Stop smoking interventions and services

NICE guideline

Draft for consultation

September 2017

This guideline covers stop smoking interventions and services delivered in primary care and community settings for everyone over the age of 12. The recommendations focus on vulnerable groups who find it hard to quit or who smoke a lot.

Who is it for?

- Commissioners of stop smoking services.
- Providers of stop smoking interventions or services, including those in the voluntary and community sectors who have a role or responsibility for this.
- Health, social care and other frontline staff with links to stop smoking services
- Health and wellbeing boards.

It may also be relevant for:

- Members of the public who want to stop smoking or who want to help others to stop.

This guideline will update and replace NICE guidelines PH1 (published March 2006) and PH10 (published February 2008).

We have updated or added new recommendations about interventions to help people stop smoking.

You are invited to comment on the new and updated recommendations in this guideline. These are marked as **[2018]** if the evidence has been reviewed.

You are also invited to comment on recommendations that NICE proposes to delete from the 2006 or 2008 guidelines.

We have not updated recommendations shaded in grey, and cannot accept comments on them. In some cases, we have made minor wording changes for clarification.

See Update information for a full explanation of what is being updated.

This guideline contains the draft recommendations, information about implementing the guideline, context, the guideline committee's discussions and recommendations for research. Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the evidence reviews, the scope, and details of the committee and any declarations of interest.

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Contents

Recommendations

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.

1.1 Providing stop smoking interventions and services to meet local needs

1.1.1 Use sustainability and transformation partnerships and plans, health and wellbeing strategies, and any other relevant local strategies and plans to ensure evidence-based stop smoking interventions and services are available for everyone who smokes. **[2018]**

1.1.2 Use the joint strategic needs assessment to estimate smoking prevalence among the local population. **[2018]**

1.1.3 Prioritise specific groups who are at high risk of tobacco-related harm for intervention. These may include:

- people with mental health problems, including mental health disorders (see NICE's guidelines on smoking: acute, maternity and mental health services and depression in adults)
- people with health conditions made worse by smoking or who have a smoking-related illness (see NICE's guidelines on cardiovascular disease: identifying and supporting people most at risk of dying early and chronic obstructive pulmonary disease)
- communities with particularly high smoking prevalence
- people in custodial settings
- populations with a high prevalence of smoking-related morbidity or a particularly high susceptibility to harm
- people living in disadvantaged circumstances

- pregnant women who smoke (see NICE's guideline on smoking: stopping in pregnancy and after childbirth). **[2018]**

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

- treating at least 5% of the estimated local population who smoke each year
- achieving a successful quit 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) in the third and fourth week after the quit date. **[2018]**

1.1.5 Check and confirm quit attempts using carbon monoxide monitoring, with success defined as less than 10 parts per million (ppm) at 4 weeks after the quit date. This does not imply that treatment should stop at 4 weeks. **[2018]**

1.1.6 Monitor performance data for specialist stop smoking services routinely and independently. Make these results publicly available. **[2018]**

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

1.2 Advice and referral

Healthcare workers and others who advise people how to quit smoking

1.2.1 At every opportunity, ask people if they smoke and advise them to stop smoking in a way that is sensitive to their preferences and needs. **[2018]**

1.2.2 Refer people who want to stop smoking to a local specialist stop smoking service. **[2018]**

1.2.3 If people are not ready to stop smoking:

- 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 NICE's guideline on smoking: harm reduction)
- encourage them to seek help to quit smoking completely in the future
- record the fact that they smoke and ask them about it again at every opportunity. **[2018]**

Healthcare professionals who offer smoking cessation advice and referral

1.2.4 If people opt out of a referral to a local specialist stop smoking service, offer them pharmacotherapy and brief advice. **[2018]**

1.2.5 Discuss how to stop smoking with people who want to quit (see the National Centre for Smoking Cessation and Training (NCSCT) programmes). **[2018]**

1.2.6 Encourage people to discuss their use of personally purchased nicotine replacement products. **[2018]**

1.2.7 Encourage people being referred for elective surgery to stop smoking before their surgery. Offer to refer them to the local specialist stop smoking service. **[2018]**

See also recommendations 1, 7 and 9 in NICE's guideline on smoking cessation in secondary care: acute, maternity and mental health services.

1.3 Smoking cessation aids

All staff providing stop smoking interventions and services: agree the approach

1.3.1 Discuss any stop-smoking aids the person has used before, including personally purchased nicotine replacement products (see recommendations 1.3.8 and 1.3.9). **[2018]**

1.3.2 Set out the pharmacotherapy and behavioural options as listed in recommendations 1.3.5 and 1.3.10. **[2018]**

1.3.3 Explain:

- that a combination of pharmacotherapy and behavioural support is likely to be most effective
- which combination of pharmacotherapy is most effective
- any potential adverse effects from the different pharmacotherapies on offer. **[2018]**

1.3.4 Agree the approach to stopping smoking that best suits the person's preferences. Review this approach at future visits. **[2018]**

Providing stop smoking aids

Pharmacotherapy

1.3.5 Offer single or combined pharmacotherapy based on the person's preferences and the likelihood that they will follow the course of treatment. Choose from:

- varenicline
- bupropion
- short-acting nicotine replacement therapy (NRT; gum, inhalator, lozenge, microtabs or spray)
- long-acting NRT (nicotine patches)
- varenicline and long-acting NRT
- varenicline and short-acting NRT
- bupropion and long-acting NRT
- bupropion and short-acting NRT
- long-acting and short-acting NRT. **[2018]**

1.3.6 Prescribe varenicline or bupropion (or NRT if provided on prescription) while the person still smokes. Agree a quit date set within the first 2 weeks of bupropion treatment and within the first 1 to 2 weeks of varenicline

treatment. Reassess the person shortly before the prescription ends. **[2018]**

1.3.7 Consider NRT[1] for young people over 12 who are smoking and dependent on nicotine. If this is prescribed, offer it within a specialist stop smoking service. **[2018]**

Nicotine replacement products on general sale

1.3.8 Offer advice on using nicotine replacement products on general sale, including e-cigarettes. **[2018]**

1.3.9 Ask people about their use of nicotine-containing e-cigarettes and explain that:

- although these products are not licensed medicines, they are regulated by the Tobacco and Related Products Regulations 2016
- some smokers have found them helpful to quit smoking cigarettes and
- there is currently little evidence on the long-term benefits or harms of these products. **[2018]**

Be aware that Public Health England[2] and the Royal College of Physicians[3] have stated that e-cigarettes are significantly less harmful to health than tobacco.

