Recommendations on commissioning and designing services.**

These recommendations are for directors and senior managers in settings where stop-smoking support is needed, and commissioners, providers and managers of stop-smoking support.

1.22.15 Ensure secondary care service specifications and service-level agreements require:

* all staff to be trained to give advice on stopping smoking and to make a referral to behavioural support

relevant staff to undertake regular continuing professional development in how to provide behavioural support to stop smoking.

1.22.18 Ensure secondary care pathways cover the following actions:

* identifying people who smoke
* providing advice on likely smoking-related complications
* providing advice on how to stop smoking

proactively referring people to stop-smoking support.

**Recommendation on training.**

1.23.2 Train all frontline healthcare staff to offer very brief advice on how to stop smoking in accordance with the section on support to stop smoking in primary care and community settings. Also train them to make referrals, if necessary and possible, to local stop-smoking support. Frontline secondary care staff should also be trained to refer people for behavioural support.

[NICE’s guideline on community pharmacies: promoting health and wellbeing](https://www.nice.org.uk/guidance/ng102) (NG102):

1.4.3 Offer brief advice and education as the opportunity arises, on stopping smoking and reducing alcohol consumption.

#### Current quality statements

[NICE’s quality standard on smoking: supporting people to stop](https://www.nice.org.uk/guidance/qs43) (QS43):

Statement 1 People are asked if they smoke by their healthcare practitioner, and those who smoke are offered advice on how to stop.

Statement 3 People in contact with healthcare practitioners who provide stop-smoking support are offered stop-smoking advice and interventions.

[NICE’s quality standard on community pharmacies: promoting health and wellbeing](https://www.nice.org.uk/guidance/qs196) (QS196):

Statement 1 People who have a long-term health condition or those who look for support to improve their health and wellbeing are offered advice and education when they use community pharmacy services.

#### Current UK practice

[Action on Smoking and Health and Cancer Research UK’s many ways forward: stop smoking services and tobacco control work in English local authorities](https://ash.org.uk/information-and-resources/reports-submissions/reports/many-ways-forward/) (2019) reports that 77% of local authorities provide/commission very brief advice or brief advice. This survey had completed responses from 120 individuals who provided data on 127 local authorities. This is 81% of the local authorities in England with responsibility for public health.

The [British Thoracic Society’s national smoking cessation audit report](https://www.brit-thoracic.org.uk/quality-improvement/clinical-audit/national-smoking-cessation-audit-2021/) (2019) reports smoking cessation activity in NHS acute hospitals. Part 2 of the audit reports on training of staff in smoking cessation. 50% of institutions offered regular training to frontline staff. [Preliminary findings of the audit for 2021](https://www.brit-thoracic.org.uk/news/2022/preliminary-results-from-the-bts-tobacco-dependency-treatment-services-audit-2021/) found that 45% of smokers in hospitals received very brief advice (from over 14,000 patient records from 120 hospitals in the UK).

No published studies on current practice were highlighted for this suggested area for quality improvement in settings such as community pharmacy; this area is based on stakeholder’s knowledge and experience.

### Resource impact

These recommendations are not included in the resource impact reports for tobacco & community pharmacies guidelines (NG209, NG102). They were not identified as areas of the guidelines that would be likely to have a significant resource impact (>£1m in England each year).

### Issues for consideration

**For discussion:**

* What is the priority for improvement? Stakeholders suggested:
  + Provision of brief advice.
  + Specific advice to be given, including information on the harm associated with passive smoking and health risks associated with smoking.
* What is the key action that will lead to improvement?
* Could we focus on a specific audience or setting?
  + Stakeholder suggested a number of different settings and professionals who could offer stop-smoking advice.
* Can we develop a specific, measurable statement?
  + Quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. Stakeholders suggest that training could support improvement in the provision of brief advice. Training may be referred to in the audience descriptors if a statement on stop-smoking advice is progressed,

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Access to stop-smoking support

Stakeholders highlighted access to services and interventions as a priority for quality improvement. The following areas were suggested:

* The range of stop-smoking interventions in NICE’s guideline on tobacco should be made accessible to those who want to stop smoking. Stakeholders suggested that these should be made available using a variety of interfaces, such as face-to-face, telephone, video or digital apps, and providers, such as local government, community pharmacists and NHS. This may help to address health inequalities that arise through limited access and uptake.
* Stakeholders commented on the importance of providing immediate stop-smoking treatment where this is possible, for example supporting temporary abstinence using nicotine replacement therapy during an inpatient admission or during an outpatient appointment in secondary care. They highlighted the benefits of stopping smoking before a planned admission and noted that advance knowledge of smokefree policies can promote temporary abstinence.
* Stakeholders also suggested that provision of specialist smoking cessation for parents/carers or household members who smoke when children are admitted to a ward is a priority for quality improvement.
* Stakeholders noted that people should be referred to stop-smoking services such as those from local government or community pharmacy on discharge from hospital. They also commented on the importance of evaluating the transfer of care to local stop-smoking services and how this can be used for quality improvement.
* Stakeholders also identified population groups that have high smoking rates, and the need for targeted and specialist stop-smoking support as a priority for quality improvement.

Stakeholders commented that treatment should be offered on opt-out basis and noted the difference between referral and treatment and highlighted reasons why people may not receive treatment despite a referral being made.

#### Selected recommendations

[NICE’s guideline on tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209) (NG209):

**Recommendations on identifying people who smoke.**

These recommendations are for health and social care professionals and those providing stop-smoking support or advice.

1.11.8 At the earliest opportunity, ask if any of the following people smoke:

* partners of pregnant women
* parents or carers of people using acute or mental health services

anyone else in the household.

1.11.10 If they do smoke:

* encourage them to stop if they are present, and refer them to a hospital or local stop-smoking support using local arrangements if they want to stop or cut down their smoking

if they are not present, ask the person using services to suggest they contact stop-smoking support and provide contact details.

**Recommendations on stop-smoking interventions.**

These recommendations are for people providing stop-smoking support or advice.

1.12.1 Tell people who smoke that a range of interventions is available to help them stop smoking. Explain how to access them and refer people to stop-smoking support if appropriate.

1.12.2 Ensure the following are accessible to adults who smoke:

* behavioural interventions
  + behavioural support (individual and group
  + very brief advice
* medicinally licensed products:
  + bupropion (see BNF information on bupropion hydrochloride)
  + nicotine replacement therapy – short and long acting
  + varenicline (see NICE's technology appraisal guidance on varenicline for smoking cessation and the BNF information on varenicline)

nicotine-containing e-cigarettes.

**Recommendations on support to stop smoking in secondary care services.**

These recommendations are for health and social care professionals in all acute, maternity and mental health services (including both inpatient and community mental health services, health visitors and midwives).

1.14.1 Give people information about the smokefree policy before their appointment, procedure or hospital stay. This should cover:

* the short- and long-term health benefits of stopping smoking at any time; for example, stopping smoking at any time before surgery has no ill effects (although people may experience short-term withdrawal symptoms such as headaches or irritability from quitting), and people who stop in the 8 weeks before surgery can benefit significantly
* the risks of secondhand smoke
* the fact that all buildings and grounds are smokefree so they must not smoke while admitted to, using or visiting these services (see the section on policy)
* the types of support available to help them stop smoking completely or temporarily before, during and after an admission or appointment (see the sections on behavioural support in acute and mental health services and supporting people who have to stop smoking temporarily)

about the different pharmacotherapies that can help with stopping smoking and temporary abstinence, where to obtain them (including from GPs) and how to use them.

1.14.3 Encourage people being referred for elective surgery to stop smoking before their surgery. Refer them to local stop-smoking support.

1.14.5 Offer and, if the person agrees, arrange for them to receive behavioural support to stop smoking during either their current outpatient visit or their inpatient stay.

1.14.6 For people using secondary care services in the community, staff trained to provide behavioural support to stop smoking should offer and provide support. Other staff should offer and, if accepted, arrange a referral to local stop-smoking support.

1.14.10 Offer and arrange or supply prescriptions of stop-smoking options (see the sections on stop-smoking interventions and stop-smoking pharmacotherapies in acute and mental health services).

1.14.13 For people who smoke who are admitted to secondary care, as well as following the recommendations in this section:

* Provide immediate support if necessary, otherwise within 24 hours of admission.
* Provide support (on site) as often and for as long as needed during admission.

Offer weekly sessions, preferably face to face, for at least 4 weeks after discharge. If it is not possible to provide this support after discharge, arrange a referral to local stop-smoking support.

1.14.14 For people who smoke who are receiving secondary care services in the community or at outpatient clinics (including preoperative assessments) follow the recommendations in this section and:

* Provide immediate support at the outpatient site.

Offer weekly sessions, preferably face to face, for at least 4 weeks after the date they stopped smoking. Arrange a referral to local stop-smoking support if the person prefers.

1.14.15 If stop-smoking pharmacotherapy is accepted, make sure it is provided immediately.

1.14.20 For those who need to abstain temporarily to use acute and mental health services:

* tell them about the different types of medicinally licensed nicotine-containing products and how to use them and

encourage the use of medicinally licensed nicotine-containing products to help them abstain and, if possible, prescribe them.

1.14.26 Ensure people using secondary care have access to stop-smoking pharmacotherapies at all times.

**Recommendation on commissioning and designing services.**

This recommendation is for directors and senior managers where stop-smoking support is needed, and commissioners, providers and managers of stop-smoking support.

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

[NICE’s guideline on behaviour change: digital and mobile health interventions](https://www.nice.org.uk/guidance/ng183): (NG183):

1.5.1 Consider digital and mobile health interventions as an option to help people stop smoking as an adjunct to existing services. Be aware that their effectiveness is variable.

1.5.2 Advise the person who wants to stop smoking using a digital or mobile health intervention that text message-based interventions with tailored messages may be more effective than other digital and mobile health interventions.

#### Current quality statements

[NICE’s quality standard on smoking: supporting people to stop](https://www.nice.org.uk/Guidance/QS43) (QS43):

Statement 1 People are asked if they smoke by their healthcare practitioner, and those who smoke are offered advice on how to stop.

Statement 3 People in contact with healthcare practitioners who provide stop-smoking support are offered stop-smoking advice and interventions.

#### Current UK practice

The [Quality and Outcomes Framework](https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20) (QOF) indicator SMOK004 is reported by NHS Digital. This reports the percentage of patients aged 15 and over who are recorded as current smokers who have a record of an offer or support and treatment within the preceding 24 months. Data from 2019 to 2020 shows an intervention rate of 89.7% for general practice. Data for individual practices shows a range from 15.1% to 100% intervention rate (median 91.4%, interquartile range 7.6%).

[NHS Digital’s statistics on NHS stop smoking services in England](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england) reports that in 2020 to 2021, 178,815 people set a quit date. 59% of people were supported by telephone and 37% had one-to-one support. This can be compared to data from 2019 to 2020 (pre-COVID-19 pandemic) which showed a total of 221,678 people setting a quit date, with 7% supported by telephone compared to 78% who had one-to-one support. There is no data for digital or mobile interventions.

[Action on Smoking and Health and Cancer Research UK’s reaching out: tobacco control and stop smoking services in local authorities in England 2021](https://ash.org.uk/information-and-resources/reports-submissions/reports/reaching-out/) reports on the methods of providing stop-smoking advice in local authority commissioned services. Data shows that in August 2021, 98% of services offered telephone advice and 60% offered video conferencing. 75% used text messages, 47% email and 40% used mobile phone apps. This can be compared with data in 2019 that showed 81% offering telephone advice but no services using the other remote methods. Survey responses note that “some service users are finding this preferable and are more likely to engage and continue treatment”.

The [British Thoracic Society’s national smoking cessation audit report](https://www.brit-thoracic.org.uk/quality-improvement/clinical-audit/national-smoking-cessation-audit-2021/) (2019) reports smoking cessation activity in NHS acute hospitals. Part 1 audits how many smokers are asked if they would like to quit and were referred to stop-smoking services:

* 44% of people who smoked were asked if they would like to quit.
* 38% did not want referral.
* 16% were referred to a hospital smoking cessation service.
* 8% to a community service.
* 2% to their GP.
* 3% were provided with self-referral information.

