NICE National Institute for Health and Care Excellence

NICE guideline

Tobacco: preventing uptake, promoting quitting and treating dependence

NICE guideline
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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline replaces PH5, PH14, PH23, PH26, PH39, PH45, PH48 and NG92.

This guideline is the basis of QS17, QS82, QS22, QS207 and QS209.

Overview

This guideline covers support to stop smoking for everyone aged 12 and over, and help to reduce people's harm from smoking if they are not ready to stop in one go. It also covers ways to prevent children, young people and young adults aged 24 and under from taking up smoking.

Who is it for?

- Commissioners and providers of stop-smoking interventions and support, including those in the voluntary and community sectors
- Commissioners and providers of interventions and support for preventing uptake of smoking
- Health and social care professionals, including clinical leads in secondary care services and managers of clinical services
- People working in local authorities, education and the wider public, private, voluntary and community sectors
- Those commissioning, planning and delivering mass-media campaigns
- People with a remit to improve the health and wellbeing of children and young people aged 24 and under; this includes those working in the NHS, local authorities and tobacco control alliances
- Retailers of tobacco products
- Employers, estate managers and other managers
- Employee and trade union representatives

It may also be relevant for:

- Researchers and policy makers
- Manufacturers and retailers of medicinally licensed nicotine-containing products and nicotine-containing e-cigarettes
- Members of the public, including:
  - children, young people, their parents and carers
  - people using health and social care services, and their families and carers
  - women, trans men and non-binary people who are pregnant or planning a pregnancy, or who have a child aged up to 12 months, and their families and carers
  - people over 16 who smoke and are in paid or voluntary employment

Preventing uptake

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

This guideline should be read alongside NICE's guidelines on patient experience in adult NHS services and babies, children and young people's experience of healthcare, which have guidance on giving information to people and discussing their views and preferences.

In this guideline, we use the following terms for age groups:

- children: aged 5 to 11
- young people: aged 12 to 17
- young adults: aged 18 to 24
- adults: aged 18 and over.

Unless otherwise stated, the recommendations on preventing uptake are for children and those aged 24 and under.

At the time of publication (February 2025), no nicotine-containing e-cigarettes were licensed as a medicine for stopping smoking by the Medicines and Healthcare products Regulatory Agency (MHRA) and commercially available in the UK market. All nicotine-containing e-cigarettes in the UK that are not licensed as a medicine by the MHRA are regulated by the Tobacco and Related Products Regulations (2016), and cannot be marketed by the manufacturer for use for stopping smoking.

These recommendations aim to prevent children, young people and young adults from

taking up smoking. They cover anti-smoking mass-media and digital campaigns, measures to prevent tobacco being sold to and bought for children and young people, and prevention interventions in educational settings.

1.1 Organising and planning national, regional or local mass-media campaigns

These recommendations are for commissioners and organisers of mass-media campaigns.

1.1.1 Develop national, regional or local mass-media campaigns to prevent the uptake of smoking among young people under 18. Work in partnership with: the NHS, national, regional and local government and non-governmental organisations, children and young people, media professionals, healthcare professionals, public relations agencies and local anti-tobacco activists. **[2008]**

1.1.2 Integrate regional and local campaigns to prevent smoking in children and young people with any national communications strategy to tackle tobacco use. **[2008]**

1.1.3 Think about targeting campaigns towards groups that epidemiological data identify as having higher than average or stagnant rates of smoking. Base the campaigns on research that identifies and helps to understand the target audiences. **[2008]**

1.1.4 Base campaign messages on strategic research and qualitative before-and-after testing with the target audiences. Repeat the messages in various ways and regularly update them to keep the audience's attention. **[2008, amended 2021]**

1.1.5 Use a range of media channels to get unpaid press coverage and generate as much publicity as possible. Reach specific audiences by using:

- regional and local channels
- the full range of media used by children and young people. **[2008, amended 2021]**

1.1.6 Share effective practice in campaigns to prevent smoking in children and young people, including effective local and regional media messages, locally, regionally

and nationally. **[2008]**

1.1.7 Run campaigns to prevent smoking in children and young people for 3 to 5 years. **[2008]**

1.1.8 Use process and outcome measures to ensure campaigns are being delivered correctly and effectively. For recommendations on the principles of evaluation, see NICE's guideline on behaviour change: general approaches. **[2008]**

1.2 Campaign strategies to prevent uptake and denormalise tobacco use

These recommendations are for local authorities, trading standards bodies, organisers and planners of national, regional and local mass-media campaigns, and commissioners and planners.

1.2.1 Assess whether an advocacy campaign is needed to support policy related to illegal tobacco sales. **[2008, amended 2021]**

1.2.2 If an advocacy campaign is needed, base it on good practice. Use a range of strategies to reduce the attractiveness of tobacco and contribute to changing society's attitude towards tobacco use, so that smoking is not considered the norm by any group. This could include:

- generating news by writing articles, commissioning newsworthy research and issuing press releases
- using posters, brochures and other materials
- using digital media. **[2008]**

1.2.3 As part of an advocacy campaign, provide a clear, published statement on how to deal with underage tobacco sales. **[2008]**

1.2.4 Do not develop or deliver mass-media or access-restriction campaigns in conjunction with (or supported by) tobacco organisations. Actively discourage

use of enforcement and related campaigns developed by tobacco organisations. **[2008]**

1.3 Helping retailers avoid illegal tobacco sales

These recommendations are for local authorities and trading standards bodies.

1.3.1 Provide retailers with training and guidance on how to avoid illegal sales. This includes encouraging them to:

- ask for proof of age from anyone who appears younger than 18 who attempts to buy cigarettes, and get it verified (examples of proof include a passport or driving licence, or cards bearing the nationally accredited 'PASS' hologram)
- inform Trading Standards of each tobacco sale refused on the grounds of age. **[2008]**

1.3.2 Make it as difficult as possible for young people under 18 to get cigarettes and other tobacco products. In particular, exercise a statutory duty under the Children and Young Persons (Protection from Tobacco) Act (1991) to prevent underage sales by:

- prosecuting retailers who persistently break the law
- making test purchases each year, using local data to detect breaches in the law and auditing the breaches regularly to ensure consistent good practice across all local authorities. **[2008]**

1.3.3 Work with other agencies to:

- identify areas where underage tobacco sales are a particular problem
- improve inspection and enforcement activities related to illegal tobacco sales. **[2008]**

1.3.4 Run campaigns for retailers to publicise legislation prohibiting underage tobacco sales. These could include:

- details of possible fines that retailers can face
- details of where tobacco is being sold illegally
- successful local prosecutions
- health information. **[2008]**

1.3.5 Ensure efforts to reduce illegal tobacco sales by retailers are sustained. **[2008]**

1.4 Coordinated approach to school-based interventions

This recommendation is for schools, commissioners, local authorities, careers services or integrated youth support services, and local tobacco control alliances.

1.4.1 Ensure smoking prevention interventions in schools and other educational establishments are:

- part of a local tobacco control strategy
- evidence-based
- linked to the school or educational establishment's smokefree policy
- consistent with regional and national tobacco control strategies
- integrated into the curriculum. **[2010]**

See also NICE's guideline on behaviour change: general approaches.

1.5 Whole-school or organisation-wide smokefree policies

These recommendations are for everyone working in and with primary and secondary schools and further education colleges.

1.5.1 Develop a whole-school or organisation-wide smokefree policy in consultation with young people and staff. The policy should:

- include smoking prevention activities (led by adults or young people)
- include staff training and development
- take account of children and young people's cultural, special educational or physical needs (for example, by providing material in alternative formats such as pictures, large print, Braille, audio and video). **[2010]**

1.5.2 Ensure the policy forms part of the wider strategy on wellbeing, relationships education, relationships and sex education (RSE), health education, drug education and behaviour. **[2010]**

1.5.3 Apply the policy to everyone using the premises (grounds as well as buildings), for any purpose, at any time. Do not allow any areas in the grounds to be designated for smoking (with the exception of caretakers' homes, as specified by law). **[2010]**

1.5.4 Widely publicise the policy and ensure it is easily accessible so that everyone using the premises is aware of its content. (This includes making a printed version available.) **[2010]**

See also NICE's guidelines on alcohol interventions in secondary and further education and social, emotional and mental wellbeing in primary and secondary education.

1.6 Adult-led interventions in schools

These recommendations are for everyone working in and with primary and secondary schools and further education colleges.

1.6.1 Integrate information about the health effects of tobacco use, as well as the legal, economic and social aspects of smoking, into the curriculum. For example, classroom discussions about tobacco could be relevant when teaching subjects such as biology, chemistry, citizenship, geography, mathematics and media studies. **[2010]**

1.6.2 Include accurate information about smoking in the curriculum, including its prevalence and its consequences. Tobacco use by adults and peers should be discussed and challenged. Aim to:

- develop decision-making skills through active learning techniques
- include strategies for enhancing self-esteem and resisting the pressure to smoke from the media, family members, peers and the tobacco industry. **[2010]**

1.6.3 As part of the curriculum on tobacco, alcohol and drug misuse, discourage children, young people and young adults who do not smoke from experimenting with or regularly using e-cigarettes. Talk about e-cigarettes separately from tobacco products. **[2021]**

1.6.4 When discussing e-cigarettes, make it clear why children, young people and young adults who do not smoke should avoid e-cigarettes to avoid inadvertently making them desirable. **[2021]**

1.6.5 Provide additional 'booster' activities to support classroom education on tobacco until school leaving age. Activities might include school health fairs and guest speakers. **[2010]**

1.6.6 Ensure smoking prevention interventions are delivered by teachers and higher-level teaching assistants who are both credible and competent in the subject, or by external experts. The latter should be trained to work with children and young people on tobacco issues. Interventions should be:

- entertaining, factual and interactive
- tailored to age and ability
- sensitive to family origin, culture and gender
- non-judgemental. **[2010]**

1.6.7 Involve children and young people in schools in the design of interventions to prevent the uptake of smoking. **[2010]**

1.6.8 Encourage parents and carers to become involved. For example, let them know about classwork or ask them to help with homework assignments. **[2010]**

For a short explanation of why the committee made the 2021 recommendations and how they might affect practice, see the rationale and impact section on adult-led interventions in schools.

Full details of the evidence and the committee's discussion are in evidence reviews F and G: e-cigarettes and young people.

1.7 Peer-led interventions in schools

This recommendation is for everyone working in and with secondary schools and further education colleges.

1.7.1 Consider evidence-based, peer-led interventions aimed at preventing the uptake of smoking. They should:

- link to relevant parts of the curriculum
- be delivered both in class and informally, outside the classroom
- be led by young people nominated by the students themselves (the peer leaders could be the same age or older)
- ensure peer leaders receive support from adults who have the appropriate expertise during the course of the programme
- ensure young people can consider and, if necessary, challenge peer and family norms on smoking, discuss the risks associated with it and the benefits of not smoking. **[2010, amended 2021]**

See also NICE's guideline on alcohol interventions in secondary and further education.

Promoting quitting

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This guideline should be read alongside NICE's guidelines on patient experience in adult NHS services and babies, children and young people's experience of healthcare, which have guidance on giving information to people and discussing their views and preferences.

In this guideline, we use the following terms for age groups:

- children: aged 5 to 11
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At the time of publication (February 2025), no nicotine-containing e-cigarettes were licensed as a medicine for stopping smoking by the Medicines and Healthcare products Regulatory Agency (MHRA) and commercially available in the UK market. All nicotine-containing e-cigarettes in the UK that are not licensed as a medicine by the MHRA are regulated by the Tobacco and Related Products Regulations (2016), and cannot be marketed by the manufacturer for use for stopping smoking.

These recommendations promote options to help people stop smoking or using smokeless tobacco or, if they do not want or are not ready to stop in one go, to reduce their harm.

1.8 Using medicinally licensed nicotine-containing products

Raising awareness

These recommendations are 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 that smoking causes a range of diseases and conditions including cancer, chronic obstructive pulmonary disease and cardiovascular disease. **[2013]**

1.8.2 Provide information on how people who smoke can reduce the risk of illness and death (to themselves and others) by using 1 or more medicinally licensed nicotine-containing products. Explain that they could be used as a partial or complete substitute for tobacco, either temporarily or in the long term. **[2013]**

1.8.3 Provide the following information about nicotine:

- smoking is highly addictive mainly because it delivers nicotine very quickly to the brain and this makes stopping smoking difficult
- most smoking-related health problems are caused by other components in tobacco smoke, not by the nicotine
- nicotine levels in medicinally licensed nicotine-containing products are much lower than in tobacco, and the way these products deliver nicotine makes them less addictive than smoking. **[2013, amended 2021]**

1.8.4 Provide the following information about the effectiveness and safety of medicinally licensed nicotine-containing products:

- any risks from using medicinally licensed nicotine-containing products are much lower than those of smoking; nicotine replacement therapy (NRT) products have been demonstrated in trials to be safe to use for at least 5 years

- lifetime use of medicinally licensed nicotine-containing products is likely to be considerably less harmful than smoking. **[2013]**

1.8.5 Provide information on using medicinally licensed nicotine-containing products, including:

- what forms they take
- how to use them effectively when trying to stop or cut down smoking
- long-term use to reduce the risk of relapsing
- where to get them
- the cost compared with smoking. **[2013]**

For recommendations on what information to provide about nicotine-containing e-cigarettes, see the section on advice on nicotine-containing e-cigarettes.

Point-of-sale promotion

These recommendations are for manufacturers and retailers of medicinally licensed nicotine-containing products, including tobacco retailers.