Behavioural support

1.3.10 If people turn down pharmacotherapy, offer behavioural support (individual or group) based on individual needs or preferences. **[2018]**

1.3.11 Ensure people have behavioural support from trained stop smoking staff (see the NCSCT's training standards). **[2018]**

[1] The UK marketing authorisation for nicotine replacement therapy products varies for use in children and young people under 18. Refer to the summary of product characteristics for prescribing information on individual nicotine replacement therapy preparations.

[2] E-cigarettes around 95% less harmful than tobacco estimates landmark review Public Health England

[3] See Nicotine without smoke: Tobacco harm reduction Royal College of Physicians

Role of providers of stop smoking interventions or services

1.3.12 Specialist stop smoking services should:

- offer behavioural support, in combination with pharmacotherapy, based on individual needs or preferences
- offer text messaging support as an adjunct to existing stop smoking support. **[2018]**

1.3.13 GPs should offer pharmacotherapy plus brief advice based on individual needs or preferences. **[2018]**

1.3.14 All other prescribers should:

- offer pharmacotherapy plus very brief advice based on individual needs or preferences (see NCSCT training on very brief advice)
- offer text messaging support as an adjunct to existing stop smoking support. **[2018]**

1.4 Telephone quitlines

1.4.1 Ensure publicly sponsored telephone quitlines offer a rapid, positive and authoritative response. Where possible, callers whose first language is not English should have access to information and support in their chosen language. **[2008]**

1.4.2 All staff should receive smoking cessation training (at least in brief interventions to help people stop smoking). **[2008]**

1.4.3 Staff who offer counselling should be trained to at least NCSCT level 2 (individual behavioural counselling) and preferably, they should hold an appropriate counselling qualification. Training should comply with the Standard for training in smoking cessation treatments or its updates. **[2008, amended 2018]**

1.5 People with cardiovascular or respiratory disease

1.5.1 Offer people with cardiovascular or respiratory disease who smoke behavioural support from the local specialist stop smoking service or brief advice in primary care. Also offer prescriptions of NRT, varenicline or bupropion, according to clinical judgement. **[2008, amended 2018]**

See also NICE's technology appraisal guidance on varenicline for smoking cessation, NICE's guideline on chronic obstructive pulmonary disease, and recommendations 1, 7 and 9 in NICE's guideline on smoking: acute, maternity and mental health services.

1.6 Women who are pregnant or planning a pregnancy, and their family

1.6.1 At the first contact with a pregnant woman, ask her whether she smokes and advise her to stop in a way that is sensitive to her preferences, needs and circumstances. Provide information about the risks of smoking to the unborn child and the hazards of exposure to secondhand smoke. Address any concerns she and her partner or family may have about stopping smoking. **[2008]**

1.6.2 Offer personalised information, advice and support on how to stop smoking. Encourage pregnant women to use local stop smoking services and the NHS smokefree helpline by providing details on when, where and how to access them. Consider visiting pregnant women at home if it is difficult for them to attend specialist services. **[2008]**

1.6.3 Throughout the pregnancy and beyond, monitor the smoking status of pregnant women and offer stop smoking advice, encouragement and support. **[2008]**

1.6.4 Discuss the risks and benefits of NRT with pregnant women who smoke, particularly those who do not wish to accept the offer of help from the local specialist stop smoking service. If a woman expresses a clear wish to

receive NRT, use professional judgement when deciding whether to offer a prescription. **[2008]**

1.6.5 Advise pregnant women using nicotine patches to remove them before going to bed. **[2008]**

1.7 Nicotine replacement therapy for mothers of infants and young children, and their family

1.7.1 At the first contact, discuss the smoking status of the woman and her partner, provide information about the risks of secondhand smoke to young children and address any concerns about stopping smoking. **[2008]**

1.7.2 Offer information, advice and support on how to quit smoking and encourage use of local specialist stop smoking services by providing details on when and where they are held and whether they need a referral. **[2008]**

1.7.3 Use any opportunity to offer mothers who are (or who may be) eligible for the Healthy Start scheme practical, personalised information, advice and support to help them stop smoking. **[2008]**

1.7.4 Discuss the risks and benefits of NRT with breastfeeding mothers who have tried but have been unable to stop smoking unaided. Use professional judgement to decide whether or not to advise use of NRT or to offer an NRT prescription. **[2008]**

1.7.5 Advise breastfeeding women using nicotine patches to remove them before going to bed. **[2008]**

1.8 Education and training

Local specialist stop smoking services

1.8.1 Ensure training and continuing professional development is available for all those providing stop smoking advice and support. **[2008]**

1.8.2 Ensure training complies with the Standard for training in smoking cessation treatments or its updates. **[2008]**

Healthcare workers and others who advise people how to quit smoking

1.8.3 Train all frontline healthcare staff to offer brief advice on how to stop smoking in accordance with recommendations 1.2.4 and 1.2.5. Also train them to make referrals, if necessary and possible, to local specialist stop smoking services. **[2008]**

1.8.4 Ensure training on how to support people to stop smoking is part of the core curriculum for healthcare undergraduates and postgraduates. **[2008]**

1.8.5 Provide additional, specialised training for those working with specific groups, for example, people with mental health problems and pregnant women who smoke. **[2008]**

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

For recommendations for secondary care providers see NICE's guideline on smoking: acute, maternity and mental health services.