29% had no document.

Part 2 of the report audits smoking cessation services and policies. This reports that:

* 38% of the 124 institutions had access to a hospital-based smoking cessation service on the premises. 48% of those with access to hospital-based services had a formal referral pathway accessible to all healthcare professionals. 49% could provide inpatient access and 15% could always provide outpatient access.
* 98% of institutions provided one or more forms of pharmacotherapy which largely consisted of nicotine replacement therapy.
* 63% of institutions had healthcare professionals who were able to prescribe or supply pharmacotherapy to inpatients.
* 31% of current smokers were offered nicotine replacement therapy to help them abstain during their inpatient episode.
* 85% of institutions had access to community-based services and 75% had a formal referral pathway accessible to all healthcare professionals.

82% of hospitals offered follow-up and support after discharge via a community-based service and 20% offered this via hospital-based service.

[Action on Smoking and Health and Cancer Research UK’s reaching out: tobacco control and stop smoking services in local authorities in England](https://ash.org.uk/information-and-resources/reports-submissions/reports/reaching-out/) (2021) surveyed all 150 local authorities with public health responsibilities and had 118 responses providing data on 126 local authorities. Respondents were asked to identify which high prevalence populations they targeted. 44% of local authorities said they target BME communities, 97% targeted pregnant and post-partum women, 77% people with mental health conditions and 21% LGBTQ communities.

### Resource impact

These recommendations are not included in the resource impact report for tobacco and the resource impact statement for behaviour change (NG209, NG183). They were not identified as areas of the guidelines that would be likely to have a significant resource impact (>£1m in England each year).

### Issues for consideration

**For discussion:**

* What is the priority for improvement?
  + Access to a range of interventions, although there are limited recommendations on ways to offer support.
  + Immediate access to stop-smoking interventions.
  + Note that there are no recommendations for opt-out referral except for pregnant women.
* What is the key action that will lead to improvement?
* Could we focus on a specific audience or setting?
  + We received comments on support for people in specific population groups.
  + There were specific comments on secondary care services.
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Stop-smoking interventions

Stakeholders suggested that the provision of specific stop-smoking treatments is an area for quality improvement:

* Pharmacotherapy and behavioural support. Stakeholders suggested that stop-smoking medications and e-cigarettes should be combined with behavioural support as these methods have the best outcomes and noted that this would be provided by a specialist stop-smoking service. They note that provision of specialist support is limited or reduced in some area and there is variation in duration, medication offered or the people who are offered access to services. Other stakeholders commented that some people may not be able to commit to a course of behavioural therapy and so should be provided with pharmacotherapy regardless of if they attend behavioural support.
* People should receive a full course of their chosen pharmacotherapy.
* E-cigarettes should be recommended for smoking cessation. Stakeholders noted that smokers should be given advice about the harm associated with e-cigarettes when compared to smoking and encouraged to switch from tobacco to other nicotine containing products.
* Services should offer non-pharmacological options, with an example given of Allen Carr’s Easyway. This would be of benefit to all smokers as well as pregnant women who smoke.

Stakeholders also suggested that efficacy of treatment should be measured and reported to ensure it reaches a minimum standard.

#### Selected recommendations

[NICE’s guideline on tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209) (NG209):

The section on stop-smoking interventions will be updated in August 2022 after a review of evidence for the Allen Carr Easyway programme for smoking cessation.

**Recommendations on stop-smoking interventions.**

These recommendations are for people providing stop-smoking support or advice.

1.12.5 Offer behavioural support to people who smoke regardless of which option they choose to help them stop smoking. Explain how to access it.

1.12.7 Advise people (as appropriate for their age) that the following options, when combined with behavioural support, are more likely to result in them successfully stopping smoking:

* varenicline (offered in line with NICE's technology appraisal guidance on varenicline for smoking cessation)
* a combination of short-acting and long-acting NRT

nicotine-containing e‑cigarettes

**Recommendations on advice on nicotine-containing e-cigarettes.**

These recommendations are for people providing stop-smoking support or advice to adults.

1.12.13 Give clear, consistent and up-to-date information about nicotine-containing e‑cigarettes to adults who are interested in using them to stop smoking (for example, see the NCSCT e-cigarette guide and Public Health England's information on e-cigarettes and vaping).

1.12.14 Advise adults how to use nicotine-containing e‑cigarettes. This includes explaining that:

* e‑cigarettes are not licensed medicines but are regulated by the Tobacco and Related Products Regulations (2016)
* there is not enough evidence to know whether there are long-term harms from e‑cigarette use
* use of e‑cigarettes is likely to be substantially less harmful than smoking

any smoking is harmful, so people using e‑cigarettes should stop smoking tobacco completely.

**Recommendation on commissioning and designing services.**

This recommendation is for directors and senior managers in settings where stop-smoking support if needed, and commissioners, providers and managers of stop-smoking support.

1.22.24 Monitor performance data for stop-smoking services routinely and independently. Make the results publicly available.

#### Current quality statements

[NICE’s quality standard on smoking: supporting people to stop](https://www.nice.org.uk/guidance/qs43) (QS43):

Statement 3 People in contact with healthcare practitioners who provide stop-smoking support are offered stop-smoking advice and interventions.

Statement 4 People who seek support to stop smoking and who choose to take pharmacotherapy are offered a full course.

#### Current UK practice

[Action on Smoking and Health and Cancer Research UK’s many ways forward: stop smoking services and tobacco control work in English local authorities](https://ash.org.uk/information-and-resources/reports-submissions/reports/many-ways-forward/) (2019) reports that 97% of local authorities offered behavioural support for smoking cessation. The other respondents offered “integrated advice on multiple, behavioural health issues including smoking” or self-support. 75% offered 12-weeks of behavioural support to all smokers, 7% offered 12 weeks of support to people in priority groups and the remainder offered between 4 and 8 weeks of support.

[NHS Digital’s statistics on NHS stop smoking services in England](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england) includes data on pharmacotherapy received by people setting a quit date and the percentage of people who successfully quit using each pharmacotherapy. The data does not indicate whether the person received behaviour support with the pharmacotherapy. In 2020 to 2021 in 178,815 people setting a quit date:

* 34% were given a combination of nicotine-containing products concurrently. 55% successfully quit.
* 20% had a single nicotine-containing product. 59% successfully quit.
* 29% were prescribed varenicline only. 67% successfully quit.
* 2% had combination licensed nicotine-containing product and/or bupropion and/or varenicline consecutively. 47% successfully quit.
* 2% had an unlicensed nicotine-containing product. 61% successfully quit.
* 2% had combination of a licensed medication and an unlicensed nicotine-containing product concurrently. 68% successfully quit.

8% of people did not use any licensed medication or unlicensed nicotine-containing product. 53% successfully quit.

[Smoking in England](https://smokinginengland.info/graphs/monthly-tracking-kpi) collects monthly data on smoking habits via a household survey which involves a new representative sample of 1700 to 1800 adults, of which 450 are smokers. This does not appear to be restricted to people accessing stop-smoking services. The monthly tracking KPI reports on the percentage of those trying to stop in the past year who used support (3 month moving average). The latest figures (January 2022) report that:

* 48.7% used nothing.
* 31.6% used an e-cigarette.
* 11.2% used nicotine replacement therapy bought over the counter.
* 7.4% used prescription medication.

1% used NHS stop-smoking services.

Smoking in England also reports on the trends in e-cigarette use in England. They report on the aids used in the most recent quit attempt. Data from October 2021 shows the percentage of smokers trying to stop or who stopped in the past year:

* 33.1% had used an e-cigarette.
* 16.1% had used nicotine replacement therapy bought over the counter.
* 5.8% had used nicotine replacement therapy on prescription.
* 2.6% had used Champix (varenicline)
* 1.4% used behavioural support.
* 0.7% used a heated tobacco product.

0.6% used Juul.

It is unclear how this data relates to the KPI data referred to above, but both sets of data show higher proportions of people using an e-cigarette to stop smoking when compared with those who set a quit date in NHS stop-smoking services. There is no indication of consecutive or combination use of stop-smoking interventions in this data as there is in the data from NHS stop-smoking services.

[Action on Smoking and Health and Cancer Research UK’s reaching out: tobacco control and stop smoking services in local authorities in England 2021](https://ash.org.uk/information-and-resources/reports-submissions/reports/reaching-out/) reports that the provision of e-cigarettes has increased. 11% of surveyed local authorities offered e-cigarettes to some or all smokers accessing stop-smoking services in 2019, in 2021 40% of surveyed local authorities offered them and 15% had plans to do so. The report also includes data that shows that 76% of local authorities offered a full course of dual nicotine replacement therapy compared to 65% in 2019. 88% offer a full 12-week course of varenicline, similar to the number in 2019.

Resource impact

These recommendations are not included in the resource impact report for tobacco (NG209). They were not identified as areas of the guideline that would be likely to have a significant resource impact (>£1m in England each year).

Issues for consideration

**For discussion:**

* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Could we focus on a specific audience or setting?
* Can we develop a specific, measurable statement?
  + Note that nicotine-containing e-cigarettes are not currently licensed medicines.
* Should current statements 3 and 4 in QS43 be updated?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Harm-reduction approach

Stakeholders suggested harm reduction approaches as an area for quality improvement. Specific options suggested by stakeholders are use of medicinally licensed nicotine containing products, dual use of nicotine replacement therapy or varenicline, or complete substitution with e-cigarettes. Other stakeholders suggest an area for priority is the use of non-licensed products in harm reduction approaches. They noted the disconnect between medical and social perceptions on nicotine dependence and the barrier that may create to behaviour change. They suggested that the use of non-licensed products may be empowering for the smoker and a more cost-effective lifestyle choice. Stakeholders noted that information regarding long-term safety of e-cigarette use is not available and so should not be seen as harmless and non-addictive when promoted as a harm-reduction aid and should not encourage uptake in never smokers. This was specifically highlighted for young people who may be encouraged to use e-cigarettes due to their increased accessibility.

#### Selected recommendations

[NICE’s guideline on tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209) (NG209):

**Recommendations on supporting people who do not want, or are not ready, to stop smoking in one go to reduce their harm from smoking.**

These recommendations are for providers of stop-smoking support and other specially trained professionals.

1.15.2 If someone does not want, or is not ready, to stop smoking in one go, ask if they would like to think about reducing the harm from smoking. If they agree, help them to identify why they smoke, their smoking triggers and their smoking behaviour. Use this information to work through the approaches outlined in box 1.

Box 1 Harm reduction approaches

Cutting down before stopping smoking

* with the help of 1 or more medicinally licensed nicotine-containing products (the products may be used as long as needed to prevent relapse to previous levels of smoking)

without using medicinally licensed nicotine-containing products.

Smoking reduction

* with the help of 1 or more medicinally licensed nicotine-containing products (the products may be used as long as needed to prevent relapse to previous levels of smoking)

without using medicinally licensed nicotine-containing products.

Temporarily not smoking

* with the help of 1 or more medicinally licensed nicotine-containing products

without using medicinally licensed nicotine-containing products.

**Recommendations on medicinally licensed nicotine-containing products for harm reduction**

These recommendations are for health and social care professionals, stop-smoking advisers and voluntary and community organisations.

1.15.4 Reassure people who smoke that medicinally licensed nicotine-containing products are a safe, effective way to reduce the amount they smoke or to cut down before stopping. Also:

* advise them that these products can be used as a complete or partial substitute for tobacco, either in the short or long term
* explain that using these products also helps avoid compensatory smoking and increases their chances of stopping in the longer term

reassure them that it is better to use these products and reduce the amount they smoke than to continue smoking at their current level.

1.15.5 Advise people that medicinally licensed nicotine-containing products can be used for as long as they help stop them going back to previous levels of smoking (see box 1).