1.8.6 Encourage people who smoke to consider stopping or, if they do not want or are not ready to stop in one go, to consider the harm-reduction approaches outlined in box 1. **[2013]**

1.9 Promoting stop-smoking support

Developers of communications strategies

1.9.1 Coordinate communications strategies to support the delivery of stop-smoking support, telephone quitlines, school-based interventions, tobacco control policy changes and any other activities designed to help people to stop smoking. **[2018]**

1.9.2 Develop and deliver communications strategies about stopping smoking in partnership with the NHS, national, regional and local government and non-governmental organisations. The strategies should:

- Use the best available evidence of effectiveness, such as Cochrane reviews.
- Be developed and evaluated using audience research.
- Use 'why to' and 'how to' stop messages that are non-judgemental, empathetic and respectful. For example, use testimonials from people who smoke or used to smoke.
- Involve community pharmacies in local campaigns and maintain links with other professional groups such as dentists, fire services and voluntary groups.
- Ensure campaigns are sufficiently extensive and sustained to have a reasonable chance of success.
- Think about targeting and tailoring campaigns towards groups that epidemiological data identify as having higher than average or stagnant rates of smoking, to address inequalities. **[2018, amended 2021]**

Schools

1.9.3 Make information on local stop-smoking support easily available to staff and students. Include details on the type of help available and when, where and how to access the services. **[2010]**

Employers

1.9.4 Make information on local stop-smoking support easily available at work. Include details on the type of help available and when, where and how to access the services. Publicise these interventions. **[2007]**

1.9.5 Be responsive to individual needs and preferences of employees. If feasible, and if there is sufficient demand, provide on-site stop-smoking support. **[2007]**

1.9.6 Allow staff to attend stop-smoking support during working hours without loss of pay. **[2007]**

1.9.7 Negotiate a smokefree workplace policy with employees or their representatives. This should:

- State whether or not smoking breaks may be taken during working hours and, if so, where, how often and for how long.
- Include a stop-smoking policy developed in collaboration with staff and their representatives.
- Direct people who wish to stop smoking to local stop-smoking support. **[2018]**

Employees and their representatives

1.9.8 Encourage employers to provide advice, guidance and support to help employees who want to stop smoking. **[2007]**

1.10 Promoting support for people to stop using smokeless tobacco

These recommendations are for public sector, voluntary and community organisations, health and social care professionals and faith groups. They are particularly relevant to South Asian communities in areas of identified need.

1.10.1 Work in partnership with existing community initiatives to raise awareness of local smokeless tobacco cessation services and how to access them. Ensure any material used to raise awareness of the services:

- Uses the names that the smokeless tobacco products are known by locally, as well as the term 'smokeless tobacco'.
- Gives information about the health risks associated with smokeless tobacco and the availability of services to help people quit.

- Challenges the perceived benefits – and the relative priority that users may place on these benefits (compared with the health risks). For example, some people think smokeless tobacco is an appropriate way to ease indigestion or relieve dental pain, or help freshen the breath.
- Addresses the needs of people whose first language is not English (by providing translations).
- Addresses a range of communication needs by providing material in alternative formats, for example pictures, large print, Braille, audio and video.
- Includes information for specific South Asian subgroups (for example, older Bangladeshi women) who are known to have high rates of smokeless tobacco use.
- Discusses the concept of addiction in a way that is sensitive to culture and religion (for example, it may be better to refer to users as having developed a 'habit', rather than being 'addicted').
- Does not stigmatise users of smokeless tobacco products within their own community, or in the eyes of the general community. **[2012]**

1.10.2 Use existing local South Asian information networks (including culturally specific TV and radio channels), and traditional sources of health advice within South Asian communities to provide information on smokeless tobacco. **[2012]**

1.10.3 Use venues and events that members of local South Asian communities frequent to publicise, provide or consult on cessation services with them. (Examples include educational establishments and premises where prayer groups or cultural events are held.) **[2012]**

1.10.4 Raise awareness among those who work with children and young people about smokeless tobacco use. This includes:

- providing teachers with information on the harm that smokeless tobacco causes and that also challenges the perceived benefits – and the priority that users may place on these perceived benefits
- encouraging teachers to discuss with their students the reasons why people

use smokeless tobacco; this could take place as part of drug education, or within any other relevant part of the curriculum. **[2012]**

Treating tobacco dependence

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This guideline should be read alongside NICE's guidelines on patient experience in adult NHS services and babies, children and young people's experience of healthcare, which have guidance on giving information to people and discussing their views and preferences.

In this guideline, we use the following terms for age groups:

- children: aged 5 to 11
- young people: aged 12 to 17
- young adults: aged 18 to 24
- adults: aged 18 and over.

Unless otherwise stated, the recommendations on treating tobacco dependence are for people over the age of 12 who want to stop smoking or reduce harm from smoking.

At the time of publication (February 2025), no nicotine-containing e-cigarettes were licensed as a medicine for stopping smoking by the Medicines and Healthcare products Regulatory Agency (MHRA) and commercially available in the UK market. All nicotine-containing e-cigarettes in the UK that are not licensed as a medicine by the MHRA are regulated by the Tobacco and Related Products Regulations (2016), and cannot be marketed by the manufacturer for use for stopping smoking.

These recommendations aim to help people aged 12 or over (unless otherwise stated) to stop smoking or, if they do not want or are not ready to stop in one go, to reduce their harm from smoking. They cover interventions and services delivered in a range of settings, including NHS primary and secondary care, and emphasise the importance of targeting vulnerable groups who find giving up smoking hard or who smoke a lot. Pregnant women, and pregnant trans men and non-binary people, are mainly covered in the section on treating tobacco dependence during pregnancy and in the first year after childbirth.

1.11 Identifying and quantifying people's smoking

Identifying people who smoke

These recommendations are for health and social care professionals and those providing stop-smoking support or advice (for recommendations about pregnancy, see the section on stop-smoking support in pregnancy: identification and referral).

1.11.1 At every opportunity, ask people if they smoke or have recently stopped smoking. **[2018]**

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. **[2018]**

1.11.3 Discuss any stop-smoking aids the person has used before, including personally purchased nicotine-containing products. **[2018]**

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. **[2018]**

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. **[2013]**

1.11.6 Record smoking status and all actions, discussions and decisions related to advice, referrals or interventions about stopping smoking. **[2018]**

1.11.7 Ask about their smoking status at the next available opportunity. **[2013]**

Identifying smoking among carers, family and other household members

These recommendations are for anyone who is responsible for providing health and support services (including stop-smoking support) to people using acute, maternity or mental health services.

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

- partners of pregnant women, and partners of pregnant trans men or non-binary people
- parents or carers of people using acute or mental health services
- anyone else in the household. **[2013]**

1.11.9 If partners, parents, other household members and carers do not smoke, give them positive feedback if they are present. **[2013]**

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. **[2013]**

1.11.11 During contact with partners, parents, other household members and carers of people using acute, maternity and mental health services:

- provide clear advice about the danger of smoking and secondhand smoke, including to pregnant women, pregnant trans men and non-binary people, and babies – before and after birth
- recommend not smoking around the patient, anyone who is pregnant or has recently given birth, or baby (this includes not smoking in the house). **[2010]**

1.12 Stop-smoking interventions

These recommendations are for people providing stop-smoking support or advice. For training requirements, see the National Centre for Smoking Cessation and Training (NCSCT) standard for training in smoking cessation treatments.

For recommendations on digital and mobile health interventions for stopping smoking, see NICE's guideline on behaviour change: digital and mobile health interventions.

See recommendation 1.14.23 in the section on medicine dosages for people who have stopped smoking for advice on prescribed medicines that are affected by smoking (or stopping smoking).

Cytisinicline is sometimes referred to as cytisine. For clarity and consistency with the BNF and the medicine's marketing authorisation in the UK, we use the international non-proprietary name cytisinicline throughout this guideline.

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. **[2021]**

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:
  - cytisinicline **[2025]**
  - nicotine replacement therapy (NRT) – short and long acting
  - varenicline
  - bupropion
- nicotine-containing e-cigarettes
- Allen Carr's Easyway in-person group seminar.

  Varenicline is recommended as an option in NICE technology appraisal guidance for people who smoke who have expressed a desire to quit smoking as part of a programme of behavioural support. For full details, see the guidance on varenicline (TA123, 2007). **[2021, amended 2025]**

1.12.3 Consider NRT for young people aged 12 and over who are smoking and dependent on tobacco. If this is prescribed, offer it with behavioural support. **[2018]**

1.12.4 Do not offer cytisinicline, varenicline or bupropion to people under 18. **[2013, amended 2025]**

1.12.5 Do not offer cytisinicline to people aged 66 and over. **[2025]**

1.12.6 Offer behavioural support to people who smoke regardless of which option they choose to help them stop smoking, unless they have chosen the Allen Carr Easyway in-person group seminar. Explain how to access this support. **[2021,**

amended 2022]

1.12.7 Discuss with people which options to use to stop smoking, taking into account:

- their preferences, health and social circumstances
- any medicines they are taking
- any contraindications and the potential for adverse effects
- their previous experience of stop-smoking aids.

  Also see the advice in the recommendations on medicinally licensed products, and the recommendations on nicotine-containing e-cigarettes. **[2021]**

1.12.8 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:

- cytisinicline **[2025]**
- a combination of short-acting and long-acting NRT **[2021]**
- varenicline **[2021]**
- nicotine-containing e-cigarettes. **[2021]**

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

- bupropion
- short-acting NRT used without long-acting NRT
- long-acting NRT used without short-acting NRT. **[2021]**

1.12.10 For adults, prescribe or provide bupropion, cytisinicline, NRT or varenicline before they stop smoking, and for:

- bupropion, agree a quit date set within the first 2 weeks of treatment and reassess the person shortly before the prescription ends **[2018]**
- cytisinicline, agree a quit date set within the first 5 days of treatment and reassess the person shortly before the prescription ends **[2025]**
- NRT, agree a quit date and ensure the person has NRT ready to start the day before the quit date **[2018]**
- varenicline, agree a quit date and start the treatment 1 to 2 weeks before this date; reassess the person shortly before the prescription ends. **[2018]**

For a short explanation of why the committee made the 2021, 2022 and 2025 recommendations and how they might affect practice, see the rationale and impact section on stop-smoking interventions.

Full details of the evidence and the committee's discussion are in:

- evidence review L: barriers and facilitators to using e-cigarettes for cessation or harm reduction
- evidence review M: long-term health effects of e-cigarettes
- evidence review K: cessation and harm-reduction treatments
- evidence review P: effectiveness and cost effectiveness of Allen Carr's Easyway
- evidence review Q: cytisinicline for smoking cessation.

Advice on medicinally licensed products

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

1.12.11 Emphasise that:

- most smoking-related health problems are caused by other components in tobacco smoke, not by the nicotine

- any risks from using medicinally licensed nicotine-containing products or other stop-smoking pharmacotherapies are much lower than those of smoking. **[2013, amended 2021]**

1.12.12 Explain how to use medicinally licensed nicotine-containing products correctly. This includes ensuring people know how to achieve a high enough dose to:

- control cravings
- prevent compensatory smoking
- achieve their goals on stopping or reducing the amount they smoke. **[2013]**

1.12.13 Advise people using short-acting NRT to replace each cigarette with the product they are using, for example a lozenge or piece of gum. Ideally, they should use this before the usual time they would have had the cigarette, to allow for the slower nicotine release from these products. **[2013]**

Advice on nicotine-containing e-cigarettes

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

1.12.14 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 the Office for Health Improvement and Disparities' information on e-cigarettes and vaping). **[2021]**

1.12.15 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. **[2021]**

1.12.16 Discuss:

- how long the person intends to use nicotine-containing e-cigarettes for
- using them for long enough to prevent a return to smoking **and**
- how to stop using them when they are ready to do so. **[2021]**

1.12.17 Ask adults using nicotine-containing e-cigarettes about any side effects or safety concerns that they may experience. Report these to the MHRA Yellow Card scheme, and let people know they can report side effects directly. **[2021]**

1.12.18 Explain to adults who choose to use nicotine-containing e-cigarettes the importance of getting enough nicotine to overcome withdrawal symptoms, and explain how to get enough nicotine. **[2021]**

For a short explanation of why the committee made the 2021 recommendations and how they might affect practice, see the rationale and impact section on advice on nicotine-containing e-cigarettes.

Full details of the evidence and the committee's discussion are in:

- evidence review L: barriers and facilitators to using e-cigarettes for cessation or harm reduction
- evidence review M: long-term health effects of e-cigarettes
- evidence review K: cessation and harm-reduction treatments.

Telephone quitlines

1.12.19 Ensure publicly sponsored telephone stop-smoking quitlines offer a rapid, positive and authoritative response. If possible, give callers whose first language

is not English access to information and support in their chosen language. **[2018]**

1.12.20 Ensure all staff giving advice through stop-smoking quitlines receive stop-smoking training (at least in brief interventions to help people stop smoking). **[2018]**

1.12.21 Train staff who offer counselling through stop-smoking quitlines so that they meet the NCSCT Training Standard (individual behavioural counselling). Preferably, they should also have a relevant counselling qualification. Training should comply with the NCSCT Training Standard for training in smoking cessation treatments or its updates. **[2008, amended 2018]**

1.13 Support to stop smoking in primary care and community settings

This recommendation is for health and social care professionals in primary care and community settings. See recommendation 1.14.23 in the section on medicine dosages for people who have stopped smoking for advice on prescribed medicines that are affected by smoking (or stopping smoking).

See also the section on treating tobacco dependence during pregnancy and in the first year after childbirth.

1.13.1 For people who want to stop smoking:

- discuss with them how they can stop (NCSCT programmes explain how to do this)
- provide stop-smoking interventions and advice; see the section on stop-smoking interventions
- if you are unable to provide stop-smoking interventions, refer them to local stop-smoking support, if available
- if they opt out of a referral to stop-smoking support, refer them to a professional who can offer pharmacotherapy and very brief advice. **[2018, amended 2021]**

1.14 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). See also the section on treating tobacco dependence during pregnancy and in the first year after childbirth.

Information on stopping smoking for those using acute, maternity and mental health services

These recommendations are about information and support before any secondary care admission.

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. **[2013, amended 2021]**

1.14.2 Before a planned or likely admission to an inpatient setting, work with the person

to include how they will manage their smoking on admission or entry to the secondary care setting in their personal care plan. **[2013]**

1.14.3 Encourage people being referred for elective surgery to stop smoking before their surgery. Refer them to local stop-smoking support. **[2018]**

1.14.4 Provide information and take the opportunity to provide advice to visitors about the benefits of stopping smoking and how to contact local stop-smoking support. **[2013]**

Referring to behavioural support in acute, maternity and mental health services

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. **[2013]**

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. **[2013]**

Behavioural support in acute and mental health services

These recommendations are for healthcare professionals, stop-smoking advisers and others trained to provide behavioural support to stop smoking. For recommendations on pregnancy, see the section on providing support to stop smoking during pregnancy.