1.9 Campaigns to promote awareness of local stop smoking services

1.9.1 Coordinate communications strategies to support the delivery of stop smoking services, telephone quitlines, school-based interventions, tobacco control policy changes and any other activities designed to help people to stop smoking. **[2008]**

1.9.2 Develop and deliver communications strategies in partnership with the NHS, 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' quit messages that are non-judgemental, empathetic and respectful, for example, 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.
- Consider targeting and tailoring campaigns towards low income and some minority ethnic groups to address inequalities. **[2008, amended 2018]**

For recommendations on campaigns for secondary care providers see recommendation 12 in NICE's guideline on smoking: acute, maternity and mental health services.

1.10 Closed institutions

1.10.1 Develop a policy, using guidance provided by the Department of Health, to ensure effective stop smoking services are provided and promoted in prisons, military establishments and long-stay health centres, such as mental healthcare units. **[2008]**

See also NICE's guideline on smoking: workplace interventions and recommendations 9 and 10 in NICE's guideline smoking: harm-reduction.

1.11 Employers

1.11.1 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.

- Direct people who wish to stop smoking to local stop smoking services.
- Implement NICE's guideline on smoking: workplace interventions.

[2008]

For recommendations for employees of secondary care providers see NICE's guideline on smoking: acute, maternity and mental health services.

Terms used in this guideline

Brief interventions in health and community care

Brief interventions involve opportunistic advice, discussion, negotiation or encouragement. They are commonly used in many areas of health promotion and are delivered by a range of primary and community care professionals.

For smoking cessation, brief interventions typically take between 5 and 10 minutes and may include 1 or more of the following:

- simple opportunistic advice to stop
- an assessment of the patient's commitment to quit
- an offer of pharmacotherapy or behavioural support
- provision of self-help material and referral to more intensive support such as the specialist stop smoking services.

Consumer e-cigarettes

An electronic cigarette or e-cigarette is a handheld electronic device that vaporises a liquid. The user inhales the vapour. The liquid is usually made of nicotine, propylene glycol, glycerine, and flavourings. Some e-liquids do not contain nicotine.

The term 'consumer' is used here to distinguish e-cigarettes on general sale from those that are licensed by the Medicines and Healthcare products Regulatory Agency (MHRA) as medicinal products with a therapeutic indication for smoking cessation and harm reduction. Consumer e-cigarettes that do not state they are for health use will also be subject to regulation by the MHRA (according to the revised European Union Tobacco Products Directive) but will not be a granted a licence for medicinal use.

Group behavioural support

Group behaviour support involves scheduled meetings where people who smoke receive information, advice and encouragement and some form of behavioural intervention (for example, cognitive behavioural therapy). This therapy is offered weekly for at least the first 4 weeks of a quit attempt (that is, for 4 weeks after the quit date). It is normally combined with pharmacotherapy).

Individual behavioural counselling

Individual behavioural counselling involves scheduled face-to-face meetings between someone who smokes and a counsellor trained in smoking cessation. Typically, it involves weekly sessions over a period of at least 4 weeks after the quit date and is normally combined with pharmacotherapy.

Nicotine replacement products on general sale

This includes over the counter products and nicotine-containing e-cigarettes.

For other public health and social care terms see the Think Local, Act Personal Care and Support Jargon Buster.

Putting this guideline into practice

[This section will be finalised after consultation]

NICE has produced tools and resources [link to tools and resources tab] to help you put this guideline into practice.

[Optional paragraph if issues raised] Some issues were highlighted that might need specific thought when implementing the recommendations. These were raised during the development of this guideline. They are:

- [add any issues specific to guideline here]
- [Use 'Bullet left 1 last' style for the final item in this list.]

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.

4. **Think about what data you need to measure improvement** and plan how you will collect them. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a

senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

Context

Smoking is the main cause of preventable illness and premature death in England. In 2014/15, an estimated 475,000 NHS hospital admissions in England were linked to smoking-related conditions. An estimated 17% (78,000) of all deaths in 2014 were attributed to smoking (Statistics on smoking Health and Social Care Information Centre).

Treating smoking-related illness is estimated to cost the NHS £2.5 billion a year (Statistics on smoking) and the wider cost to society is approximately £12.7 billion a year (The local costs of smoking Action on Smoking and Health).

The number of people using stop smoking services has declined (Statistics on NHS stop smoking services in England – April 2014 to March 2015 Health and Social Care Information Centre). Reasons for this are not clear. The number of prescriptions of stop smoking medications has also fallen by over 50% since 2011 (Statistics on NHS stop smoking services in England – April 2014 to March 2015).

This guideline will update NICE's guideline on brief interventions and referral for smoking cessation in primary care and other settings and recommendations 1, 2, 4, 6 and 10 of NICE's guideline on stop smoking services.

This guideline will also incorporate recommendation 7, and recommendations 11 to 16 of NICE's guideline on stop smoking services. Recommendation 5 of that guideline has been updated by NICE's guideline on smoking: harm reduction, recommendation 6 has been partially updated by NICE's guideline on smoking: acute, maternity and mental health services and recommendations 8 and 9 have been updated by NICE's guideline on smoking: stopping in pregnancy and after childbirth.

Commissioning

Local authorities are responsible for commissioning tobacco control and stop smoking services. They are guided by the Public Health Outcomes Framework, their local joint strategic needs assessment and joint health and wellbeing strategy.

This guideline will help local authorities and the NHS to meet smoking-related outcomes within the 'health improvement' domain in the Public Health Outcomes Framework 2016 to 2019 (Department of Health).

More information

To find out what NICE has said on topics related to this guideline, see our web page on smoking and tobacco.

The committee's discussion

Overview

The committee were tasked with partially updating recommendations from 2 NICE guidelines about smoking cessation. The aim was to develop a single NICE guideline about smoking cessation that would reflect changes in current practice and commissioning. Some recommendations from the 2006 and 2008 guidelines were not reviewed by the committee as part of this update, these original

recommendations are retained. However, some recommendations have been edited to ensure that they meet current editorial standards, and reflect the current policy and practice context. Because this update is for smoking cessation only, we have not included guidance on smokeless tobacco cessation. Users should consult NICE's guideline on smokeless tobacco: South Asian communities. Other recommendations were reviewed taking into account any new evidence and expert opinion.