1.15.6 If possible, supply or prescribe medicinally licensed nicotine-containing products. Otherwise, encourage people to ask their GP or pharmacist for them, or tell them where they can buy the products themselves.

#### Current quality statements

[NICE’s quality standard on smoking: harm reduction](https://www.nice.org.uk/guidance/qs92) (QS92)

Statement 1 People who do not want, or are not ready, to stop smoking are offered a harm-reduction approach to smoking.

Statement 3 People who do not want, or are not ready, to stop smoking are advised about and supported to obtain medicinally licensed nicotine-containing products.

Statement 4 Providers of stop-smoking support offer harm-reduction approaches alongside existing approaches to stopping smoking in one go.

#### Current UK practice

[Smoking in England](https://smokinginengland.info/graphs/monthly-tracking-kpi) collects monthly data on smoking habits via a household survey which involves a new representative sample of 1700 to 1800 adults. The monthly tracking KPI reports on the percentage of cigarette smokers using a harm reduction approach (3 month rolling average). The latest figures (January 2022) report that 53.7% of smokers report cutting down, 15.5% using e-cigarettes to cut down and 5.9% using nicotine replacement therapy to cut down. There is no data for how people accessed these options, whether via formal stop-smoking support or not.

No further published studies on current practice were highlighted for provision of harm reduction approaches as an area for quality improvement; this area is based on stakeholder’s knowledge and experience.

#### Resource impact

These recommendations are not included in the resource impact report for tobacco (NG209). They were not identified as areas of the guideline that would be likely to have a significant resource impact (>£1m in England each year).

Issues for consideration

**For discussion:**

* What is the priority for improvement?
* What is the key action that will lead to improvement?
  + Do any of the existing quality statements in QS92 capture stakeholder comments or priority?
* Could we focus on a specific audience or setting?
* Can we develop a specific, measurable statement?
  + There are no NICE recommendations on the use of e-cigarettes in a harm-reduction approach. There is a research recommendation to assess whether e-cigarettes are effective and safe for harm reduction when used alongside tobacco products to cut down on smoking.
  + Limited current practice information was identified for this area.

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Support to stop smoking in pregnancy

Stakeholders suggested that provision of stop-smoking support in pregnancy is an area for quality improvement including identifying pregnant women who smoke and referring them to stop-smoking support. Carbon monoxide testing should take place at all antenatal appointments. They note that some factors can prevent pregnant women from accessing stop-smoking support and suggested that remote or home-based stop-smoking support could address some of these factors. They note that home carbon monoxide monitors can support a remote quit smoking programme and that biochemical verification of a quit attempt is important to validate smoking status and can be used as a marker of quality service provision. Stakeholders also commented on stop-smoking interventions that can be used in pregnancy and suggested an area for quality improvement is consideration of nicotine replacement therapy, alongside behavioural support, at the earliest opportunity.

#### Selected recommendations

[NICE’s guideline on tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209) (NG209):

**Identifying pregnant women who smoke and referring them for stop-smoking support.**

These recommendations are for healthcare professionals providing maternity care.

1.18.1 Provide routine carbon monoxide testing at all antenatal appointments to assess the pregnant woman's exposure to tobacco smoke.

1.18.2 Provide an opt-out referral to receive stop-smoking support for all pregnant women who:

* say they smoke or have stopped smoking in the past 2 weeks or
* have a carbon monoxide reading of 4 parts per million (ppm) or above or

have previously been provided with an opt-out referral but have not yet engaged with stop-smoking support.

See also the section on identifying smoking among carers, family and other household members.

**Following up women who have been referred for stop-smoking support.**

These recommendations are for people providing stop-smoking support or advice.

1.19.4 Address any factors that prevent pregnant women from using stop-smoking support. This could include:

* a lack of confidence in their ability to quit
* lack of knowledge about the services on offer
* difficulty accessing them
* lack of suitable childcare

fear of failure and concerns about being stigmatised.

1.19.5 If pregnant women are reluctant to attend the stop-smoking service, think about providing structured self-help materials or giving details of telephone quitlines or NHS online stop-smoking support. Also think about offering to visit them at home, or at another venue, if it is difficult for them to attend specialist services.

1.20.1 Provide the pregnant woman with intensive and ongoing support (brief interventions alone are unlikely to be sufficient) throughout pregnancy and beyond. This includes regularly monitoring her smoking status using carbon monoxide tests. Use carbon monoxide measurements to encourage her to quit and as a way to provide positive feedback once a quit attempt has been made.

1.20.2 Biochemically validate that the pregnant woman has quit on the date she set and 4 weeks after. If possible, use urine or saliva cotinine tests, as these are more accurate than carbon monoxide tests. (They can detect exposure over the past few days rather than hours.)

1.20.6 Consider NRT alongside behavioural support to help women stop smoking in pregnancy.

1.20.7 Consider NRT at the earliest opportunity in pregnancy and continue to provide it after pregnancy if the woman needs it to prevent a relapse to smoking, including if the pregnancy does not continue.

1.20.12 In addition to NRT and behavioural support, offer voucher incentives to support women to stop smoking during pregnancy, as follows:

* refer women to an incentive scheme at the first maternity booking appointment or at the next available opportunity
* provide vouchers only for abstinence validated using a biochemical method, such as a carbon monoxide test with a reading of less than 4 ppm
* stagger incentives until at least the end of pregnancy (incentives totalling around £400 have been shown to be effective)
* do not exclude women who have relapsed or those whose pregnancy does not continue from continuing to take part in the scheme and try again

ensure vouchers cannot be used to buy products that could be harmful during pregnancy (for example, alcohol and cigarettes).

#### Current quality statements

[NICE’s quality standard on antenatal care](https://www.nice.org.uk/guidance/qs22) (QS22):

Statement 5 Pregnant women who smoke are referred for evidence-based stop-smoking support at the booking appointment.

#### Current UK practice

[NHS Digital’s maternity services monthly statistics](https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics) (December 2021) shows that 68% of women had a recorded smoking status at the time of their booking appointment. Data from December 2020 showed at this time, only 32% had a recorded smoking status. This is experimental data only and reporting for smoking status at booking is only available from May 2019. The data derived from SNOMED codes is still being developed and so data submitted may be limited depending on system supplier.

[NHS Digital’s statistics on NHS stop smoking services in England](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england/april-2020-to-march-2021/datasets) reports data for the number of pregnant women setting a quit date. In 2020 to 2021, 18,087 pregnant women set a quit date. 48% of these were successful, 28% did not quit and 24% were lost to follow up or quit status not known. The report also details the number people setting a quit date by intervention setting. 3,032 people set a quit date in a maternity setting. 49% of these were successful quitters (self-reported). There is no data for which other settings were accessed by pregnant women. [Action of Smoking and Health and Cancer Research UK’s stepping up: the response of stop-smoking services in England to the COVID-19 pandemic](https://ash.org.uk/information-and-resources/reports-submissions/reports/steppingup/) (2021) reports that 59% of stop-smoking services made special provisions for vulnerable groups including pregnant women in response to the COVID-19 pandemic, such as remote methods of delivering advice and medications.

[NHS Digital’s statistics on NHS stop smoking services in England](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england/april-2020-to-march-2021/datasets) shows that 4% of self-reported successful quitters were validated by carbon monoxide measurement in 2020 to 2021. This is 2% of all pregnant women setting a quit date. This can be compared to 2018 to 2019 (pre-COVID 19 pandemic) which reports 61% of self-reported successful quitters confirmed by carbon monoxide measurement. It is not clear if the remainder of people had a carbon monoxide test that did not confirm success or had no validation attempt made. The [Healthcare Safety Investigation Branch national learning report on intrapartum stillbirth](https://www.hsib.org.uk/investigations-and-reports/intrapartum-stillbirth-during-covid-19/) (2021) notes that carbon monoxide monitoring was suspended during COVID-19 along with some face-to-face antenatal visits which also impacted on the provision of carbon monoxide testing. [Action on Smoking and Health and Cancer Research UK’s reaching out: tobacco control and stop smoking services in local authorities in England 2021](https://ash.org.uk/information-and-resources/reports-submissions/reports/reaching-out/) reports that the difficulty in obtaining carbon monoxide confirmed quitting data is a negative effect of the move to remote support.

A study of smoking cessation support for pregnant women provided by English stop-smoking services and NHS trusts by [Thomson et al (2022)](https://www.mdpi.com/1660-4601/19/3/1634/htm) found that 11% of local authorities and 33% of trusts did not have a budget for nicotine replacement therapy. The survey was distributed to 151 local authorities in England (66% responded) and 140 NHS trusts that provide maternity care (68% responded). Half of those responding reported supplying nicotine replacement therapy directly to pregnant women. 92% of local authorities and 95% of trusts that provided nicotine replacement therapy provided combination treatment (dual therapy). It was commonly offered for 12 weeks but a quarter of local authorities and trusts offer in excess of 12 weeks. The survey showed that specialist support was delivered by GPs and pharmacists in 16% of local authorities.

Data from the Clinical Practice Research Database (CPRD) on trends in prescribing of nicotine replacement therapy to pregnant women in primary care in England reported by [Szatkowski et al (2021)](https://academic.oup.com/ntr/article/23/9/1607/6159707?login=false) showed that nicotine replacement therapy was prescribed by primary care in 79% of pregnancies (2005 to 2017) and dual nicotine therapy in 1.7% of pregnancies. Prescribing of nicotine replacement therapy declined by -1.37% per year from 2013. This study covered 398 general practices in England and did not review data of prescriptions from stop-smoking services. The report states that around 20% of stop-smoking services issue prescriptions through primary care.

Resource impact

NG209 recommendation 1.20.12 about offering voucher incentives to support women to stop smoking during pregnancy was identified in the [resource impact report](https://www.nice.org.uk/guidance/ng209/resources) as an area that may have a significant resource impact (>£1m in England each year).

There is expected to be a cash cost for provision of vouchers to support women to stop smoking during pregnancy; the guideline resource impact products used an average voucher cost of £300 per woman. There may be some additional costs for training midwives or maternity support workers to help promote and deliver the vouchers.

Additional costs are expected to be offset by a reduction in appointments, treatments and admissions for complications associated with smoking during pregnancy, resulting in an overall net saving.

The other recommendations listed above are not areas included in the resource impact report for tobacco (NG209). They were not identified as areas of the guideline that would be likely to have a significant resource impact (>£1m in England each year).

Issues for consideration

**For discussion:**

* What is the priority for improvement?
  + Access to stop-smoking support.
  + Stop-smoking interventions.
  + Biochemical validation.
* What is the key action that will lead to improvement?
  + Would a quality statement have more impact if it was included in the antenatal care quality standard which is due to be updated this year?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Additional areas

### Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However, they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or need further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the Advisory Committee meeting.

Table 2 Summary of information available for additional areas

| Suggested area for improvement | Within remit of NICE QS | In scope | Guideline recs | Relevant  existing QS |
| --- | --- | --- | --- | --- |
| Awareness in the population | No | No | Yes | No |
| School-based interventions | Yes | No | Yes | Yes |
| Emerging from COVID-19 | No | No | No | No |
| Innovation in stop-smoking pharmacotherapy | No | No | No | No |

### Awareness in the population

Stakeholders commented on the need for “myth-busting” and suggested this could be provided on cigarette packaging. Stakeholders also noted misconceptions in the population about nicotine and tobacco use for example the belief that shisha is safer than smoking cigarettes and vaping is equally as harmful as cigarettes. These suggestions have not been progressed as because quality standards focus on areas that can be addressed by local commissioners. National awareness campaigns are outside of the scope of quality standards.

### School-based interventions

Stakeholders specifically commented on the importance of integration of education on smoking into the curriculum. They noted the need for education on e-cigarettes and “myth-busting” about smoking. Stakeholder also highlighted the need for similar education on smoking in other educational settings such as university and when giving advice in primary care. These suggestions have not been progressed as they are instead within the scope of [NICE’s quality standard on smoking: reducing and preventing tobacco use](https://www.nice.org.uk/guidance/qs82) (QS82).