1.14.7 Discuss current and past smoking behaviour and develop a personal stop-smoking plan as part of a review of the person's health and wellbeing. **[2013]**

1.14.8 Provide information about the different types of stop-smoking options and how to use them. **[2013, amended 2021]**

1.14.9 Provide information about the types of behavioural support to stop smoking

available. **[2013]**

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). **[2013, amended 2021]**

1.14.11 Offer to measure people's exhaled carbon monoxide level during each contact and use these measurements to motivate them to stop smoking and provide feedback on their progress. **[2013]**

1.14.12 Alert the person's other healthcare providers and prescribers to changes in smoking behaviour because dosages of other medicines may need adjusting (see the section on drug dosages for people who have stopped smoking). **[2013]**

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. **[2013]**

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. **[2013]**

Stop-smoking pharmacotherapies in acute and mental health

services

For recommendations on pregnancy, see the recommendations on nicotine replacement therapy and other pharmacological support in pregnancy.

Also see the recommendations on smoking in the physical health section of NICE's guideline on psychosis and schizophrenia in adults.

1.14.15 If stop-smoking pharmacotherapy is accepted, make sure it is provided immediately. **[2013]**

1.14.16 Advise people to remove nicotine replacement therapy patches 24 hours before microvascular reconstructive surgery and surgery using vasopressin injections. **[2013]**

1.14.17 When people are discharged from hospital, ensure they have enough stop-smoking pharmacotherapy to last at least 1 week or until their next contact with stop-smoking support. **[2013]**

1.14.18 Tell them about local policies on indoor and outdoor use of nicotine-containing e-cigarettes. **[2013, amended 2021]**

See also the section on stop-smoking interventions.

Stop-smoking support in mental health services

1.14.19 For people with severe mental health conditions who may need additional support to stop smoking, offer:

- delivery by a specialist adviser with mental health expertise
- support that is tailored in duration and intensity to the person's needs. **[2021]**

See also the section on stop-smoking interventions.

For a short explanation of why the committee made the 2021 recommendation and how it might affect practice, see the rationale and impact section on stop-smoking support in mental health services.

Full details of the evidence and the committee's discussion are in evidence review O: tailored interventions for those with mental health conditions.

Supporting people who have to stop smoking temporarily

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

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. **[2013]**

1.14.21 Provide behavioural support alongside medicinally licensed nicotine-containing products to maintain abstinence from smoking while in secondary care. **[2013]**

1.14.22 Offer behavioural support to people who want or need to abstain from smoking temporarily in all settings, including closed institutions for example. Support could include:

- one-to-one or group sessions by specialist services
- discussing why it is important to reduce the harm caused by smoking (to others as well as themselves)
- encouraging people to consider other times or situations when they could stop. **[2013]**

Medicine dosages for people who have stopped smoking

These recommendations are for people who prescribe stop-smoking pharmacotherapies, and for pharmacists, and health and social care professionals in acute, maternity and mental health services (including both inpatient and community mental health services).

1.14.23 Monitor people's use of prescribed medicines that are affected by smoking (or stopping smoking) for efficacy and adverse effects. Adjust the dosage as appropriate. Medicines that are affected include: clozapine, olanzapine, theophylline and warfarin. Refer to specific information for individual medicines, such as in the BNF or summaries of product characteristics in the electronic medicines compendium. **[2013, amended 2021]**

1.14.24 Discuss with people who use secondary care and their carers that it might be possible to reduce the dose of some prescribed medicines when they stop smoking. Also advise them to seek medical advice if they notice any side effects from changing the amount they smoke. **[2013]**

Making stop-smoking options available in hospital

These recommendations are for hospital pharmacists and managers.

1.14.25 Ensure hospital pharmacies stock the medicinally licensed products recommended in the section on stop-smoking interventions for patients and staff. **[2013]**

1.14.26 Ensure people using secondary care have access to stop-smoking pharmacotherapies at all times. **[2013]**

See also recommendation 1.22.14 in the section on stop-smoking support in secondary care.

Supporting staff in secondary care and closed institutions to stop smoking

These recommendations are for providers of secondary care and stop-smoking support, and managers of closed institutions and other services where smoking is not permitted.

1.14.27 Advise all staff who smoke to stop. Ensure systems are in place for staff who smoke to receive advice and guidance on how to stop in one go. **[2013]**

1.14.28 Encourage staff to use stop-smoking support to stop or cut down the amount they smoke. Provide contact details for community support if preferred. **[2013]**

See also the section on stop-smoking interventions and the NCSCT's service and delivery guidance 2014.

Supporting staff in secondary care and closed institutions to reduce their harm from smoking and comply with smokefree policies

These recommendations are for providers of secondary care, and managers of closed institutions and other services where smoking is not permitted.

1.14.29 For staff in secondary care and closed institutions who do not want, or are not ready, to stop smoking in one go:

- Ask them if they would like to think about reducing the harm from smoking (see box 1).
- Advise them to use medicinally licensed nicotine-containing products to help them not to smoke immediately before and during working hours. Advise them where to get them. **[2013]**

1.14.30 Offer and provide behavioural support to help staff in secondary care and closed institutions not to smoke during working hours. **[2013]**

1.15 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.

Choosing a harm-reduction approach

1.15.1 Advise people that stopping smoking in one go is the best approach. **[2013]**

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. **[2013]**

1.15.3 Suggest which approaches to stopping smoking might be most suitable, based on the person's smoking behaviour, previous attempts to stop and their health and social circumstances. Briefly discuss the merits of each approach to help them choose. **[2013]**

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.

[2013, amended 2021]

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. **[2013]**

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). **[2013, amended 2021]**

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. **[2013]**

1.15.7 If more intensive support is needed, refer to stop-smoking support. **[2013]**

Behavioural support for harm reduction

These recommendations are for stop-smoking advisers and those trained to provide behavioural support to help people stop smoking, including telephone quitlines and internet support sites.

1.15.8 Use the information gathered about smoking behaviour (see the section on identifying and quantifying people's smoking) to help people set goals and

discuss reduction strategies. This may include:

- increasing the time interval between cigarettes
- delaying the first cigarette of the day
- choosing periods during the day, or specific occasions, when they will not smoke. **[2013]**

1.15.9 Help people who are cutting down before stopping smoking to set a specific quit date. Normally this quit date should be within 6 weeks of them starting behavioural support, although the sooner the better. Help them to develop a schedule detailing how much they aim to cut down (and when) in the lead up to that date. **[2013]**

1.15.10 Help people who are aiming to reduce the amount they smoke (but not intending to stop) to set a date when they will have achieved their goal. Help them to develop a schedule for this or to identify specific periods of time (or specific events) when they will not smoke. **[2013]**

1.15.11 Tell people who are not prepared to stop smoking that the health benefits from reducing the amount they smoke are unclear. But advise them that if they reduce their smoking now, they are more likely to stop smoking in the future. Explain that this is particularly true if they use medicinally licensed nicotine-containing products to help reduce the amount they smoke. **[2013]**

1.15.12 If necessary, advise people how to use medicinally licensed nicotine-containing products effectively. **[2013]**

Harm-reduction self-help materials

1.15.13 Provide self-help materials in a range of formats and languages, tailored to meet the needs of groups in which smoking is widespread and many people are dependent on tobacco, for example, those listed as being at high risk of harm in the section on commissioning and designing services. **[2013, amended 2021]**

1.15.14 Self-help materials for people who smoke should include advice about the areas

covered in the section on choosing a harm-reduction approach, as well as details of where to find more help and support. Use social media websites to publicise self-help materials. **[2013]**

Manufacturer information supplied with medicinally licensed nicotine-containing products

1.15.15 Provide consumers with clear, accurate information on the health risks of any medicinally licensed nicotine-containing product, compared with continuing to smoke and not smoking. Include details on long-term use. **[2013]**

1.15.16 Provide simple, clear instructions on how to use medicinally licensed nicotine-containing products to support the harm-reduction approaches outlined in box 1. **[2013]**

1.15.17 Think about providing information on the outer packaging as well as in the enclosed leaflet for medicinally licensed nicotine-containing products. **[2013]**

1.15.18 Package medicinally licensed nicotine-containing products in a way that makes it as easy as possible for people to take the recommended dose for the right amount of time. **[2013]**

1.16 Stopping use of smokeless tobacco

Identifying people who use smokeless tobacco and offering referral

These recommendations are for GPs, dentists, pharmacists and other healthcare professionals, particularly those providing services for South Asian communities.

1.16.1 Ask people if they use smokeless tobacco, using the names that the various products are known by locally. If necessary, use visual aids to show them what the products look like. (This may be necessary if the person does not speak English well or does not understand the terms being used.) Record the outcome

in the person's notes. **[2012]**

1.16.2 If someone uses smokeless tobacco, ensure they are aware of the health risks (for example, the risk of cardiovascular disease, oropharyngeal cancers and periodontal disease). Use a brief intervention to advise them to stop. **[2012]**

1.16.3 Refer people who use smokeless tobacco who want to quit to local specialist tobacco cessation services (see the section on stop-smoking interventions). This includes services specifically for South Asian groups, where they are available. **[2012]**

1.16.4 Record the person's response to any attempts to encourage or help them to stop using smokeless tobacco in their notes (as well as recording whether they smoke). **[2012]**

Providing support to stop using smokeless tobacco

These recommendations are for people providing support or advice as part of a comprehensive specialist tobacco cessation service.

1.16.5 Use the local names when referring to smokeless tobacco products. **[2012, amended 2021]**

1.16.6 Provide advice on how to quit to people who use smokeless tobacco (or recommend that they get advice to help them quit). **[2012, amended 2021]**

1.16.7 Offer people who use smokeless tobacco help to prevent a relapse after an attempt to stop. If possible, check the success of the attempt by using a cotinine test (saliva examination). Monitor for any possible increase in tobacco smoking or use of areca nut. **[2012, amended 2021]**

1.16.8 Advise people on how to cope with the potential adverse effects of quitting smokeless tobacco. This may include, for example, referring people for help to cope with oral pain, as well as providing general support to cope with withdrawal symptoms. **[2012, amended 2021]**

1.16.9 Check whether people who use smokeless tobacco also smoke tobacco and, if that is the case, provide help to quit them both. **[2012, amended 2021]**

Developing services for people using smokeless tobacco

Assessing local need for smokeless tobacco services for South Asian communities

These recommendations are for people who commission, plan and run services to help people stop using tobacco.

1.16.10 As part of the local joint strategic needs assessment, gather information on where, when and how often smokeless tobacco cessation services are promoted and provided to local South Asian communities – and by whom. Aim to get an overview of the services on offer. **[2012]**

1.16.11 Consult with local voluntary and community organisations that work with, or alongside, South Asian communities to understand their specific issues and needs in relation to smokeless tobacco (see the section on working with local South Asian communities). **[2012]**

1.16.12 Collect and analyse data on the use of smokeless tobacco among local South Asian communities. For example, collect data from local South Asian voluntary and community organisations, dental health professionals and primary and secondary care services. This data should provide information on:

- prevalence and incidence of smokeless tobacco use and detail on the people who use it (for example, their age, family origin, gender, language, religion, disability status and socioeconomic status)
- people who use smokeless tobacco and do not use cessation services
- types of smokeless tobacco used
- perceived level of health risk associated with these products
- circumstances in which these products are used locally

- proportion and demographics of people who both smoke and use smokeless tobacco products. **[2012]**

1.16.13 When collecting and analysing information on smokeless tobacco, use consistent terminology to describe the products. Note any local variation in the terminology used by retailers and consumers. **[2012]**

1.16.14 Think about working with neighbouring local authorities to analyse routinely collected data from a wider geographical area on the health problems associated with smokeless tobacco among local South Asian communities. In particular, collect and analyse data on the rate of oropharyngeal cancers. Note any demographic patterns. Data could be gathered from local cancer registers, Hospital Episode Statistics, joint strategic needs assessments and local cancer networks. **[2012]**

1.16.15 Collect information from tobacco cessation services on the number of South Asian people who have recently sought help to give up smoking or smokeless tobacco. Depending on the level of detail available, data should be broken down demographically (for example, by age, family origin, gender, religion and socioeconomic status). **[2012]**

Working with local South Asian communities

These recommendations are for public sector, voluntary and community organisations, health and social care professionals and faith groups.

1.16.16 Work with local South Asian communities to plan, design, coordinate, implement and publicise activities to help them stop using smokeless tobacco:

- Develop relationships and build trust between relevant organisations, communities and people by involving them in all aspects of planning.
- Take account of existing and past activities to address smokeless tobacco use and other health issues among these communities.
- Also see NICE's guideline on community engagement: improving health and wellbeing and reducing health inequalities. **[2012]**

1.16.17 Work with local South Asian communities to understand how to make smokeless tobacco cessation services more accessible. For example, if smokeless tobacco cessation services are provided within existing mainstream stop-smoking support, find out what would make it easier for South Asian people to use the service. **[2012]**

Commissioning and providing smokeless tobacco services

These recommendations are for directors of public health and those responsible for commissioning and managing tobacco cessation services.