Given the large body of research about smoking cessation, a pragmatic approach to identifying evidence was developed. Evidence was identified through a series of steps. Briefly the first step involved a review of high quality systematic reviews conducted by the Cochrane collaboration. The committee used the results of this to update some recommendations, and to identify gaps where further evidence was required to inform decisions. Gaps identified by the committee included evidence about the use of digital media as an adjunct to other interventions.

The committee considered the body of evidence (published or expert testimony) presented at for each review question, and then drafted recommendations based on this evidence and the experiences of the topic experts. More detailed information on how the evidence or testimony was considered by the committee is available in the systematic reviews done to support this guideline. Where original recommendations from PH1 and PH10 were deleted, the committee discussed these in light of the new recommendations to ensure that not recommendations were deleted without a satisfactory update or reason for deletion.

This committee only discussed evidence linked to recommendations being updated, the original evidence reviews and deliberations of the 2006 and 2008 guideline committees were not reviewed as part of this update process.

See the evidence pages for NICE's guidelines on smoking: brief interventions and referrals and stop smoking services.

Economic modelling

A stepped approach was taken to the effectiveness evidence. No in-house cost-effectiveness review was done. The effectiveness evidence from 30 different interventions was modelled. Intervention costs ranged from £19 to £763 per person.

Intervention effectiveness ranged from 9 to 47% and they were all highly cost effective. Additionally, a new threshold analysis showed that even when the lowest quit rate identified in the effectiveness studies (9%) is combined with the most expensive intervention cost (£763 per person), the intervention is still cost effective. Because patient preference is essential for successful intervention, the committee considered any cost effective intervention to be an option for use.

Impact of the recommendations on practice

Smoking is the main cause of preventable illnesses and deaths in England. Treating smoking-related illness is estimated to cost the NHS £2.5 billion a year (Statistics on smoking Health and Social Care Information Centre). But if all health and community health professionals could identify which of the people they see are smokers and give them information and support to help them quit, these figures could change. In some cases it might lead to people getting help to quit at an earlier stage, preventing smoking-related health problems entirely or stopping them getting worse.

Targeting groups who smoke heavily or who find it most difficult to stop will make the most difference, because they are most at risk of becoming ill or dying. Focusing time and resources where they will make the most difference will also reduce costs for the NHS.

1.1 Providing stop smoking interventions and services to meet local needs

The discussion below explains how the committee made recommendations 1.1.1 through to 1.1.7.

Recommendations

1.1.1 Use sustainability and transformation partnerships and plans, health and wellbeing strategies, and any other relevant local strategies and plans to ensure evidence-based stop smoking interventions and services are available for everyone who smokes. **[2018]**

1.1.2 Use the joint strategic needs assessment to estimate smoking prevalence among the local population. **[2018]**

1.1.3 Prioritise specific groups who are at high risk of tobacco-related harm for intervention. These may include:

- people with mental health problems, including mental health disorders (see NICE's guidelines on smoking: acute, maternity and mental health services and depression in adults)
- people with health conditions made worse by smoking or who have a smoking-related illness (see NICE's guidelines on cardiovascular disease: identifying and supporting people most at risk of dying early and chronic obstructive pulmonary disease)
- communities with particularly high smoking prevalence
- people in custodial settings
- populations with a high prevalence of smoking-related morbidity or a particularly high susceptibility to harm
- people living in disadvantaged circumstances
- pregnant women who smoke (see NICE's guideline on smoking: stopping in pregnancy and after childbirth). **[2018]**

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

- treating at least 5% of the estimated local population who smoke each year
- achieving a successful quit 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) in the third and fourth week after the quit date. **[2018]**

1.1.5 Check and confirm quit attempts using carbon monoxide monitoring, with success defined as less than 10 parts per million (ppm) at 4 weeks after the quit date. This does not imply that treatment should stop at 4 weeks. **[2018]**

1.1.6 Monitor performance data for specialist stop smoking services routinely and independently. Make these results publicly available. **[2018]**

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

Rationale and impact

Why the committee updated the recommendations

The committee agreed that it was important to understand the needs of the local population. They agreed that recommendations about commissioning and providing local stop smoking services are still important, but updated the recommendations because of changes in government policy. Areas now use joint plans agreed between the NHS and local authorities, known as sustainability and transformation plans, to improve health and care services. They suggested using joint strategic needs assessments and health and wellbeing strategies to help identify people who smoke heavily or who find it hard to stop.

Some local authorities are reducing or cutting their stop smoking services because of competing demands on local budgets. The original evidence showed that services could make a bigger difference and target resources more effectively if they focused on certain groups. So NICE's 2008 guideline on stop smoking services highlighted the need to target some minority ethnic and socioeconomically disadvantaged communities. Similarly, some people in the groups listed are likely to smoke heavily or find it harder to quit than the general population of smokers, and are also more likely to have other physical health problems. By targeting these people, services could make better use of resources.

Impact of the recommendations on practice

The recommendations will reinforce current best practice and many organisations will not need to change practice.

1.2 Advice and referral

The discussion below explains how the committee made recommendations 1.2.1 to 1.2.7.