### Emerging from COVID-19

Stakeholders commented that people who smoke may not be more susceptible to COVID-19 when compared to the general population. They note this is an emerging area. This suggestion has not been progressed. Research is within the remit of the National Institute for Health Research.

### Innovation in stop-smoking pharmacotherapy

Stakeholders highlighted the need for alternative options for stop-smoking pharmacotherapy. They noted that varenicline is no longer available in the UK and as a result there is a reduction of the therapies that can be offered and resulted in lack of engagement with some people who want to quit smoking. They suggest that manufacturers should offer a replacement for varenicline or make this available again. This suggestion has not been progressed because quality standards focus on areas of quality improvement that can be addressed by local commissioners.

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# Appendix 1: Suggestions from registered stakeholders

| ID | Stakeholder | Suggested key area for quality improvement | Why is this a key area for quality improvement? | Supporting information |
| --- | --- | --- | --- | --- |
| 1 | The British Thoracic Oncology Group / RCP | **General**: We have liaised our Tobacco Advisory Group (TAG) and would like to comment as follows.  Our experts fully agree with the plan to merge and update QS43 and QS92 as planned due to changes in practice, new evidence and updated guidelines. Many of my suggestions refer to language and processes that are important if we are to make any progress. The current NG209 recommendations are necessary but not sufficient without considering process and language. |  |  |
| 2 | SCM5 | **General**: Areas in QS43 and QS92 are still a priority. |  |  |
| 3 | BAME Health Collaborative | **Identifying people who smoke:** Identifying and quantifying people's smoking Identifying people who smoke | A public health agenda should also encourage health professionals to 'ask' patients/clients if they have considered smoking/using tobacco. It then suggests that the patient/vulnerability client's to smoking or willingness to smoke in the near future be assessed, providing an opportunity to 'advise' on the importance of not smoking and/or referral for behavioural support, as well as 'arrange' a follow-up appointment, if possible, with those patients who wish to refrain from smoking. |  |
| 4 | The British Thoracic Oncology Group/RCP/ NHS E&I (NSA) | **Identifying people who smoke:** Screening everyone systematically for smoking at every NHS contact | Screening everyone systematically for smoking at every NHS contact -this should be recorded electronically and be updated in the persons medical record. By doing so, changes in smoking status can be tracked (many people will relapse to smoking after previous quit attempts) to facilitate the triggering of new quit attempts. Electronic recording of smoking status facilitates transfer of information and smoking intervention across treatment pathways e.g., elective surgery/ cancer referrals (between Primary and Secondary Care) or between organisations providing care in an integrated patient pathway (e.g., NHS and local government) |  |
| 5 | British Thoracic Society | **Identifying people who smoke:** Identifying tobacco dependence in secondary care | All secondary care organisations should have a systematic way of identifying smokers accessing their services. You can only treat what is known and visible to you. BTS Smoking cessation audit have identified that this is an area that still requires improvement, not every patient is being asked about their smoking status and not every organisation has a digital way of recording smoking status and generating prompts to action brief advice and referral. | BTS Smoking cessation audit have identified that this is an area that still requires improvement, not every patient is being asked about their smoking status and not every organisation has a digital way of recording smoking status and generating prompts to action brief advice and referral.  1 in 4 patients were not asked about their smoking status in 2019 audit report < <https://www.brit-thoracic.org.uk/document-library/quality-improvement/audit-reports/smoking-cessation-audit-report-2019/> > 2022 Audit report soon to be published |
| 6 | SCM1 | **Identifying people who smoke:** Identifying and quantifying people’s smoking |  |  |
| 7 | British Thoracic Society | **Stop-smoking advice**: Mandatory Very brief training VBA Training for secondary care staff | Healthcare professionals will see many conditions caused or exacerbated by smoking, and smoking cessation will often be the most clinically and cost effective of interventions for individuals who smoke. VBA is short and effective and training is free . | Fu S, Partin M, Snyder A et al. Promoting repeat tobacco dependence treatment: are relapsed smokers interested? Am J Managed Care 2006; 12: 235–243.  BTS Tobacco Dependency Audit 2022 – preliminary report demonstrates only 45% of inpatient smokers are offered VBA. And only 50% of trusts offer training  <https://www.brit-thoracic.org.uk/news/2022/preliminary-results-from-the-bts-tobacco-dependency-treatment-services-audit-2021/> |
| 8 | Cochrane Tobacco Addiction Group, Nuffield Department of Primary Care Health Sciences, University of Oxford | **Stop-smoking advice:** The provision of opportunistic face-to-face brief advice on stopping smoking with an offer of assistance in any clinical practice | Opportunistic brief advice is not provided in all clinical settings (<https://www.blf.org.uk/taskforce/plan/prevention/smoking>).  Even in primary care where this would be expected to be consistent, in some cases face-to-face intervention has been replaced by text message prompts. Clinicians report a number of barriers to offering advice such as time, lack of training and lack of motivation from patients (<https://www.cambridge.org/core/journals/journal-of-smoking-cessation/article/systematic-review-of-clinicianreported-barriers-to-provision-of-smoking-cessation-interventions-in-hospital-inpatient-settings/55367AD65083623A01069377C25D4B24>) | Please see the following systematic review and meta-analysis, which found that providing brief smoking cessation interventions increased quit rates compared to offering no advice, regardless of people’s motivation to quit smoking. Offering assistance to quit was also more effective than simply advising people to quit on medical grounds.  <https://pubmed.ncbi.nlm.nih.gov/22175545/>  This second paper reporting on a cNMA of behavioural support to quit smoking also provides evidence that providing advice on how to quit rather than just why to quit increases the chances of people quitting smoking: <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013229.pub2/full> |
| 9 | Diabetes UK | **Stop-smoking advice**: Be clear that smoking leads to increased risk of developing broader health problems e.g. type 2 diabetes and diabetes complications | Evidence shows that smoking is associated with an increased risk of developing type 2 diabetes. For people already living with diabetes, smoking can double the risk of serious complications such as cardiovascular disease.  This is in the context of a growing prevalence of diabetes. Our 2021 figures show that this has more than doubled in the last 15 years with 4.9 million people – 1 in 14 - now living with the condition in the UK. 90% of people living with diabetes have type 2; with a further 13.6 million people now at an increased risk of developing type 2 diabetes.  It is important to make these connections clear in discussions with people to encourage them to stop smoking or reduce the amount they smoke. | Diabetes UK’s information pages:  [Help with giving up smoking | Diabetes UK](https://www.diabetes.org.uk/guide-to-diabetes/life-with-diabetes/help-with-giving-up-smoking)  <https://www.diabetes.org.uk/about_us/news/diabetes-diagnoses-doubled-prevalence-2021>  Action on Smoking and Health (ASH) also have a useful factsheet on the associated risks between smoking and diabetes:  <https://ash.org.uk/information-and-resources/fact-sheets/smoking-and-diabetes/>  This widescale study found that active and passive smoking is associated with significantly increased risks of type 2 diabetes: <https://pubmed.ncbi.nlm.nih.gov/26388413/> |
| 10 | Diabetes UK | **Stop-smoking advice:** A meaningful discussion with a trained healthcare professional about stopping smoking should happen at point-of-sale for nicotine replacement therapies | There is an important role healthcare professionals like pharmacists can play in encouraging people to stop smoking by having a meaningful conversation when selling nicotine replacement therapies. | The below Public Health England report outlines how community pharmacy teams can make a significant contribution to reducing the risk of disease and improving outcomes for those with long term conditions by promoting healthy choices like stopping smoking:  <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643520/Pharmacy_a_way_forward_for_public_health.pdf> |
| 11 | Diabetes UK | **Stop-smoking advice:** People should be made aware of the harms of passive smoking from both cigarettes and e-cigarettes | Research has shown that passive or second-hand nicotine vape exposure was associated with increased risk of bronchitic symptoms and shortness of breath among young adults.  The potential dangers of passive or second-hand vape exposure are not mentioned in the [NICE guideline on tobacco: preventing uptake, promoting quitting and treating dependence so it is important to be aware of this when discussing harm reduction and quitting.](https://www.nice.org.uk/guidance/ng209)  The harms of passive tobacco smoking have been well documented, and this should also be clear within the quality standard | This study looks at the effects on second-hand nicotine vape exposure in young adults: <https://thorax.bmj.com/content/early/2022/01/05/thoraxjnl-2021-217041> |
| 12 | PAGB, the consumer healthcare association | **Stop-smoking advice:** Every opportunity should be taken by health professionals – including GPs, pharmacists, dentists and smoking cessation advisers – to provide very brief advice (VBA) to people who smoke on stopping smoking and interventions. | PAGB believes that people who smoke should have access to advice and interventions to help them stop smoking, as appropriate for their age or if they are pregnant. Therefore, in line with existing NICE guidelines and NHS England policy (NHS Health Education England, Making Every Contact Count: Smoking. Available at: <http://makingeverycontactcount.co.uk/training/healthy-lifestyle-information/smoking/>  (Accessed 7 March 2022), healthcare professionals need to ensure that every contact counts.  This quality standard should be measured through the collection of local data to analyse evidence of local arrangements and the proportion of people in contact with healthcare professionals who are offered stop-smoking advice and interventions. | This area of quality improvement is supported by NICE’s quality standard 43 and section 1.23.2 of the guideline on ‘Tobacco: preventing uptake, promoting quitting and treating dependence’.  National Institute for Health and Care Excellence, Tobacco: preventing uptake, promoting quitting and treating dependence [NICE Guideline 209], 30 November 2021, p.100. Available at: <https://www.nice.org.uk/guidance/ng209/resources/tobacco-preventing-uptake-promoting-quitting-and-treating-dependence-pdf-66143723132869>  (Accessed: 7 March 2022) |
| 13 | SCM3 | **Stop-smoking advice:** Train all frontline staff to deliver Very Brief Advice | Smokers attending NHS services need to be identified and offered treatment for tobacco dependence. | Please see BTS audit report 2019. BTS audit report 2019 states that half of the identified smokers were not being engaged with. |
| 14 | SCM2 | **Stop-smoking advice:** Primary Care Very Brief Advice and referral of Smokers to stop Smoking Services. | NCSCT Service and Delivery Guidance recommends that services should treat at least 5% of all local smokers.  The NHS Long Term Plan, aims to offer Tobacco Dependence Treatment to Acute inpatients and patients attending secondary care services, however, they are more likely to already have smoking related conditions and comorbidities at this stage. In order to have the best impact at reducing health inequalities, the sooner a smoker can be offered support to quit the better.  Therefore, primary care remains the best opportunity to offer VBA and referral to stop Smoking support, either with an in-surgery advisor, or through community support services.  Primary Care and General Practice has been severely impacted by the pandemic and access to face to face GP consultations remains difficult. Telephone consultations has helped however, GP referrals in to Stop Smoking Services or support from in-house advisors has reduced since the pandemic and does not seem to be reversing, implying that VBA is less likely to happen during telephone consultations, or through reduced GP contact.  It is known that 60% of smokers want to quit, and around 40% of smokers will try to quit based on advice from a Health Care Professional, and with reduced contacts with a Health Care professional, we need to maximise every opportunity to refer smokers to support.  Therefore, VBA and the offer of support should occur with “Every smoker at Every contact” with health care professional, particularly in primary care, and particularly when the consultation occurs by phone as visual messaging will not be seen. | See ASH and CRUK joint annual report “Reaching Out: Tobacco control and stop smoking services in local authorities in England, 2021”  States that the impact of COVID has led to “Decline in primary care support and referrals”  <https://ash.org.uk/information-and-resources/reports-submissions/reports/reaching-out/> |
| 15 | BAME Health Collaborative | **Access to stop-smoking support:** Promoting support for people to stop using smokeless tobacco.  The recommendation **only** addresses information specific for South Asian subgroups (for example, older  Bangladeshi women) who are known to have high rates of smokeless tobacco | The UK government has statistical data indicating that certain demographic groups, including Irish and Pakistani men, as well as Black Caribbean women, have relatively high smoking rates, not just Bangladeshi women.  This was never considered during the consultation process. | **Smoking reinforces health inequalities**  “There are relatively high smoking levels among certain demographic groups, including Bangladeshi, Irish and Pakistani men and among Irish and Black Caribbean women”.  <https://www.gov.uk/government/publications/health-matters-smoking-and-quitting-in-england/smoking-and-quitting-in-england> |
| 16 | The British Thoracic Oncology Group/RCP/ NHS E&I (NSA) | **Access to stop-smoking support:** The word ‘referral’ should be replaced as much as possible by ‘treatment’. | The word ‘referral’ should be replaced as much as possible by ‘treatment’. In many circumstances ‘referral’ is mistakenly assumed to be the same as ‘treatment’ when in fact they are not the same at all, many patients do not get referred from an NHS organisation to the local government due to processes (paper referral cards), nor does it happen in a timely way. Many patients are not contactable (deliberately or misinformation about phone numbers) and even if are contactable, many patients are no longer motivated to quit for example when they are back at work or in their home environment. The net result is that many patients are not treated for tobacco dependency despite referral and the opportunity is lost. The NHS LTP is supporting immediate opt-out treatment of patients when people first attend hospitals/ maternity services with a subsequent ’transfer of care’ to local government services /pharmacists upon hospital discharge to continue the treatment pathway. As part of a quality improvement process the success of these ‘transfers of care’ should be evaluated by organisations contributing to the patient pathway to identify processes to improve this critical step. |  |
| 17 | The British Thoracic Oncology Group/RCP/ NHS E&I (NSA) | **Access to stop-smoking support**: Treatment should be offered on an ‘opt-out’ basis. | Treatment should be offered on an ‘opt-out’ basis as is the case with most other serious medical conditions e.g. diabetes and pneumonia. |  |
| 18 | The British Thoracic Oncology Group/RCP/ NHS E&I (NSA) | **Access to stop-smoking support:** The full range of treatments specified in NG209 should be made available through a variety of interfaces (face to face, telephone, video, digital apps) and providers (local government, community pharmacists, NHS) provided that treatment efficacy is measured, reported and reviewed routinely and as an integral part of service provision and achieves a minimum standard. | The full range of treatments specified in NG209 should be made available through a variety of interfaces (face to face, telephone, video, digital apps) and providers (local government, community pharmacists, NHS) provided that treatment efficacy is measured, reported and reviewed routinely and as an integral part of service provision and achieves a minimum standard. This choice of treatment, interfaces and providers will support treatment uptake for people who smoke and go some way to addressing health inequalities that arise through limited access and uptake of treatment. |  |