1.16.18 If local needs assessment shows that it is necessary, commission a range of services to help South Asian people stop using smokeless tobacco. Services should be in line with any existing local agreements or local enhanced service arrangements. **[2012]**

1.16.19 Provide services for South Asian people who use smokeless tobacco either within existing stop-smoking support or, for example, as:

- Part of services offered within a range of healthcare and community settings (for example, GP or dental surgeries, community pharmacies and community centres – see the section on identifying people who use smokeless tobacco and offering referral).
- A stand-alone service tailored to local needs (see the section on providing support to stop using smokeless tobacco). This might cater for specific groups such as South Asian women, speakers of a specific language or people who use a certain type of smokeless tobacco product. (The latter type of service could be named after the product, for example, it could be called a 'gutkha' cessation service.) **[2012]**

1.16.20 Ensure local smokeless tobacco cessation services are coordinated and integrated with other tobacco control, prevention and cessation activities, as part of a comprehensive local tobacco control strategy. The services (and activities to promote them) should also be coordinated with, or linked to, national stop-smoking initiatives and other related national initiatives (for example, dental health campaigns). **[2012]**

1.16.21 Ensure smokeless tobacco cessation services are part of a wider approach to addressing the health needs facing South Asian communities. They should be planned in partnership with relevant local voluntary and community organisations and user groups, and in consultation with local South Asian communities. **[2012]**

1.16.22 Ensure smokeless tobacco cessation services take into account the fact that some people who use smokeless tobacco products also smoke. **[2012]**

1.16.23 Ensure smokeless tobacco cessation services take into account the needs of people:

- from different local South Asian communities (for example, by using staff with relevant language skills or translators, or by providing translated materials or resources in a non-written format)
- who may be particularly concerned about confidentiality
- who may not realise smokeless tobacco is harmful
- who may not know help is available
- who may find it difficult to use existing local services because of their social circumstances, gender, language, culture or lifestyle. **[2012]**

Monitoring smokeless tobacco cessation services

1.16.24 Regularly monitor and evaluate all local smokeless tobacco cessation services (and activities to promote them). Ensure they are effective and acceptable to service users. If necessary, adjust services to meet local need more effectively. The following outcomes should be reported:

- number of quit attempts
- percentage of successful quit attempts at 4 weeks
- percentage of quit attempts leading to an adverse or unintended consequence (such as someone switching to, or increasing, their use of smoked tobacco or areca nut-only products). **[2012]**

1.17 Adherence and relapse prevention

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

Supporting people trying to stop smoking

1.17.1 Discuss ways of preventing a relapse to smoking. This could include talking about coping strategies and practical ways of making it easier to prevent a relapse to smoking. Do this at an early stage and at each contact. **[2021]**

1.17.2 Offer the opportunity for a further course of varenicline, NRT or bupropion to prevent a relapse to smoking.

In February 2025, this was an off-label use of bupropion. See NICE's information on prescribing medicines. **[2021]**

For a short explanation of why the committee made the 2021 recommendations and how they might affect practice, see the rationale and impact section on supporting people trying to stop smoking.

Full details of the evidence and the committee's discussion are in evidence review N: smoking relapse prevention.

Supporting people cutting down or stopping temporarily

1.17.3 If people who set out to reduce the amount they smoke or to stop temporarily have been successful, assess how motivated they are to:

- maintain that level
- reduce the amount they smoke even more
- stop completely. **[2013]**

1.17.4 At appropriate intervals, measure people's exhaled breath for carbon monoxide to gauge their progress and help motivate them to stop smoking. Ask them whether

daily activities, for example climbing the stairs or walking uphill, have become easier. Use this feedback to prompt discussion about the benefits of cutting down and, if appropriate, to encourage them to cut down even more or stop completely. **[2013]**

1.17.5 Offer medicinally licensed nicotine-containing products, as needed, to help prevent a relapse among people who have reduced the amount they smoke. **[2013, amended 2021]**

Reviewing the approach for people trying to stop smoking, cutting down or stopping temporarily

1.17.6 For people attempting to stop smoking and those reducing their harm, offer follow-up appointments and review the approach taken at each contact. **[2021]**

1.17.7 Encourage people who have not achieved their quitting or harm-reduction goals to try again. Remind them that various interventions are available to help them and discuss which option to use next. See the sections on stop-smoking interventions and on supporting people who do not want, or are not ready, to stop smoking in one go to reduce their harm from smoking. **[2021]**

For a short explanation of why the committee made the 2021 recommendations and how they might affect practice, see the rationale and impact section on reviewing the approach.

Full details of the evidence and the committee's discussion are in evidence review N: smoking relapse prevention.

Treating tobacco dependence during pregnancy and in the first year after childbirth

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

This guideline should be read alongside NICE's guidelines on patient experience in adult NHS services and babies, children and young people's experience of healthcare, which have guidance on giving information to people and discussing their views and preferences.

At the time of publication (February 2025), no nicotine-containing e-cigarettes were licensed as a medicine for stopping smoking by the Medicines and Healthcare products Regulatory Agency (MHRA) and commercially available in the UK market. All nicotine-containing e-cigarettes in the UK that are not licensed as a medicine by the MHRA are regulated by the Tobacco and Related Products Regulations (2016), and cannot be marketed by the manufacturer for use for stopping smoking.

These recommendations aim to help women, and trans men and non-binary people, stop smoking during pregnancy and in the first year after childbirth.

Other recommendations relevant in pregnancy are in the section on support to stop smoking in secondary care services.

1.18 Stop-smoking support in pregnancy: identification and referral

These recommendations are for healthcare professionals providing maternity care to pregnant women, and pregnant trans men and non-binary people.

1.18.1 Provide routine carbon monoxide testing at the first antenatal appointment and at the 36-week appointment to assess the pregnant woman or pregnant person's exposure to tobacco smoke. Provide carbon monoxide testing at all other antenatal appointments if they:

- smoke **or**
- are quitting **or**
- used to smoke **or**
- tested with 4 parts per million (ppm) or above at the first antenatal appointment. **[2023]**

1.18.2 Provide an opt-out referral to receive stop-smoking support during pregnancy for those who:

- say they smoke or have stopped smoking in the past 2 weeks **or**
- have a carbon monoxide reading of 4 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. **[2021]**

1.18.3 Explain:

- that it is normal practice to refer anyone who is pregnant and who smokes or has recently quit
- that the carbon monoxide test will allow them to see a physical measure of their smoking and exposure to other people's smoking

- what the carbon monoxide reading means, taking into consideration the time since they last smoked and the number of cigarettes smoked (and when) on the day of the test. **[2021]**

1.18.4 If the pregnant woman or pregnant person does not smoke but has a carbon monoxide level of 3 ppm or more, help them to identify the source of carbon monoxide and reduce it. (Other sources include household or other secondhand smoke, heating appliances or traffic emissions.) **[2013]**

1.18.5 If the pregnant woman or pregnant person has a high carbon monoxide reading (more than 10 ppm) but says they do not smoke:

- advise about possible carbon monoxide poisoning
- ask them to contact the Gas Emergency Line (0800 111 999) for gas safety advice
- phrase any further questions about smoking sensitively to encourage a frank discussion. **[2010]**

1.18.6 Record carbon monoxide level and any feedback given in individual antenatal records. If these antenatal records are not available locally, use local protocols to record this information. **[2010]**

For a short explanation of why the committee made the 2021 and 2023 recommendations and how they might affect practice, see the rationale and impact section on stop-smoking support in pregnancy: identification and referral.

Full details of the evidence and the committee's discussion are in evidence review H: opt-out stop-smoking support.

1.19 Following up on referrals for stop-smoking support made during pregnancy

These recommendations are for people providing stop-smoking support or advice to pregnant women, and pregnant trans men and non-binary people.

1.19.1 Contact anyone who has been referred for help. Discuss smoking and pregnancy and the issues they face, using an impartial, person-centred approach. Invite them to use the service. If necessary (and resources permit), make at least 3 contacts using different methods. Advise the maternity booking midwife of the outcome. **[2010]**

1.19.2 Try to see those who cannot be contacted by other methods. This could happen during a routine antenatal care visit (for example, when they attend for a scan). **[2010]**

1.19.3 Provide information about the risks of smoking to an unborn child and the benefits of stopping for both the pregnant woman or pregnant person, and the baby. **[2010]**

1.19.4 Address any factors that could prevent pregnant women or pregnant people 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 these services
- lack of suitable childcare
- fear of failure and concerns about being stigmatised. **[2010]**

1.19.5 If pregnant women or pregnant people 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. **[2010]**

1.19.6 Address any concerns pregnant women or pregnant people, and their partners or family, may have about stopping smoking and offer personalised information, advice and support on how to stop. **[2010]**

1.19.7 Send information on smoking and pregnancy to those who opt out during the initial telephone call. This should include details on how to get help to quit at a

later date. **[2010]**

1.20 Providing support to stop smoking

These recommendations are for people providing stop-smoking support or advice to pregnant women, and pregnant trans men and non-binary people.

1.20.1 Provide the pregnant woman or pregnant person with intensive and ongoing support (brief interventions alone are unlikely to be sufficient) throughout pregnancy and beyond. This includes regularly monitoring smoking status using carbon monoxide tests. Use carbon monoxide measurements to encourage them to quit and as a way to provide positive feedback once a quit attempt has been made. **[2010]**

1.20.2 Biochemically validate that the pregnant woman or pregnant person has quit on the date they 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.) **[2010]**

1.20.3 When carrying out tests, check whether the pregnant woman or pregnant person is using nicotine replacement therapy (NRT) as this may raise cotinine levels. Take into account that no measure can be 100% accurate. Some people may smoke so infrequently – or inhale so little – that their intake cannot reliably be distinguished from that from passive smoking. **[2010]**

1.20.4 For anyone who has stopped smoking in the 2 weeks before their maternity booking appointment, continue to provide support in line with the recommendations in this section and stop-smoking support practice protocols. **[2010]**

1.20.5 Establish links with contraceptive services, fertility clinics and antenatal and postnatal services so that everyone working in those organisations knows about local stop-smoking support. Ensure they understand what these services offer and how to refer to them. **[2010]**

For guidance on the use of prescribed medicines during pregnancy, also see the section on medicine dosages for people who have stopped smoking.

Nicotine replacement therapy and other pharmacological support

These recommendations are for people providing stop-smoking support or advice to pregnant women, and pregnant trans men and non-binary people.

Cytisinicline is sometimes referred to as cytisine. For clarity and consistency with the BNF and the medicine's marketing authorisation in the UK, we use the international non-proprietary name cytisinicline throughout this guideline.

1.20.6 Consider NRT alongside behavioural support to help pregnant women and pregnant people to stop smoking in pregnancy (see the BNF's information on NRT). **[2021]**

1.20.7 Consider NRT at the earliest opportunity in pregnancy and continue to provide it after pregnancy if it is needed to prevent a relapse to smoking, including if the pregnancy does not continue (see the BNF's information on NRT). **[2021]**

1.20.8 Give pregnant women and pregnant people clear and consistent information about NRT. Explain:

- that it may help them stop smoking and reduce their cravings
- how to use NRT correctly, including how to get a high enough dose of nicotine to control cravings, prevent compensatory smoking and stop successfully. **[2021]**

1.20.9 Advise those using nicotine patches during pregnancy to remove them before going to bed. **[2010]**

1.20.10 Emphasise to pregnant women and pregnant people that:

- most smoking-related health problems are caused by other components in tobacco smoke, not by the nicotine
- any risks from using NRT are much lower than those of smoking
- nicotine levels in NRT are much lower than in tobacco, and the way these products deliver nicotine makes them considerably less addictive than smoking. **[2021]**

1.20.11 Do not offer cytisinicline, varenicline or bupropion during pregnancy or breastfeeding. **[2010, amended 2025]**

For a short explanation of why the committee made the 2021 recommendations and how they might affect practice, see the rationale and impact section on nicotine replacement therapy and other pharmacological support.

Full details of the evidence and the committee's discussion are in evidence review J: nicotine replacement therapy and e-cigarettes in pregnancy: update.

Incentives to stop smoking

These recommendations are for providers of stop-smoking support for pregnant women, and pregnant trans men and non-binary people.

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

- refer pregnant women and pregnant people 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 those who have relapsed or whose pregnancy does not continue from continuing to take part in the scheme and trying again
- ensure vouchers cannot be used to buy products that could be harmful during pregnancy (for example, alcohol and cigarettes). **[2021]**

1.20.13 Consider providing voucher incentives jointly to the pregnant woman or pregnant person, and to a friend or family member that they have chosen to support them during their quit attempt. **[2021]**

1.20.14 Ensure staff are trained to promote and deliver incentive schemes to pregnant women and pregnant people to stop smoking. **[2021]**

For a short explanation of why the committee made the 2021 recommendations and how they might affect practice, see the rationale and impact section on incentives to stop smoking.

Full details of the evidence and the committee's discussion are in evidence review I: incentives during pregnancy.

Enabling all pregnant women, and pregnant trans and non-binary people, to access stop-smoking support

These recommendations are to help providers of stop-smoking support reach all pregnant women, and pregnant trans men and non-binary people, including those whose circumstances may make it more difficult to use services (for example, because of cultural or sociodemographic factors, age or language).

1.20.15 Involve pregnant women and pregnant people who find it difficult to use or access existing stop-smoking support in the planning and development of services. **[2010]**

1.20.16 Collaborate with the family nurse partnership and other outreach schemes to identify additional opportunities for providing intensive and ongoing stop-smoking support during pregnancy. (Note: family nurses make frequent home visits.) **[2010]**

1.20.17 Work in partnership with agencies that support pregnant women and pregnant people with complex social and emotional needs. This includes substance misuse services, youth and teenage pregnancy support and mental health services. **[2010]**

Helping partners and others in the household who smoke

These recommendations are for providers of stop-smoking support. See also the section

on identifying smoking among carers, family and other household members.

1.20.18 Offer pregnant women's partners, and the partners of pregnant trans and non-binary people, who smoke help to stop. Use an intervention that comprises 3 or more elements and multiple contacts. Discuss with them which options to use – and in which order, taking into account:

- their preferences
- contraindications and the potential for adverse effects from stop-smoking pharmacotherapies
- the likelihood that they will follow the course of treatment
- their previous experience of stop-smoking aids
- do not favour one course of treatment over another; together, choose the one that seems most likely to succeed taking into account the above. **[2010]**

Policy, commissioning and training

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

This guideline should be read alongside NICE's guidelines on patient experience in adult NHS services and babies, children and young people's experience of healthcare, which have guidance on giving information to people and discussing their views and preferences.

In this guideline, we use the following terms for age groups:

- children: aged 5 to 11
- young people: aged 12 to 17
- young adults: aged 18 to 24
- adults: aged 18 and over.

At the time of publication (February 2025), no nicotine-containing e-cigarettes were licensed as a medicine for stopping smoking by the Medicines and Healthcare products Regulatory Agency (MHRA) and commercially available in the UK market. All nicotine-containing e-cigarettes in the UK that are not licensed as a medicine by the MHRA are regulated by the Tobacco and Related Products Regulations (2016), and cannot be marketed by the manufacturer for use for stopping smoking.

These recommendations are for people with responsibility for developing smokefree policy, and for commissioning and training services.