Recommendations

Healthcare workers and others who advise people how to quit smoking

1.2.1 At every opportunity, ask people if they smoke and advise them to stop smoking in a way that is sensitive to their preferences and needs. **[2018]**

1.2.2 Refer people who want to stop smoking to a local specialist stop smoking service. **[2018]**

1.2.3 If people are not ready to stop smoking:

- 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 NICE's guideline on smoking: harm reduction)
- encourage them to seek help to quit smoking completely in the future
- record the fact that they smoke and ask them about it again at every opportunity. **[2018]**

Healthcare professionals who offer smoking cessation advice and referral

1.2.4 If people opt out of a referral to a local specialist stop smoking service, offer them pharmacotherapy and brief advice. **[2018]**

1.2.5 Discuss how to stop smoking with people who want to quit (see the National Centre for Smoking Cessation and Training (NCSCT) programmes). **[2018]**

1.2.6 Encourage people to discuss their use of personally purchased nicotine replacement products. **[2018]**

1.2.7 Encourage people being referred for elective surgery to stop smoking before their surgery. Offer to refer them to the local specialist stop smoking service. **[2018]**

Rationale and impact

Why the committee updated the recommendations

To continue helping more people to stop smoking, healthcare practitioners working in primary care and the community need to provide them with information, encouragement and support whenever they see them. This is particularly important for people from more disadvantaged groups who have much lower than average stop-smoking rates. They are also more likely to have respiratory, heart or other chronic conditions related to, or made worse by, smoking.

The committee confirmed that advice and referral is effective in helping people to stop smoking. So the committee agreed that recommendations on referring people to specialist stop smoking services or offering them other types of support were still relevant. They made some changes to the existing recommendations to make the messages clearer.

Impact of the recommendations on practice

The recommendations will reinforce current best practice and many organisations will not need to change practice

1.3 Smoking cessation aids

The discussion below explains how the committee made recommendations 1.3.1 to 1.3.14.

Recommendations

All staff providing stop smoking interventions and services: agree the approach

1.3.1 Discuss any stop-smoking aids the person has used before, including personally purchased nicotine replacement products (see recommendations 1.3.8 and 1.3.9). **[2018]**

1.3.2 Set out the pharmacotherapy and behavioural options as listed in recommendations 1.3.5 and 1.3.10. **[2018]**

1.3.3 Explain:

- that a combination of pharmacotherapy and behavioural support is likely to be most effective
- which combination of pharmacotherapy is most effective
- any potential adverse effects from the different pharmacotherapies on offer.

[2018]

1.3.4 Agree the approach to stopping smoking that best suits the person's preferences. Review this approach at future visits. **[2018]**

Providing stop smoking aids

Pharmacotherapy

1.3.5 Offer single or combined pharmacotherapy based on the person's preferences and the likelihood that they will follow the course of treatment. Choose from:

- varenicline
- bupropion
- short-acting nicotine replacement therapy (NRT; gum, inhalator, lozenge, microtabs or spray)
- long-acting NRT (nicotine patches)
- varenicline and long-acting NRT
- varenicline and short-acting NRT
- bupropion and long-acting NRT
- bupropion and short-acting NRT
- long-acting and short-acting NRT. **[2018]**

1.3.6 Prescribe varenicline or bupropion (or NRT if provided on prescription) while the person still smokes. Agree a quit date set within the first 2 weeks of bupropion treatment and within the first 1 to 2 weeks of varenicline treatment. Reassess the person shortly before the prescription ends. **[2018]**

1.3.7 Consider NRT[4] for young people over 12 who are smoking and dependent on nicotine. If this is prescribed, offer it within a specialist stop smoking service. **[2018]**

Nicotine replacement products on general sale

1.3.8 Offer advice on using nicotine replacement products on general sale, including e-cigarettes. **[2018]**

1.3.9 Ask people about their use of nicotine-containing e-cigarettes and explain that:

- although these products are not licensed medicines, they are regulated by the Tobacco and Related Products Regulations 2016
- some smokers have found them helpful to quit smoking cigarettes and
- there is currently little evidence on the long-term benefits or harms of these products. **[2018]**

Be aware that Public Health England and the Royal College of Physicians have stated that e-cigarettes are significantly less harmful to health than tobacco.

Behavioural support

1.3.10 If people turn down pharmacotherapy, offer behavioural support (individual or group) based on individual needs or preferences. **[2018]**

1.3.11 Ensure people have behavioural support from trained stop smoking staff (see the NCSCT's training standards). **[2018]**

Role of providers of stop smoking interventions or services

1.3.12 Specialist stop smoking services should:

- offer behavioural support, in combination with pharmacotherapy, based on individual needs or preferences
- offer text messaging support as an adjunct to existing stop smoking support. **[2018]**

[4] The UK marketing authorisation for nicotine replacement therapy products varies for use in children and young people under 18. Refer to the summary of product characteristics for prescribing information on individual nicotine replacement therapy preparations.

1.3.13 GPs should offer pharmacotherapy plus brief advice based on individual needs or preferences. **[2018]**

1.3.14 All other prescribers should:

- offer pharmacotherapy, plus very brief advice based on individual needs or preferences (see NCSCT training on very brief advice)
- offer text messaging support as an adjunct to existing stop smoking support. **[2018]**

Rationale and impact

Why the committee updated the recommendations

Many people try to quit smoking using a variety of methods and quitting should always be encouraged. Smokers often ask healthcare practitioners about using e-cigarettes to help them stop smoking. The committee agreed that advice should be provided to allow an informed discussion of e-cigarettes as an aid to smoking cessation. So the NHS and stop smoking services should all offer effective combinations of stop smoking aids and behavioural support to help people stop.

New evidence confirms that providing a combination of pharmacotherapy and behavioural support is still an effective way of helping people to stop smoking.

We made some changes to the wording of recommendations to make them easier to read or to reflect new products on general sale.

Impact of the recommendations on practice

The recommendations will reinforce current best practice, as well as knowledge on e-cigarettes, and many organisations will not need to change practice.

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Stop smoking services

What is the relative effectiveness and cost effectiveness of different types of service model to deliver stop smoking interventions and behavioural support?

Why this is important

There is limited evidence on the type and range of stop smoking services that should be available to tackle high rates of smoking and reduce health inequalities particularly on quit rates amongst those from disadvantaged groups. There is also little known on the impact of the provider of the service and content of the package on effectiveness outcomes

2 Consumer e-cigarettes

How effective and cost effective are consumer (non-prescription) e-cigarettes in helping people to stop smoking and to prevent relapse?