| 19 | British Thoracic Society | **Access to stop-smoking support**: Ensure Patients are supported with temporary abstinence during inpatient admission | Patients who remain smoke free during a stay in hospital will heal more quickly and are less likely to be readmitted. In addition, patients are more receptive to smoking-cessation support while in hospital, and are often more motivated to stop smoking following admission (Department of Health, 2009). Secondary care should have measures in place to support staff in supporting patients (e.g. patient group directives to allow prescribing and dispensing of NRT). | Cochrane review confirmed the positive impact of implementing stop-smoking services for inpatients. This systematic review found that stop-smoking programmes aimed at inpatients with support for at least one month after discharge are effective, regardless of admitting diagnosis (Rigotti et al, 2008).  BTS national audit 2022 report highlights only 1/3 of patients with tobacco dependency were prescribed NRT < <https://www.brit-thoracic.org.uk/document-library/quality-improvement/audit-reports/smoking-cessation-audit-report-2019/> > |
| 20 | British Thoracic Society | **Access to stop-smoking support:** Patients who have tobacco dependency should be offered referral to an NHS Funded Stop Smoking Service | All patients accessing secondary care, whether inpatient or outpatient, should be able to access a specialist stop smoking service offering both behaviour support and pharmacotherapy as part of their quit journey. This should be regardless of postcode or NHS organisation they are being treated at. This quality improvement area covers two areas. The first relates to having robust referral systems in place to ensure smokers are identified and offered referral, as well as each and every patient having access to a dedicated and specialist stop smoking service. | BTS National Audit 2019 identified that only 1 in 8 smokers were referred to a stop smoking service as part of their care. The majority of patients are missing out. <https://www.brit-thoracic.org.uk/document-library/quality-improvement/audit-reports/smoking-cessation-audit-report-2019/> |
| 21 | Cochrane Tobacco Addiction Group, Nuffield Department of Primary Care Health Sciences, University of Oxford | **Access to stop-smoking support:** Providing support for temporary abstinence when people are in hospital, with ongoing support following discharge (as well as during their stay), regardless of diagnosis. | Services to help hospitalised patients to quit are not always available or provided <https://www.cambridge.org/core/journals/journal-of-smoking-cessation/article/systematic-review-of-clinicianreported-barriers-to-provision-of-smoking-cessation-interventions-in-hospital-inpatient-settings/55367AD65083623A01069377C25D4B24>)  and even if a person is provided with assistance to remain abstinence whilst in hospital discharged patients are not necessarily transferred to ongoing care. With cuts to the funding for stop smoking services within local authorities external stop smoking services may be difficult to locate and refer patients to. Therefore, having a clear route for ongoing support is important. | Please see below Cochrane Review which finds evidence that high intensity behavioural interventions that begin during a hospital stay and include at least one month of supportive contact after discharge promote smoking cessation among hospitalised patients: <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001837.pub3/full>  (Nancy Rigotti’s review; Ottawa model) |
| 22 | Kings College Hospital | **Access to stop-smoking support:**  Smoking Cessation in Paediatric Respiratory clinic by a Specialist nurse children nurse | The number of specialist smoking cessation clinics in community have decreased in London alone. Second hand smoke exposure is detrimental to all but especially to children with chronic lung disease.  Providing a specialist smoking cessation in paediatric respiratory clinic offering advice via motivational interview and Carbon Monoxide measurement along with a respiratory review is beneficial to reduce second hand smoke exposure and providing a support in a ‘teachable moment’ when a smoker parent is in a clinic with a chronic lung disease.  Support in tertiary hospitals with training a paediatric specialist nurse in smoking cessation for parents/ smokers or adolescent smokers and including this service as an integral part of the service. | This service has been established by Paediatric Respiratory service in Kings College Hospital for outpatient and referrals to parents/smokers for children that are admitted to wards since 2016.   * ‘Admission to hospital provides an opportunity to help stop smoking as people should be more open to help at the time of perceived vulnerability i.e ‘Seize the moment’ where motivation is translated into immediate action.’ BTS Recommendations for Hospital Smoking Cessation Services for Commissioners and Health Care Professionals December 2012 * ‘Meta-analysis of 20 RCTs involving over 30,000 patients attending hospital suggests nursing-delivered interventions of smoking cessation significantly increase the odds of quitting’ , ‘Benefit of Stop Smoking Champion that receives high level training in smoking cessation that can provide this service’. BTS Recommendations for Hospital Smoking Cessation Services for Commissioners and Health Care Professionals December 2012 * ‘A mandatory training programme for all frontline healthcare staff to use Very Brief Smoking Advice and where possible, train in Motivational Interviewing in order to Make Every Contact Count (mecc.nhs.net). BTS The Case for Change Why dedicated, comprehensive and sustainable stop smoking services are necessary for hospitals, June 2013 * Our Paediatric Respiratory service published a paper in The Lancet Respiratory Medicine: Lancet Respir Med. 2021 Jul;9(7):693-694. doi: 10.1016/S2213-2600(21)00231-9. Epub 2021 May 21. |
| 23 | SCM3 | **Access to stop-smoking support:** Offer NRT to all patients that smoke and are admitted to an acute, maternity and mental health setting. | NRT should be accessible to adults that smoke to help manage withdrawal symptoms and support a quit attempt. Products should be issued immediately after being accepted by the patient. The BTS audit (2019) found that 1 in 3 patients were offered licensed Nicotine Replacement Therapy (NRT). All patients that smoke should be offered NRT to temporarily abstain or make a quit attempt during their admission. Provision of NRT is variable. The time elapsed from the offer of NRT to it being issued is not always measured. | Please see BTS audit 2019. |
| 24 | SCM3 | **Access to stop-smoking support:** Give people information about stopping smoking for those using acute, maternity and mental health services | There are significant benefits to be gained from stopping smoking before a planned admission, e.g. prior to surgery. Advance knowledge of smokefree policies and available support can help promote temporary abstinence during the patient’s admission/ visit and help support smokefree NHS grounds.  Smokefree NHS grounds supports smokers trying to quit and protects the health of patients and staff. Where possible primary care providers can discuss and provide stop smoking support prior to admission. Smoking cessation should be incorporated as a systematic and opt out component of all NHS Services as cited in the RCP report (2018). | Royal College of Physicians (2018) Hiding in plain sight: treating tobacco dependency in the NHS. |
| 25 | SCM3 | **Access to stop-smoking support:** A range of interventions is available to help people stop smoking | Service models have changed during the covid pandemic. Whilst providing flexibility, remote support is being offered on permanent basis post pandemic instead of face to face contact. A range of interventions should be available.  An emphasis on remote support instead of face to face negatively affects the provision of face to face support and the use of CO monitoring as a motivational tool and means of verifying abstinence. The CRUK ASH report documents the changes to service provision. | CRUK ASH report -Tobacco control and stop smoking services in local authorities in England 2021. |
| 26 | SCM2 | **Access to stop-smoking support:** Increased focus on communities that have higher smoking prevalence | Evidence shows that Smoking Prevalence is reducing nationally, however the decline has reduced and is unlikely to reach the government ambition of 5% by 2030.  What we are finding in more affluent, less deprived population groups, smoking is becoming a behaviour of the past. However, in the more income poor and deprived groups smoking behaviours remain entrenched and rates remain high.  These are also the population groups with more health inequalities and care needs. This often leads to large differences in health outcomes even within local boroughs.  Such groups include: people living in social housing; long-term sick and unemployed, smokers from minority ethnic groups.  Stop Smoking Service, in partnership with local governments and local NHS service need to jointly focus on targeting smoking cessation activity on these population groups at local level to ensure that there is effective support available for these communities.  These smokers will often have more complex need and require more specialist smoking cessation treatment and may require the support of specialist support teams working locally rather than combined support from “lifestyle” programmes which offer more broad support. GP and Pharmacy services, while effective at supporting smokers within the community, they will often lack the time for longer support sessions.  Smoking is directly attributable to much of the ill health and poor income within these communities, further increasing the likelihood of admission to hospital, social care needs and cycle of deprivation within families.  Dedicated programmes of work need to be planned for these to target these communities to reduce the burden on both the NHS and Local Government, and to lift these smokers out of their cycle of addiction and increase their healthy, and disability free life expectancy | Office for National Statistics (2019) [Adult smoking habits in the UK](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2019)  Department of Health and Social Care (2018) [Tobacco control plan delivery plan 2017 to 2022](https://www.gov.uk/government/publications/tobacco-control-plan-delivery-plan-2017-to-2022)  Department of Health and Social Care (2017) [Towards a smoke-free generation: a tobacco control plan for England](https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england) |
| 27 | SCM4 | **Access to stop-smoking support**:  Remove quality statement 3 from Smoking: harm reduction | Whilst the health community recognises the medical model of addiction this is largely at odds with the general population’s perspective which is one of lifestyle choice.  The disconnect between medical and social perceptions of nicotine dependence is likely to create a barrier to behaviour change. Emphasis on the licensed medical products may be perceived as an imposition to the committed smoker: the doctor “elbowing in” on their lifestyle choice. Whereas recommending an alternative, readily available nicotine product can be empowering for the smoker and is certainly a more cost effective lifestyle choice.  Medicinal licensing is inherently expensive and bureaucratic for obvious reasons but inevitably stifles innovation. The developments in the e-cigarette market over the last decade have been substantial and enable an experience more akin to tobacco smoking. By prioritising non licensed products over licensed products we encourage innovation which will lead to more smokers choosing vaping of their own volition. |  |
| 28 | SCM5 | **Access to stop-smoking support:** Populationgroups with higher prevalence of smoking. Specifically, people with mental health conditions and people who are LGBT+. |  |  |
| 29 | Allen Carr’s Easyway | **Stop-smoking interventions**: Inclusion of a clinically proven non-pharmacological option for smokers with at least two RCTs. | Currently, stop smoking services are not required to offer a non-pharmacological option to stop smoking instead the offer RCT, Champix or e-cigarettes. However, many smokers need a non-pharmacological option such as pregnant women and all smokers would like such an option so it appears to be a large omission not to include this provided the solution has at least two successful independent RCTs. | Allen Carr’s Easyway is an example see RCTs below:  Published Trial paper: UK Study with Addiction: Frings et al., (2020).  The study comprised a randomised controlled trial (n = 620) which compared the efficacy of two psychological stop smoking interventions. Specifically, Allen Carr's Easyway smoking cessation programme comprising one 5/6 hour group session (plus one or two 3 hour booster sessions over the following 3 months for those who require them) and a 1-1 counselling service with funded pharmacotherapy available via the NHS (comprising one 30 minute session and four weekly follow ups of 10-15 minutes) were compared. Participants in the NHS arm were advised on e-cig use, but devices were not funded. The efficacy of both treatment arms were assessed at 4, 12 and 26 weeks after treatment. The evaluation was compliant with the Russell 6 Standard (which requires, amongst other things, a double blind, randomised design, chemical verification of quit outcomes, and the inclusion of all participants who received treatment in the final analysis). The study concluded that (i) with a well powered sample, no differences between ACE and a specialist stop smoking service with funded pharmacotherapy could be detected and (ii) both services performed at levels comparable to those observed elsewhere in the literature (i.e. in Cochrane reviews). The trial was pre-registered on the Open Science Framework (https://osf.io/9kj8d/). The osf site includes the trial registration, protocol, and data files (including syntax files registered before the data was unblinded) and related resources. Currently this is set to private but it will be made public upon the papers release. However, if there is a delay in publication beyond January 24th, the research team will open the site with the exception of the data and syntax files which will be made available on publication. The study protocol was also published in BMJOpen (Wood et al., 2017). The study concluded that Allen Carr’s Easyway method appears to have similar effectiveness to specialist 1-1 NHS smoking cessation support. |
| 30 | Cochrane Tobacco Addiction Group, Nuffield Department of Primary Care Health Sciences, University of Oxford | **Stop-smoking interventions:** The recommendation of e-cigarette use to aid a smoking quit attempt by any relevant clinician/service provider | Many clinicians feel uncertain about whether they should be recommending e-cigarettes for stopping smoking (<https://pubmed.ncbi.nlm.nih.gov/34859526/>);  however the evidence suggests that they have a positive effect on quit rates and that they are safer than continuing to smoke. | Please see Cochrane Review of ‘Electronic cigarettes for smoking cessation’ which finds moderate certainty evidence that e-cigarettes help more people to quit than nicotine replacement therapy.  <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010216.pub6/full> |
| 31 | Cochrane Tobacco Addiction Group, Nuffield Department of Primary Care Health Sciences, University of Oxford | **Stop-smoking interventions:** Providing people who want to quit with pharmacotherapy to aid their attempt regardless of whether they engage with prolonged behavioural support | Some local authorities, including Oxfordshire, are only advising the prescription of stop smoking pharmacotherapies if people trying to quit also commit to attending prolonged behavioural support. Not everyone may be willing or able to commit to such a programme and making it difficult for these people to access treatment will have an adverse effect on quit rates. | Please see the following review which found that nicotine replacement therapy was as effective for smoking cessation when provided alongside brief support vs. placebo or no pharmacotherapy, as when provided alongside more intensive support vs. placebo or no pharmacotherapy: <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000146.pub5/full?highlightAbstract=nicotine%7Cnicotin%7Ctherapi%7Ctherapy%7Creplacement%7Creplac> |
| 32 | Diabetes UK | **Stop-smoking interventions:** Prescriptions for nicotine replacement therapies and other alternatives must be accompanied by a stop smoking service that offers emotional and psychological support | Research on the effectiveness of medications, nicotine replacement therapies and e-cigarettes in helping people stop smoking shows that these methods have the best outcomes when combined with behavioural support.  NHS Stop Smoking service also advise that “using both treatment and specialist support is proven to give you the best chance of stopping smoking” and estimate that people are up to 4 times more likely to stop smoking for good if they use stop smoking treatments whilst also receiving support from an NHS Stop Smoking Service. | Study assessing the effectiveness of nicotine replacement therapies and e-cigarettes in making people stop smoking:  <https://www.nejm.org/doi/full/10.1056/NEJMoa1808779>  The NHS Stop Smoking service advice and evidence on quitting:  <https://www.nhs.uk/live-well/quit-smoking/nhs-stop-smoking-services-help-you-quit/> |