1.21 Policy

1.21.1 Develop a policy for smokefree grounds in collaboration with secondary care staff and people who use secondary care services, including services in the community, or their representatives. The policy should:

- set out a clear timeframe to establish or reinstate smokefree grounds
- identify the roles and responsibilities of staff
- ban staff from supervising or helping people to take smoking breaks
- identify the resources needed to support the policy
- ban the sale of tobacco products
- be periodically reviewed and updated, in line with all other organisational policies. **[2013]**

1.21.2 Ensure smokefree implementation plans include:

- support for staff and people who use secondary care services to stop smoking completely or temporarily
- training for staff (see the section on training for healthcare staff)
- removing shelters or other designated outdoor smoking areas
- staff, contractor and volunteer contracts that do not allow smoking during work hours or when recognisable as an employee (for example, when in uniform, wearing identification, or handling hospital business)
- how secondary care staff can work with people who use services and carers to protect themselves from tobacco smoke when they visit people's homes. (In accordance with smokefree legislation, employers must take action to reduce the risk to the health and safety of their employees from secondhand smoke to as low a level as is reasonably practicable.) **[2013]**

1.21.3 Ensure policies, procedures and resources are in place to:

- help comply with, and resolve immediately, any breaches of smokefree

policies, including a process for staff to report incidents

- support staff to encourage others to comply with the smokefree policy
- work with people who use services, carers, visitors and staff to overcome any problems that may result from smoking restrictions (supported by 'personal care plans' as covered in the section on information on stopping smoking for those using acute, maternity and mental health services). **[2013]**

1.21.4 Ensure all staff are aware of the smokefree policy and comply with it. **[2013]**

Communicating the smokefree policy

1.21.5 Develop, deliver and maintain a communications strategy on local smokefree policy requirements. This could include newsletters, pamphlets, posters and signage (smokefree signs for vehicles or areas that are enclosed or substantially enclosed must comply with regulations under the Health and Safety at Work etc Act 1974). Include information for people who use secondary care services, their parents or carers, staff and visitors, and the wider local population. Also include:

- clear, consistent messages about the need to keep buildings and grounds smokefree
- positive messages about the health benefits of a smokefree environment
- the fact that health and social care professionals have a duty to provide a safe, healthy environment for staff and people who use or visit secondary care services
- information about stop-smoking support and how to access services, including support to temporarily stop, for staff and people who use secondary care services
- the fact that staff are not allowed to smoke at any time during working hours or when recognisable as an employee, contractor or volunteer (for example, when in uniform, wearing identification, or handling hospital business). **[2013]**

Closed institutions

1.21.6 Include management of smoking in the care plan of people in closed institutions who smoke. **[2013]**

1.21.7 Develop a policy to ensure effective stop-smoking interventions are provided and promoted in prisons, military establishments and long-stay health centres, such as mental healthcare units. Use Department of Health and Social Care guidance to develop the policy. **[2018]**

See also the sections on employers, support to stop smoking in secondary care services and supporting people who do not want, or are not ready, to stop smoking in one go to reduce their harm from smoking.

Ensuring local tobacco control strategies include secondary care

These recommendations are for people with responsibility for planning, commissioning and running tobacco control strategies.

1.21.8 Ensure the joint strategic needs assessment:

- takes into account the impact of smoking on local communities
- identifies expected numbers of particular groups of people who are at very high risk of tobacco-related harm (for example, those listed as being at high risk of harm in the section on commissioning and designing services)
- identifies the proportion of people at very high risk reached by services and the numbers who successfully stop smoking. **[2013]**

1.21.9 Make it clear in the local tobacco control strategy that people working in secondary care should:

- communicate key messages about tobacco-related harm to everyone who uses services
- develop policies and support to help people stop smoking
- identify people who want to stop smoking and, if appropriate, refer them to a

stop-smoking adviser

- implement a comprehensive smokefree policy that includes the grounds of the establishment. **[2013]**

1.21.10 Develop a local stop-smoking care pathway and referral procedure to ensure there is continuity of care between primary, community and secondary care. **[2013]**

1.22 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.

1.22.1 Use integrated care systems plans, health and wellbeing strategies, and other relevant local strategies and plans to make the range of interventions in the section on stop-smoking interventions accessible to adults who smoke. **[2021]**

1.22.2 Ensure service specifications require providers of stop-smoking support to offer nicotine replacement therapy (NRT) for as long as needed to help prevent a relapse to smoking. **[2021]**

1.22.3 Use the government's local tobacco control profiles to estimate smoking prevalence among the local population. **[2018]**

1.22.4 Prioritise groups at high risk of tobacco-related harm. These may include:

- people with mental health conditions (for example, see NICE's guideline on depression in adults)
- people who misuse substances (for example, see NICE's guideline on coexisting severe mental illness and substance misuse: community health and social care services)
- people with health conditions caused or made worse by smoking (for example, see NICE's guidelines on cardiovascular disease: identifying and

supporting people most at risk of dying early, type 1 diabetes in adults, asthma and chronic obstructive pulmonary disease)

- people with a smoking-related illness (see NICE's guideline on lung cancer)
- populations with a high prevalence of smoking-related morbidity or a particularly high susceptibility to harm
- communities or groups with particularly high smoking prevalence (such as manual workers, travellers and LGBT+ people)
- people with a low socioeconomic status
- pregnant women, and pregnant trans men and non-binary people, who smoke. **[2018]**

For a short explanation of why the committee made the 2021 recommendations and how they might affect practice, see the rationale and impact section on commissioning and designing services.

Full details of the evidence and the committee's discussion are in:

- evidence review N: smoking relapse prevention
- evidence review K: cessation and harm-reduction treatments.

Providing stop-smoking support to employers

1.22.5 Offer support to employers who want to help their employees to stop smoking. If appropriate and feasible, provide support on the employer's premises. **[2007]**

1.22.6 If initial demand exceeds the resources available, focus on the following:

- small and medium-sized enterprises
- enterprises with a high proportion of employees on low pay
- enterprises with a high proportion of employees at high risk of tobacco-

related harm. **[2007]**

Harm reduction within stop-smoking support

1.22.7 Ensure investment in harm-reduction approaches does not detract from, but supports and extends the reach and impact of, existing stop-smoking support. **[2013]**

1.22.8 Develop stop-smoking referral and treatment pathways to ensure a range of approaches and interventions is available to support people who opt for a harm-reduction approach (see box 1). **[2013]**

1.22.9 Ensure service specifications require providers of stop-smoking support to offer medicinally licensed nicotine-containing products on a long-term basis to help people maintain a lower level of smoking. **[2013, amended 2021]**

Stop-smoking support in secondary care

1.22.10 Ensure all secondary care buildings and grounds are smokefree. **[2013]**

1.22.11 Ensure the NHS standard contract and local authority contract includes smokefree strategies. **[2013]**

1.22.12 Ensure all hospitals have on-site stop-smoking support. **[2013]**

1.22.13 Ensure stop-smoking medicinally licensed products are included in secondary care formularies. **[2013]**

1.22.14 Include NICE-recommended nicotine-containing products as options for sale in secondary care settings (for example, in hospital shops). **[2021]**

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. **[2013]**

1.22.16 Monitor and audit the implementation and impact of recommendations for secondary care services. This may include recording:

- individual smoking status (including for pregnant women, and pregnant trans and non-binary people, at the time of giving birth)
- number of referrals
- uptake of interventions
- prescribing of stop-smoking pharmacotherapies
- 4-week quit rates
- staff training.

Ensure the needs of higher-risk groups identified in the joint strategic needs assessment are being met (see the section on ensuring local tobacco control strategies include secondary care). **[2013]**

1.22.17 Ensure secondary care providers have enough resources to maintain a smokefree policy. **[2013]**

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. **[2013]**

1.22.19 Secondary care directors and managers leading on stop-smoking support should assign a clinical or medical director to lead on stop-smoking support for people who use, or work in, secondary care services. As well as implementing the

recommendations in this guideline on providing and commissioning stop-smoking support in secondary care, the designated lead should ensure:

- the organisation has an annual improvement programme for stop-smoking support given to people who use, or work in, secondary care services
- stop-smoking support (for patients and staff) is promoted and communicated effectively (see the section on communicating the smokefree policy) to start a cultural change within the organisation
- the quality of stop-smoking support continues to improve
- performance monitoring and feedback on outcomes is provided to all staff. **[2013]**

For a short explanation of why the committee made the 2021 recommendation and how it might affect practice, see the rationale and impact section on stop-smoking support in secondary care.

Full details of the evidence and the committee's discussion are in evidence review K: cessation and harm-reduction treatments.

Referral systems for people who smoke

1.22.20 Ensure there are systems for consistently recording and maintaining records of smoking status. All patient records should:

- provide a prompt for action (including referral to stop-smoking support)
- be stored for easy access and audit. **[2013]**

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. **[2013]**

Monitoring stop-smoking services by commissioners and managers

1.22.22 Set targets for stop-smoking services, including the number of people using the service and the proportion who successfully stop smoking. Performance targets should include:

- treating at least 5% of the estimated local population who smoke each year
- achieving a stop-smoking rate of at least 35% at 4 weeks, based on everyone who starts treatment and defining success as not having smoked (confirmed by carbon monoxide monitoring of exhaled breath) in the fourth week after the quit date. **[2018]**

1.22.23 Check self-reported smoking abstinence using a carbon monoxide test. Define success as the person having less than 10 parts per million (ppm) of carbon monoxide in their exhaled breath at 4 weeks after the quit date. This does not imply that treatment should stop at 4 weeks. **[2018]**

1.22.24 Monitor performance data for stop-smoking services routinely and independently. Make the results publicly available. **[2018]**

1.22.25 Audit exceptional results (for example, 4-week smoking quit rates lower than 35% or above 70%). Use the audit to determine the reasons for unusual performance as well as to identify good practice and ensure it is being followed. **[2018]**

1.22.26 Assess the performance of providers that support people who want to reduce the harm from smoking. Additional measures could include:

- numbers attending the services (for comparison with the numbers attending before harm-reduction options were offered)
- classifying the harm-reduction approaches used (see box 1)
- characteristics of people using the service (such as demographic data, cigarette usage, level of dependency and previous attempts to stop)
- type and amount of medicinally licensed nicotine-containing products supplied or prescribed, and over-the-counter sales of these products

- number of people setting a quit date. **[2013]**

1.23 Training

Training to prevent uptake of smoking

This recommendation is for those with responsibility for improving the health and wellbeing of children, young people and young adults who attend school.

1.23.1 Work in partnership with those involved in smoking prevention and stop-smoking activities to design, deliver, monitor and evaluate smoking prevention training and interventions. Partners could include:

- national and local education agencies
- training agencies
- local authorities
- tobacco control alliances
- school nursing service
- voluntary sector organisations
- local health improvement services
- providers of stop-smoking support
- universities. **[2010]**

See also NICE's guidelines on behaviour change: general approaches and alcohol interventions in secondary and further education.

Training on stopping smoking

Healthcare staff

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. **[2013, amended 2018]**

1.23.3 Provide additional, specialised training on providing stop-smoking support for those working with specific groups, for example, people with mental health conditions and pregnant women, and pregnant trans men and non-binary people, who smoke. **[2008, amended 2018]**

1.23.4 Encourage and train healthcare professionals to ask people about smoking and to advise them of the dangers of exposure to secondhand smoke. **[2008, amended 2018]**

People working in closed institutions

1.23.5 Ensure staff working in closed institutions recognise that some people see smoking as an integral part of their lives. Also ensure staff recognise the issues arising from being forced to stop, as opposed to doing this voluntarily. **[2013]**

1.23.6 Ensure staff recognise how the closed environment may restrict the techniques and coping mechanisms that people would normally use to stop smoking or reduce the amount they smoke. Provide the support needed for their circumstances. This includes prescribing or supplying medicinally licensed nicotine-containing products. **[2013]**

1.23.7 Ensure staff understand that if someone reduces the amount they smoke, or stops completely, this can affect psychotropic and some other medications (see the summaries of product characteristics for individual drugs in the electronic medicines compendium for further details). Ensure arrangements are in place to adjust their medication accordingly. See the section on medicine dosages for

people who have stopped smoking. **[2013]**

1.23.8 Do not allow staff with health and social care or custodial responsibilities to smoke during working hours in locations where the people in their care are not allowed to smoke. **[2013]**

Midwives and others working with pregnant women, and pregnant trans men and non-binary people

1.23.9 Ensure all midwives are trained to assess and record the pregnant woman or pregnant person's smoking status and their readiness to quit. They should also:

- know about the health risks of smoking and the benefits of quitting
- understand why it can be difficult to stop
- know about the treatments that can help people to quit, including nicotine replacement therapy
- know how to refer people who smoke to local services for treatment.

  See the National Centre for Smoking Cessation and Training's (NCSCT) module on very brief advice on smoking for pregnant women. **[2010, amended 2021]**

1.23.10 Ensure all healthcare and other professionals who work with pregnant women and pregnant people are trained in the same skills to support women to stop smoking, and to the same standard, as midwives. This includes:

- GPs, practice nurses
- health visitors
- obstetricians
- paediatricians
- sonographers
- midwives (including young people's lead midwives)

- family nurses
- those working in fertility clinics, dental facilities and community pharmacies
- those working in youth and teenage pregnancy services, children's centres, social services and voluntary and community organisations. **[2010]**

1.23.11 Ensure that all healthcare and other professionals who work with pregnant women and pregnant people (see recommendation 1.23.10):

- understand the impact that smoking can have on them and their unborn child
- understand the dangers of exposing someone who is pregnant and their unborn child – and other children – to secondhand smoke. **[2010]**

1.23.12 Train all midwives who deliver intensive stop-smoking interventions (one-to-one or group support) to the same standard as stop-smoking advisers. The minimum standard for these interventions is set by the NCSCT. Also provide additional, specialised training and offer them ongoing support and training updates.

See NCSCT's briefings and resources on stopping smoking in pregnancy and the postpartum period. **[2010]**

1.23.13 Ensure that midwives and specialist stop-smoking advisers who work with pregnant women and pregnant people:

- know how to ask them questions in a way that encourages them to be open about their smoking
- always recommend quitting rather than cutting down
- have received accredited training in the use of carbon monoxide monitors. **[2010]**

Healthcare staff and others who advise people how to stop using smokeless tobacco

1.23.14 Ensure training for health, dental health and allied professionals (for example,

community pharmacists) covers:

- the fact that smokeless tobacco may be used locally – and the need to keep abreast of statistics on local prevalence
- the reasons why, and how, members of the South Asian community use smokeless tobacco (including the cultural context for its use)
- the health risks associated with smokeless tobacco
- the fact that some people of South Asian family origin may be less used to a preventive approach to health than the general population
- the local names used for smokeless tobacco products, while emphasising the need to use the term 'smokeless tobacco' as well when talking to users about them. **[2012]**

1.23.15 Ensure training helps professionals to:

- recognise the signs of smokeless tobacco use
- know how to ask someone, in a sensitive and culturally aware manner, whether they use smokeless tobacco
- provide information in a culturally sensitive way on the harm smokeless tobacco causes (this includes being able to challenge any perceived benefits – and the relative priority that users may place on these benefits)
- deliver a brief intervention and refer people to tobacco cessation services if they want to quit. **[2012]**

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions, see the NICE glossary or, for public health and social care terms, the Think Local Act Personal Care and Support Jargon Buster.