Why this is important

It is important to know whether consumer e-cigarettes are an effective aid to quitting smoking both in the short and long term, and for whom (especially in disadvantaged groups), as part of self-help or through local stop smoking services. It is also important to know whether they help people to switch completely or partly from tobacco cigarettes, prevent relapse and if there are as yet unknown adverse effects.

3 Digital media

How effective and cost effective are stop smoking interventions delivered using web-based packages or apps?

Why this is important

There is limited evidence on the effectiveness and cost effectiveness of digital media either as an adjunct to specialist help. Web-based packages and apps are cheap,

easy to access and are freely available. So it is important to find out if they work in the short or longer term.

Update information

March 2018

This guideline is an update of NICE guidelines on smoking: brief interventions and referrals (published March 2006) and stop smoking services (published February 2008) and will replace them.

New recommendations have been added for the interventions and services for people who smoke.

Recommendations are marked as **[2018]** if the recommendation is new or the evidence has been reviewed.

NICE proposes to delete all the recommendations from the 2006 guideline and some recommendations from the 2008 guideline, because either the evidence has been reviewed and the recommendations have been updated, or NICE has updated other relevant guidance and has replaced the original recommendations. Recommendations that have been deleted or changed sets out these recommendations and includes details of replacement recommendations. Where there is no replacement recommendation, an explanation for the proposed deletion is given.

Where recommendations are shaded in grey and end **[2008]** the evidence has not been reviewed since the original guideline.

Where recommendations are shaded in grey and end **[2008, amended 2018]**, the evidence has not been reviewed but changes have been made to the recommendation. These may be:

- changes to the meaning of the recommendation (for example, because of equalities duties or a change in the availability of medicines, or incorporated guidance has been updated)
- editorial changes to the original wording to clarify the action to be taken.

These changes are marked with yellow shading, and explanations of the reasons for the changes are given in 'Recommendations that have been deleted or changed' for information.

See the original guideline and supporting documents for NICE's guidelines on smoking: brief interventions and referrals and stop smoking services.

Recommendations that have been deleted or changed

Recommendations to be deleted

Recommendation in 2006 guideline	Comment
Recommendation 1 Everyone who smokes should be advised to quit, unless there are exceptional circumstances. People who are not ready to quit should be asked to consider the possibility and encouraged to seek help in the future. If an individual who smokes presents with a smoking-related disease, the cessation advice may be linked to their medical condition.	Replaced by: 1.2.1 At every opportunity, ask people if they smoke and advise them to stop smoking in a way that is sensitive to their preferences and needs. 1.2.3 If people are not ready to stop smoking: • 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 NICE's guideline on smoking: harm reduction) • encourage them to seek help to quit smoking completely in the future • record the fact that they smoke and ask them about it again at every opportunity.
Recommendation 2 People who smoke should be asked how interested they are in quitting. Advice to stop smoking should be sensitive to the individual's preferences, needs and circumstances: there is no evidence that the 'stages of change' model is more effective than any other approach.	Replaced by: 1.2.1 At every opportunity, ask people if they smoke and advise them to stop smoking in a way that is sensitive to their preferences and needs. Information about the 'stages of change' model has not been retained because it is no longer relevant.
Recommendation 3 GPs should take the opportunity to advise all patients who smoke to quit when they attend a consultation. Those who want to stop should be offered a referral to an intensive support	Replaced by: 1.2.1 At every opportunity, ask people if they smoke and advise them to stop smoking in a way that is sensitive to their preferences and needs.

service (for example, NHS Stop Smoking Services). If they are unwilling or unable to accept this referral they should be offered pharmacotherapy in line with NICE technology appraisal guidance no. 39 and additional support. The smoking status of those who are not ready to stop should be recorded and reviewed with the individual once a year, where possible.	1.2.2 Refer people who want to stop smoking to a local specialist stop smoking service. 1.2.3 If people are not ready to stop smoking: • 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 NICE's guideline on smoking: harm reduction) • encourage them to seek help to quit smoking completely in the future. • record the fact that they smoke and ask them about it again at every opportunity. 1.2.4 If people opt out of a referral to a local specialist stop smoking service, offer them pharmacotherapy and brief advice.
Recommendation 4 Nurses in primary and community care should advise everyone who smokes to stop and refer them to an intensive support service (for example, NHS Stop Smoking Services). If they are unwilling or unable to accept this referral they should be offered pharmacotherapy by practitioners with suitable training, in line with NICE technology appraisal guidance no. 39, and additional support. Nurses who are trained NHS stop smoking counsellors may 'refer' to themselves where appropriate. The smoking status of those who are not ready to stop should be recorded and reviewed with the individual once a year, where possible.	Replaced by: 1.2.1 At every opportunity, ask people if they smoke and advise them to stop smoking in a way that is sensitive to their preferences and needs. 1.2.2 Refer people who want to stop smoking to a local specialist stop smoking service. 1.2.3 If people are not ready to stop smoking: • 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 NICE's guideline on smoking: harm reduction) • encourage them to seek help to quit smoking completely in the future. • record the fact that they smoke and ask them about it again at every opportunity. 1.2.4 If people opt out of a referral to a local specialist stop smoking service,

	offer them pharmacotherapy and brief advice.
Recommendation 5 All other health professionals, such as hospital clinicians, pharmacists and dentists, should refer people who smoke to an intensive support service (for example, NHS Stop Smoking Services). If the individual is unwilling or unable to accept this referral, practitioners with suitable training should offer a prescription of pharmacotherapy in line with NICE technology appraisal guidance no. 39, and additional support. Those who are trained NHS stop smoking counsellors may 'refer' to themselves. Where possible, the smoking status of those who are not ready to stop should be recorded in clinical records and reviewed with the individual once a year, where possible.	Replaced by: 1.2.1 At every opportunity, ask people if they smoke and advise them to stop smoking in a way that is sensitive to their preferences and needs. 1.2.2 Refer people who want to stop smoking to a local specialist stop smoking service. 1.2.3 If people are not ready to stop smoking: • 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 NICE's guideline on smoking: harm reduction) • encourage them to seek help to quit smoking completely in the future. • record the fact that they smoke and ask them about it again at every opportunity. 1.2.4 If people opt out of a referral to a local specialist stop smoking service, offer them pharmacotherapy and brief advice.
Recommendation 6 Community workers should refer people who smoke to an intensive support service (for example, NHS Stop Smoking Services). Those who are trained NHS stop smoking counsellors may 'refer' to themselves.	Replaced by: 1.2.1 At every opportunity, ask people if they smoke and advise them to stop smoking in a way that is sensitive to their preferences and needs. 1.2.2 Refer people who want to stop smoking to a local specialist stop smoking service. 1.2.3 If people are not ready to stop smoking: • 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 NICE's guideline on smoking: harm reduction)