| 33 | PAGB, the consumer healthcare association | **Stop-smoking interventions:** People who seek support to stop smoking and who choose to take pharmacotherapy should be offered a full course. | PAGB notes that pharmacotherapy interventions, act as an aid to help people to stop smoking, and it is important that people who seek support to stop smoking receive the full course of their chosen pharmacotherapy to increase the chances of success.  This quality standard should be measured through the collection of local data to analyse evidence of local arrangements. Local data collection, Quality Outcomes Framework indicator SMOK004 and NHS Digital’s Statistics on NHS Stop Smoking Services England can be used to measure the proportion of people who seek support to stop smoking and who choose to take pharmacotherapy who receive a full a course. | This area of quality improvement is supported by NICE’s quality standard 43.  National Institute for Health and Care Excellence, Smoking: supporting people to stop [Quality Standard 43], 28 August 2013, p.13. Available at: <https://www.nice.org.uk/guidance/qs43/chapter/Quality-statement-4-Pharmacotherapy#rationale-3>  (Accessed 7 March 2022) |
| 34 | SCM3 | **Stop-smoking interventions:** Ensure nicotine containing e-cigarettes are available to adults that smoke alongside behavioural support and stop smoking pharmacotherapies. | Evidence supports the use of e-cigarettes as an aid to quitting smoking.  Use of nicotine containing e-cigarettes to support a quit attempt is less than licensed medication despite comparable quit rates, according to the NHS Digital report (2021). Availability of these products from local Stop Smoking Services is variable. | NHS Digital (2021) Statistics on NHS stop smoking services in England  Table 4.4: Persons setting a quit date and successful quitters, by type of pharmacotherapy received. |
| 35 | SCM1 | **Stop-smoking interventions:** Allen Carr Easyway method for smoking reduction | A way for some smokers to stop, particularly given the idiosyncratic nature of human beings and perhaps smokers/ addicts all the more so. |  |
| 36 | SCM2 | **Stop-smoking interventions:**  Provision of Smoking Cessation Services | Getting support to quit through stop smoking services is proven to be 3 times more effective than when quitting alone.  When it comes to using stop smoking medications, their efficacy is significantly improved when combined with behavioural support programmes.  Following the move of Public Health to Local Authority, the provision of stop smoking services was not mandated as other Public Health services have been. This has resulted in Stop Smoking Services across the country being significantly reduced or even decommissioned by Local Authorities trying to reduce spending following reductions in the Public Health budget.  Due to this, some areas have no provision of specialist behavioural support, or are forced to provide very limited or reduced services. In areas where programmes exist there is still a large amount of variation in the types of services provided in terms of programme duration and medication off provided or the patient groups eligible for the service.  Ensuring that services are available in all communities give all smokers access to behavioural support that will best improve their chances to succeed and help to offer timely support should patients relapse. It will also ensure that Acute Tobacco Dependency Treatment programmes as part of the NHS Long Term Plan, will help to have strong and effective services for referral or transfer of care post discharge. | See ASH and CRUK joint annual report “Reaching Out: Tobacco control and stop smoking services in local authorities in England, 2021”  See recommendations 3 and 4 on access for all smokers to behavioural support alongside a full course of NRT, and for provision of a dedicated specialist service.  <https://ash.org.uk/information-and-resources/reports-submissions/reports/reaching-out/> |
| 37 | SCM2 | **Stop-smoking interventions**: Health Care Professional knowledge and understanding of risk of E-Cigarettes | Public Health England (now OHID), NCSCT, and NICE all recognise that Electronic Cigarette (vapes) pose a significant benefit when it comes to treating smokers to quit and recent NICE guidance (ng209) recommends they should be offered as an equal first line option.  There is strong evidence e-cigarettes are at least 95% safer than smoking, and while not entirely risk free, they are significantly safer than smoking.  Most Stop Smoking Practitioners are well aware of the evidence, and benefits that e-cigarettes can provide and will this will often form part of the discussion, even in services that do not have this as part of their offer. However, they often have to combat conflicting messaging from experienced Health Care professionals in both primary and secondary care, advising their patients to avoid using them. This can impact on the smokers quit attempt, potentially stopping them using an effective treatment option for that person, or in some case triggering a relapse after a period of abstinence. | See ASH report: Use of e-cigarettes among adults in Great Britain, 2021  See sections highlighting Smokers perception of harm from e-cigarettes. <https://ash.org.uk/information-and-resources/fact-sheets/statistical/use-of-e-cigarettes-among-adults-in-great-britain-2021/>  See BMJ Open “Electronic cigarettes as a smoking cessation aid for patients with cancer: beliefs and behaviours of clinicians in the UK” which concludes that: ‘many clinicians providing cancer care to patients who smoke do not recommend e-cigarettes as a smoking cessation aid and were unaware of national guidance supporting recommendation of e-cigarettes as a smoking cessation aid.’  [e037637.full.pdf (bmj.com)](https://bmjopen.bmj.com/content/bmjopen/10/11/e037637.full.pdf) |
| 38 | SCM4 | **Stop-smoking interventions:** Promote switching instead of quitting | Smokers who are not ready or do not wish to quit can be offered an alternative to quitting akin to a “brand switch.” By encouraging equivalent nicotine replacement in the form of e-cigarettes, the barrier associated with quitting can be bypassed. This incorporates the goals of quality statements 1 and 2 of Smoking: harm reduction. There is a growing misperception amongst young smokers that the harm associated with vaping is equivalent to smoking. This needs to be actively challenged and can be achieved by HCPs encouraging switching from tobacco to other nicotine containing products. | Vaping in England: 2021 evidence update summary |
| 39 | SCM5 | **Stop-smoking interventions:** Vaping | Ad hoc uptake by tobacco control and stop-smoking services. Need a universal approach. |  |
| 40 | The British Thoracic Oncology Group/RCP/ NHS E&I (NSA) | **Harm-reduction approach**: Full adoption of harm reduction approaches as specified in QS92. | Full adoption of harm reduction approaches as specified in QS92. |  |
| 41 | Cochrane Tobacco Addiction Group, Nuffield Department of Primary Care Health Sciences, University of Oxford | **Harm-reduction approach**: Providing people who are not ready to quit entirely with the option to reduce their smoking behaviour either through dual use of NRT or varenicline, or complete substitution with e-cigarettes. | Most people want to quit smoking but some may not feel confident in their ability to quit straight away. The traditional approach to stop smoking services has been to advise abrupt quitting; however around half of smokers would like to try reducing their smoking first. If abrupt quitting is the only approach offered then then these people who smoke may feel like stop smoking services are not for them and lose touch with them (see the Background of the following review: <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013183.pub2/full#CD013183-sec-0044>) | Offering support to people who are not ready or willing to quit tobacco or nicotine use completely will keep them engaged with services and increase their chances of quitting altogether in the long-term. Please see the following papers:   * <https://pubmed.ncbi.nlm.nih.gov/17132521/> (shows that people who reduce their smoking are more likely to quit long-term) * <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD005231.pub3/full> (this Cochrane Review of interventions to reduce harm from continued tobacco use found evidence that people who do not wish to quit can be helped to cut down the number of cigarettes they smoke and to quit smoking in the long term, using NRT, despite original intentions not to do so) * <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013183.pub2/full#CD013183-sec-0044> (people who want to quit are as likely to quit if they reduce first as if they quit abruptly)   <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010216.pub6/full> (18 of the 61 studies included in the Cochrane e-cigarettes review were carried out in people unmotivated to quit; findings were consistent in showing that e-cigarettes helped those people to quit) |
| 42 | Diabetes UK | **Harm-reduction approach:** E-cigarettes should not be seen as harmless, non-addictive alternatives to cigarettes when used to promote harm reduction and stopping smoking, particularly for young people | The Royal College of Physicians’ report ‘Nicotine without smoke: Tobacco harm reduction’ shows the benefits of using e-cigarettes as an alternative to smoking that can prevent most of the harm from smoking. The relative harm reduction from e-cigarettes comes when a person who smokes tobacco, completely switches to e-cigarettes.  The report found that long-term use of e-cigarettes is unlikely to exceed 5% of the harms from smoking tobacco and highlights the public health benefits of promoting them as an alternative.  However, although evidence in the report shows e-cigarettes are being used almost exclusively as safer alternatives to smoked tobacco by people who are already smokers and are trying to reduce their intake or quit completely, there are still valid concerns that they could be incorrectly perceived as harmless and non-addictive.  Information regarding the safety of long term e-cigarette use is not yet available, so further research is needed on this - as well as how best to use e-cigarettes and how they compare to other methods of quitting. It is vital that high quality research continues to be conducted into the health impacts of e-cigarettes and that emerging evidence helps to shape future advice on regulation of these products.  This is of particularly concern for young people who may be encouraged to use e-cigarettes due their increased accessibility, wide varied range of flavoured liquids and pen types, and their relative harm reduction compared to smoking tobacco.  Current marketing does not clearly portray e-cigarettes as a harm reduction aid for some people and it is important that marketing should not encourage uptake in never smokers. | ‘Nicotine without smoke: Tobacco harm reduction’:  <https://www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction>  Data from England suggest that e-cigarettes may support between 50,000 and 70,000 successful quit attempts per year:  <https://pubmed.ncbi.nlm.nih.gov/31621131/>  Public Health England’s 2018 evidence review of e-cigarettes and heated tobacco products: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684963/Evidence_review_of_e-cigarettes_and_heated_tobacco_products_2018.pdf>  This paper highlights why the impacts of e-cigarettes on children and young people should continue to be closely monitored and the potential harms clearly communicated – especially since those from less affluent backgrounds have more exposure to them and there is substantially more experimentation with e-cigarettes than with smoking:  <https://pubmed.ncbi.nlm.nih.gov/31973060/> |
| 43 | PAGB, the consumer healthcare association | **Harm-reduction approach:** People who do not want, or are not ready, to stop smoking should be advised about and supported to obtain medicinally licensed nicotine-containing products. | PAGB understands that it is important to explain to people the potential benefits of using medicinally licensed nicotine-containing products, and also to ensure that medicinally licensed nicotine-containing products are readily available for people who want to use them to reduce harm from smoking. However, if transitioning to a harm reduction product such as an e-cigarette people should be advised that the long-term safety is unknown and those who wish to quit nicotine as well as tobacco should be appropriately supported to do so.  This quality standard should be measured through the collection of local data to analyse evidence of local arrangements and the proportion of people identified as not wanting, or not ready, to stop smoking who are supported to obtain medicinally licensed nicotine-containing products. | This area of quality improvement is supported by NICE’s quality standard 92 and section 1.12.14 of the guideline on ‘Tobacco: preventing uptake, promoting quitting and treating dependence’.  National Institute for Health and Care Excellence, Tobacco: preventing uptake, promoting quitting and treating dependence [NICE Guideline 209], 30 November 2021, p.100. Available at: <https://www.nice.org.uk/guidance/ng209/resources/tobacco-preventing-uptake-promoting-quitting-and-treating-dependence-pdf-66143723132869>  (Accessed: 7 March 2022) |
| 44 | SCM4 | **Harm-reduction approach:** Shift emphasis from stopping to harm reduction for those not ready to quit. | Section 1.8 of promoting quitting should be targeted solely at those wanting to quit.  After establishing smoking behaviour, the follow up should be a question about willingness to discuss smoking as is the case for obesity management and from there leaving the door open for further discussion and consider a mention of switching. |  |
| 45 | Bedfont Scientific Ltd | **Support to stop smoking in pregnancy**: 1.19.4 Address any factors that prevent pregnant women from using stop-smoking support. This could include:  a lack of confidence in their ability to quit,  lack of knowledge about the services on offer, Difficulty accessing them | During COVID-19, face to face stop smoking services were suspended for a prolonged period of time. As a result, the smoking cessation leadership Center in the US reported a significant decline in smokers proactively seeking engagement with stop smoking services and a decades-long decline in cigarette sales stopped.  <https://smokingcessationleadership.ucsf.edu/news/report-impact-covid-19-pandemic-smoking-cessation>  During COVID-19, a greater emphasis on stop smoking was pushed due to a significantly reduced risk of being hospitalised if you were to catch COVID-19 in non-smokers. Because the pandemic reduced face to face services, a greater need for remote stop smoking support was needed.  There appears to be sporadic integration of remote support which seems to be continuing after COVID, however these remote services are very reliant of self-report quit rates rather than CO verified quit rates. Biochemical (CO) verification is still considered important to validate smoking status and as a marker of quality service provision <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/647069/models_of_delivery_for_stop_smoking_services.pdf> , therefore the ability to validate quit rates using remote CO monitoring could help evaluate effectiveness of remote stop smoking services and increase access to stop smoking services via offer of remote CO monitoring from home. | Access could be improved via remote stop smoking services (combined pharmacological, behavioural support and CO validation with home use CO monitor). This could address issues with having to attend clinics in person if patient is located in a remote rural area, or issues with attending in person clinics due to child care issues, work commitments etc. CO remote testing can support a remote quit smoking programme from the comfort of their own homes, potentially more frequently than clinic support.  The following paper used the iCOquit to show success rates of remote support with biochemical validation using iCOquit remote CO monitor: <https://www.sciencedirect.com/science/article/pii/S1551714422000271> |