Allen Carr's in-person group seminar

A session lasting between 4.5 and 6 hours with elements of cognitive behavioural therapy and a brief relaxation exercise. Participants are encouraged to carry on smoking as normal until they attend the session and to smoke as normal during scheduled smoking breaks (around every 45 to 60 minutes) until a final ritual cigarette at the end. After the session, regular texts remind participants that they can contact the provider if they have further questions. The price includes up to 2 shorter (around 3.5 hours) follow-up sessions if wanted.

Behavioural support

Scheduled meetings (face to face or virtual) between someone who smokes and a counsellor trained to provide stop-smoking support. Behavioural support can be provided either individually or in a group. Discussions may include information, practical advice about goal setting, self-monitoring and dealing with the barriers to stopping smoking as well as encouragement. The support also includes anticipating and dealing with the challenges of stopping (see NICE's guideline on behaviour change: general approaches and the National Centre for Smoking Cessation and Training [NCSCT] Training Standard). Support is typically offered weekly for at least the first 4 weeks of a quit attempt (that is, for 4 weeks after the quit date) or 4 weeks after discharge from hospital (where a quit attempt may have started before discharge), and normally given with stop-smoking pharmacotherapies. Behavioural support does not include Allen Carr's Easyway in-person group seminar.

Cessation

Stopping the use of tobacco, smoked or smokeless. This includes stopping use of tobacco and moving on to pharmacotherapies (including nicotine replacement therapy) or nicotine-

containing e-cigarettes.

Closed institutions

Environments where people are detained or stay for a long time and where smoking is not permitted. These include secure mental health units, immigration removal centres and custodial sites, as well as places like long-stay mental health units and military establishments.

Compensatory smoking

Inhaling more deeply or smoking more of each cigarette to compensate for smoking fewer cigarettes.

E-cigarettes

Also called electronic cigarettes or vaping devices. A product that can be used for the inhalation of vapour through a mouthpiece. E-cigarettes can be disposable or refillable by means of a refill container and a tank, or can be rechargeable with single-use cartridges. Products may be used to consume nicotine or used without nicotine (see nicotine-containing e-cigarettes).

Products that contain or could contain nicotine in the form of e-liquid are covered under the European Union's 2014 Tobacco Products Directive and need to be notified to the Medicines and Healthcare products Regulatory Agency (MHRA). Other devices such as disposable e-cigarettes that do not contain nicotine, and 0% nicotine e-liquids, are regulated under the General Product Safety Regulations (2005; definition informed by the MHRA's e-cigarettes regulations for consumer products). E-cigarettes are not currently (February 2025) licensed medicines but are regulated by the Tobacco and Related Products Regulations (2016).

Harm reduction

Measures to reduce the illnesses and deaths caused by smoking tobacco among people who smoke and those around them. Some measures or products may reduce harm more than others. People who smoke and currently do not want, or are not ready, to stop in one

go can reduce their harm by smoking less and abstaining from smoking temporarily. The benefits of harm reduction itself are uncertain, but it may mean people are more likely to stop smoking altogether in the future.

Medicinally licensed nicotine-containing products

Nicotine-containing products that have been given marketing authorisation by the MHRA. At the time of publication (February 2025), nicotine replacement therapy products were the only type of medicinally licensed nicotine-containing product on the market. If any nicotine-containing e-cigarette were licensed by the MHRA and made commercially available, it would be included in this definition.

Nicotine-containing products

Products that contain nicotine but do not contain tobacco and so deliver nicotine without the harmful toxins found in tobacco. This currently includes nicotine replacement therapy, which has been medicinally licensed for smoking cessation by the MHRA (see nicotine replacement therapy), and nicotine-containing e-cigarettes. Currently there are no licensed nicotine-containing e-cigarettes on the market. Nicotine-containing e-cigarettes on general sale are regulated under the Tobacco and Related Products Regulations (2016) by the MHRA. For further details, see the MHRA website.

Nicotine-containing e-cigarettes

Nicotine-containing e-cigarettes are vaping devices filled with nicotine-containing e-liquid. These devices must be notified to the MHRA and must meet the requirements of the European Union (2014) Tobacco Products Directive (definition informed by the MHRA's e-cigarettes regulations for consumer products).

Nicotine replacement therapy

Products medicinally licensed for use as a stop-smoking aid and for harm reduction, as outlined in the BNF. They include transdermal patches, gum, inhalation cartridges, sublingual tablets, lozenges, mouth spray and nasal spray.

Pharmacotherapies

This covers medication licensed for smoking cessation such as cytisinicline, varenicline or bupropion, as well as nicotine replacement therapy.

Safety

This refers to the incidence of minor and major side effects associated with nicotine-containing products.

Schools

'Schools' is used to refer to:

- maintained and independent primary, secondary and special schools
- city technology colleges and academies
- pupil referral units, secure training and local authority secure units
- further education colleges
- 'extended schools' where childcare or informal education is provided outside school hours.

Secondary care

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

Self-help materials

Any manual or structured programme, in written or digital format, that someone can use to try to stop smoking or reduce the amount they smoke. These can be used without the help

of healthcare professionals, stop-smoking advisers or group support. They can be aimed at anyone who smokes, particular populations (for example, certain ages or ethnic groups), or may be tailored to individual need.

Smokefree

Air that is free of tobacco smoke. E-cigarettes are not covered by smokefree legislation.

Smokeless tobacco

Any product containing tobacco that is placed in the mouth or nose and not burned and which is typically used in England by people of South Asian family origin. It does not include products that are sucked, like 'snus' or similar oral snuff products (as defined in the European Union 2014 Tobacco Products Directive).

The types used vary across the country but they can be divided into 3 main categories, based on their ingredients (Stanfill et al. 2010):

- Tobacco with or without flavourants: misri India tobacco (powdered) and qimam (kiman).
- Tobacco with various alkaline modifiers: khaini, naswar (niswar, nass) and gul.
- Tobacco with slaked lime as an alkaline modifier and areca nut: gutkha, zarda, mawa, manipuri and betel quid (with tobacco).

South Asian family origin

People with ancestral links to countries in southern Asia, including Bangladesh, India, Nepal, Pakistan or Sri Lanka.

Specialist tobacco cessation services

Evidence-based services that offer support to help people stop smoking or using smokeless tobacco. In England, these are generally referred to as 'stop-smoking support or services' or 'smoking cessation services' because they normally focus on people who smoke tobacco. But a service might brand itself as a generic tobacco cessation or tobacco

dependence service, to emphasise a focus on more than 1 form of tobacco.

Stop in one go

The standard approach in most stop-smoking support. The person makes a commitment to stop smoking on or before a particular date (the quit date). This may or may not involve the use of pharmacotherapies or nicotine-containing e-cigarettes before the quit date and for some time afterwards, depending on the person's needs.

Stop-smoking support

Interventions and support to stop smoking, regardless of how services are commissioned or set up.

Telephone quitlines

These provide proactive or reactive advice, encouragement, counselling and support by phone to anyone who smokes who wants to quit, or who has recently quit.

Temporary abstinence

Stopping smoking with or without medication for a particular event or series of events, in a particular location, for specific time periods (for example, while at work, during long-haul flights or during a hospital stay), or for the foreseeable future. (The latter might include, for example, abstinence while serving a prison sentence or while detained in a secure mental health unit.)

Under-served groups

Groups who may be less likely to benefit from an intervention because they have specific needs that the intervention does not address, or because they may face additional challenges in engaging with the intervention.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Health effects of e-cigarettes

What are the short- and long-term health effects of e-cigarette use? Are there any specific health effects relating to use in pregnancy, or use by children and young people? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on advice on nicotine-containing e-cigarettes.

Full details of the evidence and the committee's discussion are in:

- evidence review K: cessation and harm-reduction treatments
- evidence review M: long-term health effects of e-cigarettes.

2 Nicotine replacement therapy and e-cigarettes and pregnancy

Are nicotine replacement therapy or nicotine-containing e-cigarettes effective to help stop smoking in pregnancy (and at what dose)? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on nicotine replacement therapy (NRT) and other pharmacological support.

Full details of the evidence and the committee's discussion are in evidence review J: nicotine replacement therapies and e-cigarettes in pregnancy: update.

3 Stop-smoking interventions for under-served groups

How can effective and cost-effective interventions to support people to stop smoking be modified to improve engagement with and accessibility for under-served groups? How acceptable are these interventions to these groups? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on commissioning and designing services.

Full details of the evidence and the committee's discussion are in evidence review K: cessation and harm-reduction treatments.

4 Support for people with mental health conditions to stop smoking

How can people with mental health conditions be supported effectively to stop smoking (at individual and system level)? What are the challenges and opportunities and how can they be addressed? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on stop-smoking support in mental health services.

Full details of the evidence and the committee's discussion are in evidence review O: tailored interventions for those with mental health conditions.

5 E-cigarettes and pregnancy

What are the views and concerns of:

- pregnant women who smoke
- the healthcare professionals who care for them

about the use of nicotine-containing e-cigarettes during pregnancy? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on nicotine replacement therapy and other pharmacological support.

Full details of the evidence and the committee's discussion are in evidence review J: nicotine replacement therapies and e-cigarettes in pregnancy: update.

Other recommendations for research

6 E-cigarettes for harm reduction

Are nicotine-containing e-cigarettes effective and safe for harm reduction when used alongside tobacco products to cut down on smoking (dual-use approach)? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on nicotine-containing e-cigarettes for harm reduction.

Full details of the evidence and the committee's discussion are in evidence review K: cessation and harm-reduction treatments.

7 Use of e-cigarettes (amount and frequency)

Does the effectiveness of nicotine-containing e-cigarettes as an aid to stopping smoking vary according to the amount of nicotine they contain or the frequency of use? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on advice on nicotine-containing e-cigarettes.

Full details of the evidence and the committee's discussion are in evidence review K: cessation and harm-reduction treatments.

8 E-cigarette flavours

Do the flavours used in nicotine-containing e-cigarettes have an impact on their effectiveness as an aid to stopping smoking, and are there any adverse effects associated with them? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on advice on nicotine-containing e-cigarettes.

Full details of the evidence and the committee's discussion are in evidence review K: cessation and harm-reduction treatments.

9 E-cigarettes and established future smoking

Is e-cigarette use in children, young people and young adults who do not smoke associated with future established smoking? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on adult-led interventions in schools.

Full details of the evidence and the committee's discussion are in evidence review F and G: e-cigarettes and young people.

10 Factors that may influence the use of nicotine replacement therapy and e-cigarettes

Which factors may prevent people who currently smoke tobacco from using other forms of nicotine such as NRT and nicotine-containing e-cigarettes? Does this vary according to population group, particularly among under-served groups? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on using stop-smoking interventions.

Full details of the evidence and the committee's discussion are in evidence review L: barriers and facilitators to using e-cigarettes for cessation or harm reduction.

11 Relapse prevention

Are NRT or nicotine-containing e-cigarettes effective for preventing relapse after a successful quit attempt? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on supporting people trying to stop smoking.

Full details of the evidence and the committee's discussion are in evidence review N: smoking relapse prevention.

12 Relapse prevention after enforced, temporary quit

How can people who have recently stopped or temporarily abstained from smoking in a smokefree inpatient or treatment environment be best supported after discharge to prevent relapse or to stop permanently? **[2021]**

For a short explanation of why the committee made the recommendation for research, see the rationale section on supporting people trying to stop smoking.

Full details of the evidence and the committee's discussion are in evidence review N: smoking relapse prevention.

13 Carbon monoxide monitoring

What is the validity of different thresholds of carbon monoxide in exhaled breath as markers of quitting, based on diagnostic review and modelling? **[2018]**

14 Allen Carr's Easyway

For adults who want to stop smoking, what is the effectiveness and cost effectiveness of Allen Carr's Easyway programme delivered in formats other than in-person group seminars (for example online or using the self-help book) compared with other methods of smoking cessation? **[2022]**

For specific groups who are at risk of health inequalities, for example pregnant women, people from lower socioeconomic backgrounds or people who do not speak English well:

- What is the differential effectiveness and cost effectiveness of Allen Carr's Easyway (including the in-person group seminar and other formats)?
- What strategies or interventions are effective in minimising those differences? **[2022]**

For a short explanation of why the committee made the recommendations for research, see the rationale section on stop-smoking interventions.

Full details of the evidence and the committee's discussion are in evidence review P: effectiveness and cost effectiveness of Allen Carr's Easyway.

Rationale and impact

These sections briefly explain why the committee made the 2021 recommendations and how they might affect practice and services. They link to details of the evidence and a full description of the committee's discussion.

Adult-led interventions in schools

Recommendations 1.6.3 and 1.6.4

Why the committee made the recommendations

The committee wanted to discourage e-cigarette use among young people and young adults who do not smoke because evidence shows that use of e-cigarettes is linked with a higher chance of ever smoking later in life. The committee members agreed that ideas about smoking and what is normal can start from a young age so the recommendation should also apply to this age group.

The committee agreed that school-based interventions could help to discourage e-cigarette use among those who do not smoke.

The committee noted the need to not inadvertently make e-cigarettes desirable. They also emphasised that e-cigarettes should not be confused with tobacco products, so talking about them separately is important.

The committee agreed that more evidence is needed about whether e-cigarette use is linked with habitual smoking (rather than experimental smoking) in the future, the factors that determine this link, and the levels of e-cigarette use in people under 25 (see the recommendation for research on e-cigarettes and established future smoking).

How the recommendations might affect practice

Adding information about e-cigarettes to existing curriculum-based interventions to stop people taking up smoking is a change to current practice, but it should have little resource impact.