	• encourage them to seek help to quit smoking completely in the future. • record the fact that they smoke and ask them about it again at every opportunity.
Recommendation 7 Strategic health authorities, NHS hospital trusts, primary care trusts (PCTs), community pharmacies, local authorities and local community groups should review smoking cessation policies and practices to take account of the recommendations in this guidance.	Deleted because it is no longer relevant now that local authorities have responsibility for specialist stop smoking services.
Recommendations in 2008 guideline	
Recommendation 1 first bullet • Determine the characteristics of the local population of people who smoke or use other forms of tobacco. Determine the prevalence of all forms of tobacco use locally.	The first sentence has been removed because this update focused on smoking and not other forms of tobacco. The second sentence has been replaced to take account of currently available assessments by: 1.1.2 Use the joint strategic needs assessment to estimate smoking prevalence among the local population.
Recommendation 1 second bullet • Ensure NHS Stop Smoking Services target minority ethnic and socioeconomically disadvantaged communities in the local population.	Replaced by: 1.1.2 Use the joint strategic needs assessment to estimate smoking prevalence among the local population. 1.1.3 Prioritise specific groups who are at high risk of tobacco-related harm for intervention. These may include: • people with mental health problems, including severe mental health disorders (see NICE's guidelines on smoking: acute, maternity and mental health services and depression in adults) • people with health conditions made worse by smoking or who have a smoking-related illness (see NICE's guideline on cardiovascular disease: identifying and supporting people most at risk of dying early and NICE's guideline on chronic obstructive pulmonary disease) • communities with particularly high smoking prevalence • people in custodial settings

	• populations with a high prevalence of smoking-related morbidity or a particularly high susceptibility to harm • people living in disadvantaged circumstances • pregnant women who smoke (see NICE's guideline on smoking: stopping in pregnancy and after childbirth). 1.1.4 Set targets for specialist stop smoking services, including the number of people using the service and the proportion who successfully quit smoking. Performance targets should include: • treating at least 5% of the estimated local population who smoke each year • achieving a successful quit 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) in the third and fourth week after the quit date.
Recommendation 1 third bullet • Ensure NHS Stop Smoking Services provide a good service by maintaining adequate staffing levels, including a full-time coordinator (or the equivalent).	Deleted because local authorities now have responsibility for the specialist stop smoking service and it is their responsibility to ensure staffing is appropriate.
Recommendation 1 fourth bullet • Set realistic performance targets for both the number of people using the service and the proportion who successfully quit smoking. These targets should reflect the demographics of the local population. Services should: – aim to treat at least 5% of the estimated local population of people who smoke or use tobacco in any form each year – aim for a success rate of at least 35% at 4 weeks, validated by carbon monoxide monitoring. This figure should be based on all those who start treatment, with success defined as not having smoked in the third and fourth week after the quit date. Success should be validated by a CO monitor reading of less than 10 ppm at the 4-	Replaced by: 1.1.4 Set targets for specialist stop smoking services, including the number of people using the service and the proportion who successfully quit smoking. Performance targets should include: • treating at least 5% of the estimated local population who smoke each year • achieving a successful quit 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) in the third and fourth week after the quit date. 1.1.5 Check and confirm quit attempts using carbon monoxide monitoring, with success defined as less than 10 parts

week point. This does not imply that treatment should stop at 4 weeks.	per million (ppm) at 4 weeks after the quit date. This does not imply that treatment should stop at 4 weeks.
Recommendation 1 fifth bullet • Audit performance data routinely and independently and make the results publicly available. Audits should also be carried out on exceptional results – 4-week quit rates lower than 35% or above 70% – to determine the reasons for unusual performance, and to help identify best practice and ensure it is being followed.	Replaced by: 1.1.6 Monitor performance data for specialist stop smoking services routinely and independently. Make these results publicly available. 1.1.7 Audit exceptional results (for example, 4-week quit rates lower than 35% or above 70%) to determine the reasons for unusual performance as well as identify best practice and ensure it is being followed.
Recommendation 1 sixth bullet • Establish links between contraceptive services, fertility clinics and ante- and postnatal services. These links should ensure health professionals use the many opportunities available to them (at various stages of the woman's life) to offer smoking advice or referral to a specialist service, where appropriate.	Deleted because it is covered by the recommendations for all health professionals (1.2.1 to 1.2.7).
(See also NICE public health guidance 1 on smoking cessation in primary care and other settings).	Deleted because NICE's public health guideline on smoking: brief interventions and referrals (PH1) will be replaced by this updated guidance.
Recommendation 2 bullets 1 to 3 • Offer behavioural counselling, group therapy, pharmacotherapy or a combination of treatments that have been proven to be effective (see the list at the start of this section). • Ensure clients receive behavioural support from a person who has had training and supervision that complies with the 'Standard for training in smoking cessation treatments' or its updates. • Provide tailored advice, counselling and support, particularly to clients from minority ethnic and disadvantaged groups. Provide services in the language chosen by clients, wherever possible.	Replaced by: 1.3.10 If people turn down pharmacotherapy, offer behavioural support (individual or group) based on individual needs or preferences. 1.3.11 Ensure people have behavioural support from trained stop smoking staff (see the NCSCT's standards). 1.3.12 Specialist stop smoking services should: • offer behavioural support, in combination with pharmacotherapy, based on individual needs or preferences • offer text messaging support as an adjunct to existing stop smoking support.
Recommendation 2 bullet 4 • Ensure the local NHS Stop Smoking Service aims to treat minority ethnic and disadvantaged groups at least in proportion	Replaced by: 1.1.1 Use sustainability and transformation partnerships and plans, health and wellbeing strategies, and any other relevant local strategies and plans to ensure evidence-based stop smoking