| 46 | Bedfont Scientific Ltd | **Support to stop smoking in pregnancy:**  1.19.4 Address any factors that prevent pregnant women from using stop-smoking support. This could include:  - lack of suitable childcare | During COVID-19, face to face stop smoking services were suspended for a prolonged period of time. As a result, the smoking cessation leadership Center in the US reported a significant decline in smokers proactively seeking engagement with stop smoking services and a decades-long decline in cigarette sales stopped. <https://smokingcessationleadership.ucsf.edu/news/report-impact-covid-19-pandemic-smoking-cessation>  During COVID-19, a greater emphasis on stop smoking was pushed due to a significantly reduced risk of being hospitalised if you were to catch COVID-19 in non-smokers. Because the pandemic reduced face to face services, a greater need for remote stop smoking support was needed.  There appears to be sporadic integration of remote support which seems to be continuing after COVID, however these remote services are very reliant of self-report quit rates rather than CO verified quit rates. Biochemical (CO) verification is still considered important to validate smoking status and as a marker of quality service provision <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/647069/models_of_delivery_for_stop_smoking_services.pdf> , therefore the ability to validate quit rates using remote CO monitoring could help evaluate effectiveness of remote stop smoking services and increase access to stop smoking services via offer of remote CO monitoring from home. | Addresses issues with having to attend clinics in person. CO remote testing , combined with pharmacological and behavioural support can support a remote quit smoking programme from the comfort of their own homes. |
| 47 | Bedfont Scientific Ltd | **Support to stop smoking in pregnancy:** fear of failure and concerns about being stigmatised. | During COVID-19, face to face stop smoking services were suspended for a prolonged period of time. As a result, the smoking cessation leadership Center in the US reported a significant decline in smokers proactively seeking engagement with stop smoking services and a decades-long decline in cigarette sales stopped. <https://smokingcessationleadership.ucsf.edu/news/report-impact-covid-19-pandemic-smoking-cessation>  During COVID-19, a greater emphasis on stop smoking was pushed due to a significantly reduced risk of being hospitalised if you were to catch COVID-19 in non-smokers. Because the pandemic reduced face to face services, a greater need for remote stop smoking support was needed.  There appears to be sporadic integration of remote support which seems to be continuing after COVID, however these remote services are very reliant of self-report quit rates rather than CO verified quit rates. Biochemical (CO) verification is still considered important to validate smoking status and as a marker of quality service provision <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/647069/models_of_delivery_for_stop_smoking_services.pdf> , therefore the ability to validate quit rates using remote CO monitoring could help evaluate effectiveness of remote stop smoking services and increase access to stop smoking services via offer of remote CO monitoring from home. | Address issues for women reluctant to attend stop-smoking services as remote service including behavioural, pharmacological and CO testing can be done from home, less likely to deal with stigmatisation attending stop smoking clinics/ apps. |
| 48 | Bedfont Scientific Ltd | **Support to stop smoking in pregnancy**: 19.5 If pregnant women are reluctant to attend the stop-smoking service, think about providing structured self-help materials or giving details of telephone quit-lines or NHS online stop-smoking support. Also think about offering to visit them at home, or at another venue, if it is difficult for them to attend specialist services. [2010]- | During COVID-19, face to face stop smoking services were suspended for a prolonged period of time. As a result, the smoking cessation leadership Center in the US reported a significant decline in smokers proactively seeking engagement with stop smoking services and a decades-long decline in cigarette sales stopped. <https://smokingcessationleadership.ucsf.edu/news/report-impact-covid-19-pandemic-smoking-cessation>  During COVID-19, a greater emphasis on stop smoking was pushed due to a significantly reduced risk of being hospitalised if you were to catch COVID-19 in non-smokers. Because the pandemic reduced face to face services, a greater need for remote stop smoking support was needed.  There appears to be sporadic integration of remote support which seems to be continuing after COVID, however these remote services are very reliant of self-report quit rates rather than CO verified quit rates. Biochemical (CO) verification is still considered important to validate smoking status and as a marker of quality service provision  <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/647069/models_of_delivery_for_stop_smoking_services.pdf> , therefore the ability to validate quit rates using remote CO monitoring could help evaluate effectiveness of remote stop smoking services and increase access to stop smoking services via offer of remote CO monitoring from home. | Address issues for women reluctant to attend stop-smoking services as pharmacological and behavioural support can be provided via structured remote stop smoking support with person CO monitor for stop smoking services. |
| 49 | Bedfont Scientific Ltd | **Support to stop smoking in pregnancy:**  1.20.1 Provide the pregnant woman with intensive and ongoing support (brief interventions alone are unlikely to be sufficient) throughout pregnancy and beyond. This includes regularly monitoring her smoking status using carbon monoxide tests. Use carbon monoxide measurements to encourage her to quit and as a way to provide positive feedback once a quit attempt has been made. [2010] | During COVID-19, face to face stop smoking services were suspended for a prolonged period of time. As a result, the smoking cessation leadership Center in the US reported a significant decline in smokers proactively seeking engagement with stop smoking services and a decades-long decline in cigarette sales stopped. <https://smokingcessationleadership.ucsf.edu/news/report-impact-covid-19-pandemic-smoking-cessation>  During COVID-19, a greater emphasis on stop smoking was pushed due to a significantly reduced risk of being hospitalised if you were to catch COVID-19 in non-smokers. Because the pandemic reduced face to face services, a greater need for remote stop smoking support was needed.  There appears to be sporadic integration of remote support which seems to be continuing after COVID, however these remote services are very reliant of self-report quit rates rather than CO verified quit rates. Biochemical (CO) verification is still considered important to validate smoking status and as a marker of quality service provision <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/647069/models_of_delivery_for_stop_smoking_services.pdf> , therefore the ability to validate quit rates using remote CO monitoring could help evaluate effectiveness of remote stop smoking services and increase access to stop smoking services via offer of remote CO monitoring from home. | Motivation and support, more access to regular CO testing with personal CO monitors.  provide vouchers only for abstinence validated using a biochemical method, such as a carbon monoxide test with a reading of less than 4 ppm- more regular CO validation for quit attempts with personal CO monitors you can use from home. Better  Personal use home CO monitor: https://www.icoquit.com/  Testimonials and examples of remote support and integration home CO monitors:  <https://somersetnewsroom.com/2022/03/01/get-the-right-tools-to-quit-this-no-smoking-day/>  <https://somersetnewsroom.com/2022/03/03/quitting-smoking-helps-to-create-a-low-risk-pregnancy/>  <https://www.linkedin.com/posts/tracey-hellyar-206195101_no-smoking-day-support-makes-all-the-difference-activity-6905244474788716544-_dLb> |
| 50 | PAGB, the consumer healthcare association | **Support to stop smoking in pregnancy**: NRT should be considered at the earliest opportunity, alongside behavioural support, to help women stop smoking in pregnancy and prevent relapse after pregnancy. | PABG supports the view that people who smoke should have access to appropriate advice and interventions to help them to stop smoking if they are pregnant. They should be advised that NRT should be considered alongside behavioural support. This quality standard should be measured through the collection of local data to analyse evidence of local arrangements. Local data collection, and NHS Digital’s Local Tobacco Profile indicator 93579 can be used to measure the proportion of people who seek support to stop smoking and who choose to take pharmacotherapy who receive a full a course. | This area of quality improvement is supported by NICE’s quality standard 43 and sections 1.20.6 – 1.20.10 of the guideline on ‘Tobacco: preventing uptake, promoting quitting and treating dependence’.  National Institute for Health and Care Excellence, Tobacco: preventing uptake, promoting quitting and treating dependence [NICE Guideline 209], 30 November 2021, p.100. Available at: <https://www.nice.org.uk/guidance/ng209/resources/tobacco-preventing-uptake-promoting-quitting-and-treating-dependence-pdf-66143723132869>  (Accessed: 7 March 2022) |
| 51 | SCM1 | **Support to stop smoking in pregnancy**: Identifying pregnant women who smoke and referring them to stop-smoking support, |  |  |
| 52 | SCM2 | **Support to stop smoking in pregnancy:**  Carbon Monoxide (CO) measurement for all Pregnant Smokers or those with a recent smoking history | Smoking in Pregnancy is one of the still the biggest modifiable risk factor in poor pregnancy outcomes, leading in increased risk of stillbirth, miscarriage and pre-term, low birthweight, and other complications in pregnancy and into early life. Identifying pregnant smokers and offering them support to quit has long been recognised as effective ways to improves poor outcomes in Pregnancy and early life.  The Saving Babies Lives Care Bundle states that CO measurement should be carried out as appropriate throughout pregnancy and NICE NG206 Guidance (1.18.1) clearly states that CO testing should take place at all antenatal appointments.  Although guidance has been in place through the Saving Babies lives care bundle recommending CO measurements as appropriate at all antenatal appointments, we know through experience that this is not happening in practice. Many Community Midwifery services struggle to ensure that CO measurements are done at data collection points at Booking and at 36 weeks (which is not currently mandated), and present resistance at introducing for all antenatal contacts.  The NHS Long Term Plan has new in-house Tobacco Dependency Treatment pathways and models to provide support to pregnancy smokers, partners and/or household members throughout pregnancy. However these plans will not achieve the impact needed if smokers are not identified correctly and referred to the treatment pathway and it will take a few years before the LTP pathway is fully implemented and running effectively for all pregnant smokers, therefore community support services will remain key to support this group for a few more years.  Many recent quitters do not declare if they have relapsed into smoking and this can be picked up at any antenatal contact if CO measurement occurs and the woman referred to stop smoking support. It also offers multiple opportunities to re-engage women that have opted out of support and will help to identify household smoking which might not have been flagged if the booking CO was low.  Unless KPI’s are put into place to ensure CO measurement occurs at every contact, it is likely that it will only occur at the data collection point visits (booking and 36 weeks). |  |
| 53 | SCM1 | **Awareness in the population:** | Ideally I'd like cigarette packets to come not with warnings but with advice and myth-busting information. You know the sort of thing - the idea that light smoking is okay, or that rolling tobacco is better for you, etc. ~~I~~ don't think we should generalise or normalise notions like associating weight gain with cessation. Smoking cessation leads to better choices generally. Again, some of this is probably beyond our remit but nonetheless at least I think within the health care system these things should be clearer and headlined as part of what we do. These are ways to empower addicts to make informed choices, moving the emphasis away from medicalisation and appreciating how entangled and misunderstood smoking remains within our culture |  |
| 54 | SCM4 | **Awareness in the population:** Explicitly challenge health myths around nicotine vs tobacco use (whether smoked, heated, chewed, shisha etc) | Local surveys have shown there is a misperception that smoking tobacco through water in the form of shisha is safer than smoking cigarettes. As stated above, there is a misperception amongst the next generation of potential smokers that vaping and tobacco use are equally harmful.  This is an extension of quality statement 2.  Also remove “smoke” from QS2 as tobacco in all forms is harmful.  Similarly, remove “smoke” from rationale and change “medicinally licensed” to “non-tobacco” nicotine containing products.  Recently reported studies in Sierra Leone have shown that directly challenging health myths rather than simply presenting the facts is more effective in dispelling health myths. | As described in the BBC World service programme *People fixing the World:* “How to fight fake health news” 25/1/22  Vaping in England: 2021 evidence update summary. |
| 55 | BAME Health Collaborative | **School-based interventions:** Supporting people to stop  1.4 Coordinated approach to school-based  interventions | While the recommendations are primarily directed at schools, there should be a framework for addressing younger university students. Coordinated interventions at the university level are required. | Numerous studies have discovered that at least 40% of university students’ smoke. [Drug survey reveals 40% of students smoke cannabis - Big World Tale](https://bigworldtale.com/world-news/drug-survey-reveals-40-of-students-smoke-cannabis/#:~:text=More%20than%2040%20per%20cent%20of%20students%20at,admitting%20they%20had%20taken%20drugs%20out%20of%20boredom.). |
| 56 | PAGB, the consumer healthcare association | **School based interventions**: School children are informed about the health effects of tobacco and nicotine and those who do not smoke should be discouraged from using e-cigarettes to avoid inadvertently making them desirable. | PAGB believes that it is important to explain to school children that whilst harm reduction interventions are one method to help people who smoke to stop smoking, they are not the only method of cessation. Meanwhile, children, young people and young adults who do not smoke should be discouraged from experimenting with or regularly using e-cigarettes.  This quality standard should be measured through the collection of local data to analyse evidence of local arrangements. | This area of quality improvement is supported by section 1.6.4 of the NICE guideline on ‘Tobacco: preventing uptake, promoting quitting and treating dependence’.  National Institute for Health and Care Excellence, Tobacco: preventing uptake, promoting quitting and treating dependence [NICE Guideline 209], 30 November 2021, p.100. Available at: <https://www.nice.org.uk/guidance/ng209/resources/tobacco-preventing-uptake-promoting-quitting-and-treating-dependence-pdf-66143723132869>  (Accessed: 7 March 2022) |
| 57 | SCM1 | **School-based interventions:** More could be done on smoking in the UK educational system. | Medical schools seem to deal with the phenomenon in a rather cursory way and I think that primary and (especially) secondary schools could do more. This goes beyond just having anti-smoking stances and more towards integrating smoking into the curriculum across the board. I pushed for this in the committee meetings a year or two ago and we suggested in the guidance that schools could use smoking as part of subjects like Media Studies, Sociology and so on. I appreciate this gets into the political realm but the industry and history of smoking as part of empire, slavery, etc is an underlying issues that could be part of a cultural change towards denormalising addiction. I'd like to see these things worded more strongly and to give teachers explicit license to integrate such things into a much wider range of subjects at their discretion, including History, Politics, Film Studies, Business Studies, Psychology, Economics, etc. |  |
| 58 | SCM1 | **School-based interventions** | I think smoking and smoking cessation comes with a lot of myths and I think these can be usefully dispelled both in formal education and at primary care. |  |
| 59 | SCM5 | **Emerging from COVID-19** | People who smoke may not be more susceptible to COVID-19 when compared to the general population. |  |
| 60 | SCM2 | **Innovation in stop-smoking pharmacotherapy:** Additional developmental areas of emergent practice | Since June 2021, Varenicline (Champix) has been unavailable in the UK. This is currently one of the most effective medically licenced treatment options for smokers looking to quit. Many smokers have tried NRT and either were not successful using it or did not engage with it. Champix for many years presented a effective and well tolerated alternative to NRT. The addition of e-cigarettes was meant to further engage with smokers and generate further attempts to quit. Now that Champix is unavailable, the range of treatment options has reduced again. This has already impacted on some patients desire to engage with support as their preferred treatment option is no longer available. |  |
| 61 | Royal College of Nursing | **No comment:** We do not have any comments to add on this occasion. Thank you for the opportunity to contribute. |  |  |