Return to recommendations

Stop-smoking interventions

Recommendations 1.12.1, 1.12.2, 1.12.5 to 1.12.10

Why the committee made the recommendations

The committee for the 2021 version of this guideline looked at a large amount of evidence assessing the relative effectiveness of several interventions, including medicinally licensed products (varenicline, bupropion and nicotine replacement therapy [NRT]) and nicotine-containing e-cigarettes. They also looked at these interventions combined with each other. Most of the interventions or combinations of interventions were delivered with behavioural support. Most evidence investigated medicinally licensed products, with fewer studies about e-cigarettes.

The evidence found that these interventions were effective, and that some were likely to be more effective than others, especially in combination with behavioural support. The committee also agreed with the evidence that a combination of short- and long-acting NRT was effective as well.

Based on the evidence of relative effectiveness and their expertise, the committee agreed that several individual products, as well as short-acting and long-acting NRT in combination, were likely to lead to people successfully stopping smoking when used alongside behavioural support.

The committee for the 2025 update to this guideline agreed to include cytisinicline, a medicinally licensed product, in the recommendations. Although the evidence base for cytisinicline ranged from moderate to very low quality, it was found to be effective in helping people to stop smoking when combined with behavioural support. It was found to be more effective than placebo or NRT, and there was no difference identified for the effectiveness of cytisinicline compared with varenicline. When compared with placebo or no medication, and NRT, those taking cytisinicline were at higher risk of nausea and insomnia. But when varenicline was compared with cytisinicline, those taking varenicline were at greater risk of experiencing nausea. However, the absolute numbers for these differences were small and the committee noted that side effects like nausea and headache may also be related to nicotine withdrawal.

The available cost-effectiveness evidence, although limited, showed that cytisinicline, as with other stop-smoking interventions, is likely to be cost effective. The committee also acknowledged that, because of the high costs and severe consequences of smoking-related diseases, most interventions that are clinically effective in smoking cessation are cost effective. When recommending cytisinicline, the committee acknowledged the limited evidence for various population subgroups, particularly groups affected by health inequalities. The committee discussed whether to make a research recommendation on this area but agreed that the 2 existing recommendations for research in the guideline on stop-smoking interventions for under-served groups and support for people with mental health conditions to stop smoking covered key gaps in the evidence.

The committee for the 2021 version of this guideline agreed that people should first be told about all the available options so they can make their own choice. If people do want more information about which options are likely to work best, it is important that people providing stop-smoking support or advice can make this clear. The committee discussed very brief advice and using opportunities to tell people who smoke about the range of interventions available, along with having longer discussions about these options and providing more detailed advice. They agreed these align well with the principles of NHS England's making every contact count.

The committee for the 2022 update to this guideline looked at the evidence for Allen Carr's Easyway to stop-smoking in-person group seminars. This is an approach that uses cognitive behavioural therapy and relaxation methods without pharmacotherapy. It also includes a final ritual cigarette at the end of the seminar, regular follow-ups and optional shorter follow-up sessions.

The evidence considered by the committee compared Allen Carr's Easyway in-person group seminar with 1-to-1 support provided by an NHS stop-smoking service (which includes behavioural support and the use of medicinally licensed products) and with a remote stop-smoking service (which included behavioural support and information about how to access medicinally licensed products). The committee agreed the evidence showed it was as good as other methods such as 1-to-1 support provided by local stop-smoking services, but there was not enough evidence to position Allen Carr's Easyway in-person group seminar within the hierarchy of effectiveness of interventions in recommendations 1.12.8 or 1.12.9.

The committee noted that evidence suggests Allen Carr's Easyway in-person group seminar is cost effective and represents good value for money from an NHS and public

sector perspective. They agreed that making it available through the NHS and local authorities alongside other interventions would broaden people's choice, and that the more choice people have, the more likely they are to find the right intervention for them. They also agreed that some people are reluctant to use pharmacotherapy, and Allen Carr's Easyway would potentially increase the number of people attempting to stop smoking by offering an alternative to interventions that include pharmacotherapy.

The committee discussed various ways of providing the seminar, including online, but noted that the evidence they saw was only for the in-person group seminar (although in 1 study an online follow up was offered). Therefore, they were unable to generalise from this evidence to formats other than the in-person group seminar.

The committee discussed the funding of studies of the intervention. One was funded by Allen Carr's Easyway, but the committee agreed that the methods used to conduct the study minimised any risk of bias associated with this.

The committee discussed the potential effect of Allen Carr's Easyway on inequalities in health. They noted that the length of the seminar (4.5 to 6 hours) and any travel costs to attend the seminar might be difficult for some people, and that people who are housebound would not be able to attend an in-person group seminar at all. They also noted that the evidence did not include any analysis by age, ethnicity, or pregnancy and so it was not clear whether its effectiveness differed in these groups. The committee were unaware whether the in-person group seminars were available in languages other than English, and agreed this was a potential barrier for some people. The evidence also showed that the quit rate was greater in people with higher education in the Allen Carr Easyway in-person group seminar arm. The committee discussed that commissioners would need to know and understand the needs of their local populations to be able to commission Allen Carr's Easyway in a way that would maximise access and use of the service.

The committee agreed that more research on the effects of Allen Carr's Easyway in different population groups, and on the effectiveness of other ways to deliver the programme (for example, the online and book versions) would be useful (see the recommendations for research on Allen Carr's Easyway).

The committee for the 2021 update to this guideline decided not to recommend some combinations of interventions even though they were as effective as individual options. This was because, based on their experience, they had concerns over adherence rates,

the difficulty of obtaining prescriptions for multiple interventions at once and a lack of information on contraindications that made these combinations less feasible than other options.

In most of the evidence, the stop-smoking product (medicinally licensed products or nicotine-containing e-cigarettes) was combined with some form of behavioural support. This meant that the results of the evidence depended on behavioural support being given alongside. The committee agreed that people providing stop-smoking support should offer behavioural support alongside any nicotine-containing products the person is using, irrespective of whether they are providing the product. This is to give people a better chance of stopping smoking. They also agreed that offering behavioural support to people using nicotine-containing e-cigarettes would increase their chances of stopping smoking.

In addition, the committee recognised the need for more evidence about what factors may prevent those who smoke from using other forms of nicotine, particularly among population groups with higher smoking prevalence. (See the recommendation for research on factors that may influence the use of nicotine replacement therapy and e-cigarettes.)

How the recommendations might affect practice

Conversations guided by each person's preference are good practice and should already be taking place. However, extra time may be needed for people providing stop-smoking support or advice to discuss the intervention options with people who want to stop smoking, especially for the additional advice on e-cigarettes, and, potentially, on cytisinicline which has a complex treatment regimen. If these recommendations lead people to quit successfully with fewer unsuccessful attempts, this may mean fewer appointments per person.

Commissioning Allen Carr's Easyway in-person group seminar through the NHS or local authority would have resource implications for stop-smoking services. But the intervention is cost effective and although the initial cost was higher than the comparator (Quit.ie or local stop-smoking services group), this would be quickly offset (within 5 to 7 years) by the reduction in comorbidities and associated healthcare costs. The committee were also advised that the NHS or local authority is likely to be able to negotiate a discount for the intervention if enough people take up the offer.

The committee noted that some people living in rural areas may need help with travel costs if they need to travel long distances to attend the in-person seminar.

Return to recommendations

Advice on nicotine-containing e-cigarettes

Recommendations 1.12.14 to 1.12.18

Why the committee made the recommendations

Evidence showed that nicotine-containing e-cigarettes can help people to stop smoking and are of similar effectiveness to other cessation options such as varenicline or long-acting and short-acting NRT.

Benefits and harms of e-cigarettes

The extensive harms of smoking are well known, and the committee agreed it is unlikely that e-cigarettes could cause similar levels of harm. But they also agreed that for people who do not smoke, it is unlikely that inhaling vapour from an e-cigarette is as low risk as not doing so, although the extent of that risk is not yet known. They discussed the potential benefits and risks of using nicotine-containing e-cigarettes- to stop smoking.

There was a small amount of evidence about short-term adverse events of e-cigarettes that did not show that they caused any more adverse events than NRT, e-cigarettes without nicotine or no treatment. The committee had low confidence in this evidence because studies were usually designed to investigate effectiveness and not adverse events, meaning they may not have been large enough to show an effect.

There were only 2 studies about the long-term harms of using nicotine-containing e-cigarettes, and the committee discussed the uncertainty of the evidence and their concerns with these studies. A call for evidence did not produce any additional evidence in this area.

The committee agreed that there is insufficient evidence to tell whether e-cigarettes cause long-term effects. E-cigarettes are relatively new devices, and it is important to understand whether they cause any health harms or benefits aside from their potential to reduce smoking-related harm (see the recommendation for research on health effects of e-cigarettes).

The committee recognised the need for evidence about what factors may influence use of

e-cigarettes. So they made recommendations for research relating to any possible impacts of the amount of nicotine and frequency of use, and flavourings.

The committee discussed the outbreak of serious lung disease in the US in 2019, which US authorities identified was largely caused by vaping cannabis products containing vitamin E acetate. They also noted there has been a Medicines and Healthcare products Regulatory Agency (MHRA) Drug Safety Update highlighting serious lung injury with e-cigarettes issued in January 2020 (E-cigarette use or vaping: reporting suspected adverse reactions, including lung injury). The committee discussed that the UK has well-established regulations for e-cigarettes that restrict what they can contain.

Experts from the MHRA described to the committee the monitoring process for both short- and long-term harms of using e-cigarettes. Monitoring is ongoing and the evidence may change in the future, but the committee was not aware of any major concerns being identified. Accurate information relies on adverse events being reported, so the committee recommended that people providing stop-smoking support or advice should actively report any suspected adverse events and encourage people to report any that they experience.

The committee used their knowledge and experience to supplement the very limited and uncertain evidence about harms. They agreed that because many of the harmful components of cigarettes are not present in e-cigarettes, switching to nicotine-containing e-cigarettes was likely to be significantly less harmful than continuing smoking. So, the committee agreed that people should be able to access them as part of the range of interventions they can choose to use (see the section on stop-smoking interventions). They also agreed that people should be given up-to-date information on what is known about e-cigarettes to help them make an informed decision about whether to use them.

The committee agreed that with the limited data on effects of longer-term use, people should only use e-cigarettes for as long as they help prevent them going back to smoking. They also agreed that people should be discouraged from continuing to smoke when using e-cigarettes, even if they are smoking less, because there is no information on whether this will reduce their harm from smoking.

The committee discussed that it is more likely that people will not get enough nicotine to help them stop smoking, than get too much. They agreed that not getting enough nicotine is likely to increase the risk that the person will return to smoking, so they recommended that people should be encouraged to use as much as they need and told how to use the

products effectively.

How the recommendations might affect practice

Extra time may be needed to discuss e-cigarettes with people who are interested in using them. If these recommendations lead to more successful quit attempts, this may mean fewer appointments per person and substantial savings in downstream costs associated with smoking.

Return to recommendations

Stop-smoking support in mental health services

Recommendation 1.14.19

Why the committee made the recommendation

The committee agreed the importance of stop-smoking support being available to all, and that people with mental health conditions should not be treated differently in this. However, because those with mental health conditions have a higher prevalence of smoking, and are less likely to access standard smoking cessation services and have lower quit rates, it is important to look at whether additional support could be appropriate.

There was a small amount of evidence about tailored smoking cessation interventions for people with mental health conditions. The evidence of effectiveness identified was in populations with severe mental health conditions such as bipolar disorder, schizophrenia or post-traumatic stress disorder. However, the committee noted there was a lack of consensus of what constitutes a severe mental health condition. They heard from experts that people with other mental health conditions may need additional support as well. This applies both at an individual level and, for those in mental health settings, at a system level. The committee agreed that additional support should be offered to people with severe mental health conditions, and although it might be considered for other people with mental health conditions, there was insufficient evidence to make a wider recommendation. The committee noted that the recommended additional support would fit with current stop-smoking provision. Furthermore, the committee identified this as an important research gap that needs to be addressed to reduce health inequalities (see the recommendation for research on support for people with mental health conditions to stop

smoking).

How the recommendation might affect practice

This potential additional support may need extra time and additional appointments. If these recommendations lead to more successful quit attempts, this may mean fewer appointments per person and substantial savings in downstream costs associated with smoking.

Return to recommendations

Nicotine-containing e-cigarettes for harm reduction

Recommendation for research 6

Why the committee made the recommendation for research

No evidence was found on the use of e-cigarettes specifically for harm reduction for people who do not want, or are not ready, to stop smoking in one go. So, the committee chose not to make recommendations on using e-cigarettes for harm reduction. They did discuss that e-cigarettes may be used in this way and that there may be substantial dual use; that is, when someone is both smoking and using e-cigarettes.

The committee agreed that more information is needed about the use of e-cigarettes for those who may wish to reduce the amount they smoke.

Return to the recommendation for research

Supporting people trying to stop smoking

Recommendations 1.17.1 and 1.17.2

Why the committee made the recommendations

The committee agreed that strategies to avoid relapsing are an important part of stop-

smoking advice and support, and are likely to be most effective when introduced early in the process and regularly revisited.

Evidence about NRT for preventing relapse was mixed. Although there was evidence that they may be effective in people who had recently quit, using a single type of fast-acting NRT did not reduce relapse with any certainty when people had stopped smoking for longer. The committee discussed this evidence and noted that in their experience, using NRT for longer can stop people relapsing to smoking, particularly if more than 1 type of NRT is used (usually combining patches with a fast-acting form of NRT). They discussed that only offering NRT for 12 weeks could cause people to relapse.

Evidence showed that if people who have used varenicline and bupropion to stop smoking continue taking it for longer, this improves their chances of staying stopped. This included people diagnosed with serious mental illness. There were a small number of studies and they investigated different groups of people and used varenicline in different ways, so the committee had some uncertainty about the evidence.

The committee reflected on the mixed findings from the evidence. They agreed that, because preventing relapse is so important for people who have been able to stop smoking, offering longer-term pharmacotherapy to help prevent relapse was reasonable. The committee noted that bupropion was not licensed for relapse prevention. The studies that evaluated bupropion for this indication had different dosing regimens, so the committee did not specify what dose or duration of bupropion was most effective for preventing relapse.

The committee recognised the need for more evidence about which nicotine-containing products or combination of products are best at preventing relapse after a successful quit attempt (see the recommendations for research on relapse prevention and relapse prevention after enforced, temporary quit).

How the recommendations might affect practice

Stop-smoking advisers can use existing appointments to provide information about preventing relapse to people who want to stop smoking, so this is not expected to have a resource impact, though there may costs associated with prescribing additional pharmacotherapies.