# Appendix 2: Additional suggestions

These suggestions have not been summarised in the briefing paper but were shared with the Quality Standards Advisory Committee and discussed at the prioritisation meeting.

| ID | Stakeholder | Suggested key area for quality improvement | Why is this a key area for quality improvement? | Supporting information |
| --- | --- | --- | --- | --- |
| 1 | Tobacco Control Programme, DHSC | General: On the quality standard for treating tobacco dependence, a lot has changed since they were last published. |  |  |
| 2 | Tobacco Control Programme, DHSC | General: References to ‘stop smoking services’ appears outdated (they are no longer universally provided), instead ‘local stop smoking support’ includes older services model as well as other settings/providers of help for quitting. |  |  |
| 3 | SCM 6 | Stop-smoking advice: All health care practitioners should be able to offer very brief advice and able to refer appropriately, and all health care practitioners who are able to prescribe should be offering medical treatment for dependence. |  |  |
| 4 | SCM 6 | Access to stop-smoking support: People are asked if they smoke by their healthcare practitioner, and those who smoke are offered advice on how to stop and an offer of treatment is also made. |  |  |
| 5 | Tobacco Control Programme, DHSC | Access to stop-smoking support: There is a lot more variation in models of delivery along with disruption to pharmacotherapy options. We somehow need to reflect the changes without instigating a race to the bottom for quality, which will be a tricky task. |  |  |
| 6 | Tobacco Control Programme, DHSC | Access to stop-smoking support: On the quality standard for treating tobacco dependence, a lot has changed since they were last published. There is now more variation in the models of delivery for stop smoking support in local areas. The migration to telephone/video support and use of apps has increased (particularly during covid lockdowns). |  |  |
| 7 | SCM 6 | Stop-smoking interventions: There should be access to stop smoking support (virtual or f2f) which includes behavioural and pharmacological, but if a person doesn’t want behavioural support, this should not preclude pharmacotherapy. |  |  |
| 8 | SCM 6 | Stop-smoking interventions: Pharmacotherapy options should be given in full and people are encouraged and followed up to ensure completion. Treatment which are effective mostly in combination treatment (combination NRT, medications, e-cigarettes) should be advice. |  |  |
| 9 | Tobacco Control Programme, DHSC | Stop-smoking interventions: Varenicline is currently not available and we are hopeful that Cytisine will be available for use. |  |  |
| 10 | Tobacco Control Programme, DHSC | Stop-smoking interventions: Reassuring statements on e-cigarette use in supporting quitting and harm reduction would support local areas who remain uncertain. |  |  |
| 11 | SCM 6 | Harm-reduction approach: Harm reduction approach should be encouraged which could include cutting down on cigarettes or going on e-cigarettes for those who smoke, but emphasis should be on quitting those for good too. |  |  |
| 12 | SCM 6 | Use of smokeless tobacco |  |  |
| 13 | SCM 6 | Support to stop smoking in pregnancy |  |  |