Return to recommendations

Reviewing the approach for people trying to stop smoking, cutting down or stopping temporarily

Recommendations 1.17.6 and 1.17.7

Why the committee made the recommendations

The committee discussed that it is important to review any stop-smoking or harm-reduction approach taken so that any problems can be addressed. They agreed that it can take someone multiple attempts to stop smoking for good. Encouraging people who have relapsed to smoking and talking to them about trying again may mean that they stay in touch with the service and are more likely to stop smoking in the long term.

How the recommendations might affect practice

Stop-smoking advisers can use existing appointments to discuss with people the approach they are taking and future attempts to stop or reduce harm from smoking, so this is not expected to have a resource impact.

Return to recommendations

Stop-smoking support in pregnancy: identification and referral

Recommendations 1.18.1 to 1.18.3

Why the committee made the recommendations

Stopping smoking in pregnancy is important for the health of both the woman, or trans man or non-binary person, and their baby.

Existing recommended practice, based on NICE's previous guideline on stopping smoking in pregnancy and after childbirth, is to offer opt-out provision during pregnancy. The evidence about opt-out referral systems was mixed, but the most recent evidence showed that it resulted in higher self-reported quit rates and more engagement with stop-smoking support.

Most current evidence uses carbon monoxide levels of 4 parts per million (ppm) as the cut-off for referral. Based on this and their expertise, the committee recommended that a carbon monoxide reading of 4 ppm or above would be an appropriate level for automatically referring to stop-smoking support. This also aligns with the NHS Saving Babies' Lives Care Bundle.

The evidence about women's views on opt-out referral showed that giving women information on carbon monoxide testing and the automatic referral was an important factor in whether they accepted the referral and took up the support. The committee discussed whether there was a specific need for a recommendation on giving information, because all clinical treatment pathways should ensure that people are fully informed and take an active part in their care. They agreed that a recommendation would be helpful in this case, because they considered opt-out treatment is not common in most areas of care.

During development of this guideline, carbon monoxide monitoring was not being used because of COVID-19 practice changes. The committee acknowledged that during the COVID-19 pandemic referral decisions may need to be made without using carbon monoxide monitoring.

How the recommendations might affect practice

The recommendations reflect current widespread practice and so should have little resource impact.

Return to recommendations

Nicotine replacement therapy and other pharmacological support

Recommendations 1.20.6 to 1.20.8 and 1.20.10

Why the committee made the recommendations

NICE's 2010 guideline on stopping smoking in pregnancy and after childbirth (replaced by this guideline) recommended nicotine replacement therapy (NRT) for pregnant women only if they are not able to stop smoking using a behavioural intervention without NRT, and once they have stopped smoking. New evidence showed that NRT may help women stop

smoking in pregnancy when added to a behavioural intervention.

The committee discussed that women may stop smoking temporarily during pregnancy and relapse afterwards. There was no evidence about continuing NRT after pregnancy to prevent this but, based on their expert opinion, the committee agreed it may be useful.

Evidence showed that advice from healthcare professionals, particularly midwives, was valuable to pregnant women and contributed to their decisions about using NRT. The evidence also showed that consistent advice addressing the main concerns women tend to have about NRT during pregnancy (such as addictiveness, potential side effects and any pregnancy impacts) may help women to feel comfortable using NRT during and after pregnancy.

There is little evidence about the effectiveness or safety of using nicotine-containing e-cigarettes to help support stop smoking in pregnancy. Many of the studies in the effectiveness meta-analysis for nicotine replacement therapies were over 10 years old and most used doses of nicotine that would now be considered to be low. The committee therefore made recommendations for research to help understand what type and dose of NRT is most effective and the views and concerns of pregnant women and their healthcare professionals about using nicotine-containing e-cigarettes in pregnancy.

Since the publication of this guideline, a National Institute for Health and Care Research trial on helping pregnant smokers quit has been published comparing e-cigarettes and nicotine patches. NICE reviewed this trial with the help of topic experts (see the 2023 exceptional surveillance review). Although it provides some new data, there are still important gaps in the evidence – particularly for longer-term outcomes. So NICE decided that more evidence on effectiveness and safety is still needed before it can update these recommendations.

How the recommendations might affect practice

The change in recommendations since NICE's previous guideline may increase prescriptions of NRT during pregnancy, and potentially increase how long it is prescribed for. If this leads to more cases of successful quitting, it will create considerable savings downstream.

Return to recommendations

Incentives to stop smoking

Recommendations 1.20.12 to 1.20.14

Why the committee made the recommendations

Evidence showed that offering financial incentives to help pregnant women stop smoking was both effective and cost effective. Voucher incentives were acceptable to many pregnant women and healthcare providers. The committee noted that these are already being used in some areas.

The committee discussed and agreed with the evidence that 'contingent rewards' (given only if biochemical tests prove the woman has stopped) were more effective than guaranteed payments given whether the woman has stopped or not.

More evidence is needed to find out what value of incentive works best. Evidence from the UK showed that schemes in which around £400 could be gained in vouchers staggered over time (with reductions for each relapse made) were effective and cost effective, so the committee included this amount as a guide.

Based on the evidence and their expertise, the committee agreed that incentive schemes that include both those who are pregnant and a significant other supporter could have a better chance of success.

They also agreed that some staff may be unfamiliar with incentive schemes and would benefit from training to help deliver them.

Although the guideline recommends that vouchers should be provided only to those with an abstinence validated by a biochemical method, the committee acknowledged that during the COVID-19 pandemic carbon monoxide validation may not be being used. While this is the case, vouchers are recommended even if biochemical validation using carbon monoxide is not possible.

How the recommendations might affect practice

Incentive schemes are already used in some areas. Areas that do not already use them will need staff time to run them, and financial resources to award the vouchers. Training for people promoting and delivering the incentive schemes may need resources.

Return to recommendations

Commissioning and designing services

Recommendations 1.22.1 and 1.22.2

Why the committee made the recommendations

The committee looked at a large amount of evidence assessing the relative effectiveness of interventions for stopping smoking (medicinally licensed products and nicotine-containing e-cigarettes, alone or in combination). Most of the interventions or combinations of interventions were delivered with behavioural support. The committee agreed which interventions should be accessible (see the rationale and impact section for stop-smoking interventions). They agreed that the recommendation from NICE's 2018 guideline on stop-smoking interventions and services (replaced by this guideline) to make stop-smoking interventions available through local plans and approaches to health and wellbeing was still relevant, so they drew on that to make a new recommendation.

The committee noted that not all medicinally licensed products are available in all stop-smoking services, and so local arrangements are in place to ensure that these are accessible when needed. Nicotine-containing e-cigarettes are not licensed medicines so cannot currently be provided on prescription. However, there are ways of increasing their accessibility, for example by giving evidence-based advice about them and information on where people can access them. The committee were aware that some services use vouchers or starter pack schemes.

Based on evidence and their experience of the use of NRT for preventing relapse, the committee recommended it for longer-term use (see the rationale and impact section for supporting people trying to stop smoking) and agreed this needed to be reflected in service specifications to make sure it was made available.

The committee heard from experts that smoking prevalence is high in some population groups that may not be well served by existing stop-smoking provision (such as those with mental health conditions, or those who identify as LGBT+, or those with low income). And that although these groups may be motivated to stop smoking, they may experience additional challenges to successfully stopping (see the equality impact assessment).

We did not find any evidence on how to tailor effective and cost-effective interventions to

ensure that they are engaging and accessible for under-served groups, or how acceptable those interventions may be for those groups. The committee identified this as an important gap that needs to be addressed to reduce health inequalities (see the recommendation for research on stop-smoking interventions for under-served groups).

How the recommendations might affect practice

The committee noted that schemes are already in place in some areas to support starting the use of nicotine-containing e-cigarettes for stopping smoking.

NICE's 2013 guideline on smoking harm reduction already recommended that service specifications require providers of stop-smoking support to offer long-term NRT.

Return to recommendations

Stop-smoking support in secondary care

Recommendation 1.22.14

Why the committee made the recommendation

The committee agreed that nicotine-containing products should be available for sale in secondary care settings to help people stop smoking and to support temporary abstinence for patients, staff and visitors because hospital grounds are covered by smokefree legislation.

How the recommendation might affect practice

Making the full range of effective options available for sale may be a change to current practice, but it is not expected to have a large impact on resources.

Return to recommendations

Context

In 2023, 11.9% of adults in the UK smoked cigarettes. Rates were higher than average for some groups, including those in routine and manual occupations, and those with mental health conditions. Although this is a decline of more than 8 percentage points since 2011, smoking is still the main cause of preventable illness and premature death in England (Office for National Statistics [2023] Adult smoking habits in the UK). In 2017 to 2018, an estimated 4% (489,300) of NHS hospital admissions in England, and an estimated 16% (77,800) of all deaths, were attributed to smoking (NHS Digital 2019 Statistics on smoking, England).

Treating 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 (NHS England Health matters: tobacco and alcohol CQUIN).

In 1 in 5 local authorities, the specialist service has been replaced by an integrated lifestyle service (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).

This guideline forms a single source for tobacco guidance that updates and replaces NICE's guidelines on:

- smoking: workplace interventions (PH5, 2007)
- smoking: preventing uptake in children and young people (PH14, 2008)
- smoking prevention in schools (PH23, 2010)
- smoking: stopping in pregnancy and after childbirth (PH26, 2010)
- smokeless tobacco: South Asian communities (PH39, 2012)
- smoking: harm reduction (PH45, 2013)
- smoking: acute, maternity and mental health services (PH48, 2013)
- stop-smoking interventions and services (NG92, 2018).

This guideline includes recommendations on harm reduction, which was previously

covered by PH45. In PH45, harm reduction included cutting down before stopping smoking, cutting down longer term, temporary abstinence, or stopping smoking altogether by switching to a medicinally licensed nicotine-containing product. In the current guideline, switching completely from smoking to any nicotine-containing product is considered to be stopping smoking rather than harm reduction.

The approaches for harm reduction in this guideline should not detract from providing the highly cost-effective interventions to help people stop smoking altogether. Instead, recommendations on harm reduction are intended to support and extend the reach and impact of existing stop-smoking support. Although existing evidence is not clear about the health benefits of smoking reduction, people who reduce the amount they smoke are more likely to stop smoking eventually.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic page on smoking and tobacco.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

Update information

February 2025: We have reviewed the evidence for cytisinicline as a medicinally licensed product. We have made a new recommendation, and have updated other recommendations on stop-smoking interventions and pharmacological support during pregnancy, following this review. These changes are marked **[2025]**, **[2010, amended 2025]** and **[2013, amended 2025]**. We have also added a link to NICE's technology appraisal guidance on varenicline in the section on stop-smoking interventions.

In some cases, minor changes have been made to the wording to bring the language and style up to date, without changing the meaning.

January 2023: We have amended the recommendation on carbon monoxide testing at antenatal appointments to reduce the number of tests for women with low carbon monoxide readings and no history of smoking, in line with new NHS England guidance. This recommendation is marked **[2023]**.

August 2022: We have reviewed the evidence on Allen Carr's Easyway to stop-smoking in-person seminar for people who smoke.

Recommendations updated as a result of this review are marked **[2021, amended 2022]**.

November 2021: This guideline updates and replaces NICE's guidelines on:

- smoking: workplace interventions (PH5, 2007)
- smoking: preventing uptake in children and young people (PH14, 2008)
- smoking prevention in schools (PH23, 2010)
- smoking: stopping in pregnancy and after childbirth (PH26, 2010)
- smokeless tobacco: South Asian communities (PH39, 2012)
- smoking: harm reduction (PH45, 2013)
- smoking: acute, maternity and mental health services (PH48, 2013)
- stop-smoking interventions and services (NG92, 2018).

We have reviewed the evidence and made new recommendations, if relevant, on:

- digital and mass-media stop-smoking campaigns for preventing uptake
- proxy purchasing and supply of illicit tobacco
- impact of e-cigarettes on future smoking behaviour
- Smokefree Class Competitions for preventing uptake (no recommendations made)
- opt-out referral to stop-smoking support in pregnancy
- incentives for stopping smoking in pregnancy
- effectiveness, safety and acceptability of nicotine replacement therapy and e-cigarettes for stopping smoking in pregnancy
- effectiveness of treatments for stopping smoking
- barriers and facilitators to using e-cigarettes for stopping smoking
- long-term health effects of using e-cigarettes
- relapse prevention.

These recommendations are marked **[2021]**.

We have also made some changes without an evidence review (marked as **amended 2021**) to:

- avoid duplicating other NICE guidance, and remove duplication or improve alignment between recommendations from different guidelines
- remove any recommendations about providing information or tailoring support and treatment that overlap with the general principles in NICE's guideline on patient experience in adult NHS services
- remove prevention strategies that are no longer standard practice or considered appropriate, particularly fear-based messaging for children and young people
- change the emphasis of prevention campaigns to support policy rather than enforcement

- remove mention of the ASSIST (A Stop-Smoking in Schools Trial) intervention, because current evidence has not been evaluated
- clarify who should be taking action
- clarify where mention of health problems relates specifically to smoking-related problems
- reflect uncertainty about the impact of long-term use of licensed nicotine-containing products
- clarify expected minor side effects from stopping smoking, so these are not mistaken for effects of licensed nicotine-containing products or other interventions
- clarify what interventions were intended to be used in recommendations that previously talked about 'pharmacotherapies'
- clarify reasons for monitoring prescribed medicines in people who are stopping or trying to stop smoking
- remove mention of people in custodial settings, because these are now all smokefree.

For more information about how the original guidelines were amalgamated and any changes that were made to the recommendations, see the summary of deleted and amended recommendations.

Minor changes since publication

May 2023: We removed the repeat of the explanation about the effectiveness and safety of nicotine-containing e-cigarettes from the recommendations section to avoid duplication. This information is still included in the section on why the committee made the recommendations.

March 2023: We checked the impact of helping pregnant smokers quit: a multi-centre randomised controlled trial of e-cigarette and nicotine patches on the recommendations on stop-smoking support in pregnancy. We did not update the recommendations, but added more information to the section on why the committee made the recommendations to explain the uncertainty about the effectiveness and safety of nicotine-containing e-cigarettes. We also explained this in the recommendations section. For more information, see the surveillance decision.

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