to their representation in the local population of tobacco users.	interventions and services are available for everyone who smokes.
Recommendation 4 • Offer NRT, varenicline or bupropion, as appropriate, to people who are planning to stop smoking. • Offer advice, encouragement and support, including referral to the NHS Stop Smoking Service, to help people in their attempt to quit. • NRT, varenicline or bupropion should normally be prescribed as part of an abstinent-contingent treatment, in which the smoker makes a commitment to stop smoking on or before a particular date (target stop date). The prescription of NRT, varenicline or bupropion should be sufficient to last only until 2 weeks after the target stop date. Normally, this will be after 2 weeks of NRT therapy, and 3–4 weeks for varenicline or bupropion, to allow for the different methods of administration and mode of action. Subsequent prescriptions should be given only to people who have demonstrated, on re-assessment, that their quit attempt is continuing. • Explain the risks and benefits of using NRT to young people aged from 12 to 17, pregnant or breastfeeding women, and people who have unstable cardiovascular disorders. To maximise the benefits of NRT, people in these groups should also be strongly encouraged to use behavioural support in their quit attempt. • Neither varenicline or bupropion should be offered to young people under 18 nor to pregnant or breastfeeding women. • Varenicline or bupropion may be offered to people with unstable cardiovascular disorders, subject to clinical judgement. • If a smoker's attempt to quit is unsuccessful using NRT, varenicline or bupropion, do not offer a repeat prescription within 6 months unless special circumstances have hampered the person's initial attempt to stop smoking, when it may be reasonable to try again sooner. • Do not offer NRT, varenicline or bupropion in any combination.	Replaced by: 1.3.1 Discuss any stop-smoking aids the person has used before, including personally purchased nicotine replacement products (see 1.3.8 and 1.3.9). 1.3.2 Set out the pharmacotherapy and behavioural options as listed in 1.3.5 and 1.3.10. 1.3.3 Explain: • that a combination of pharmacotherapy and behavioural support is likely to be most effective • which combination of pharmacotherapy is most effective • any potential adverse effects from the different pharmacotherapies on offer. 1.3.4 Agree the approach that best suits the person's preferences. Review this approach at future visits. Pharmacotherapy 1.3.5 Offer single or combined pharmacotherapy based on the person's preferences and the likelihood that they will follow the course of treatment. Choose from: • varenicline • bupropion • short-acting nicotine replacement therapy (NRT; gum, inhalator, lozenge, microtabs or spray) • long-acting NRT (nicotine patches) • varenicline and long-acting NRT • varenicline and short-acting NRT • bupropion and long-acting NRT • bupropion and short-acting NRT • long-acting and short-acting NRT. 1.3.6 Prescribe varenicline or bupropion (or NRT if provided on prescription) while the person still smokes. Agree a quit date set within the first 2 weeks of bupropion treatment and within the first 1 to 2 weeks of varenicline treatment. Reassess the person shortly before the prescription ends.

• Consider offering a combination of nicotine patches and another form of NRT (such as gum, inhalator, lozenge or nasal spray) to people who show a high level of dependence on nicotine or who have found single forms of NRT inadequate in the past. • Do not favour one medication over another. The clinician and patient should choose the one that seems most likely to succeed. • When deciding which therapies to use and in which order, discuss the options with the client and take into account: – whether a first offer of referral to the NHS Stop Smoking Service has been made – contra-indications and the potential for adverse effects – the client's personal preferences – the availability of appropriate counselling or support – the likelihood that the client will follow the course of treatment their previous experience of smoking cessation aids.	1.3.7 Consider nicotine replacement therapy for young people over 12 who are smoking and dependent on nicotine. If this is prescribed, offer it within a specialist stop smoking service. 1.3.8 Offer advice on using nicotine replacement products on general sale, including e-cigarettes. 1.3.9 Ask people about their use of nicotine-containing e-cigarettes and explain that • although such products are not licensed medicines, they are regulated by the Tobacco and Related Products Regulations • some smokers have found them helpful to quit smoking cigarettes and • there is currently no evidence on their long-term benefits and harms. Be aware that Public Health England and the Royal College of Physicians have stated that e-cigarettes are significantly less harmful to health than tobacco. 1.3.10 If people turn down pharmacotherapy, offer behavioural support (individual or group) based on individual needs or preferences. 1.3.11 Ensure people have behavioural support from trained stop smoking staff (see the NCSCT's training). 1.3.12 Specialist stop smoking services should: • offer behavioural support, in combination with pharmacotherapy, based on individual needs or preferences • offer text messaging support as an adjunct to existing stop smoking support. 1.3.13 GPs should offer pharmacotherapy plus brief advice based on individual needs or preferences. 1.3.14 All other prescribers should: • offer pharmacotherapy plus very brief advice based on individual needs or preferences (see NCSCT training on very brief advice)

	• offer text messaging support as an adjunct to existing stop smoking support.
Recommendation 10 • Offer young people aged 12–17 information, advice and support on how to stop smoking. Encourage use of local NHS Stop Smoking Services by providing details on when, where and how to access them. • Use professional judgement to decide whether or not to offer NRT to young people over 12 years who show clear evidence of nicotine dependence. If NRT is prescribed, offer it as part of a supervised regime.	Replaced by: 1.3.7 Consider NRT for young people over 12 who are smoking and dependent on nicotine. If this is prescribed, offer it within a specialist stop smoking service.

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2 **Amended recommendation wording (change to meaning)**

3 This table will be retained for publication, but the other tables in this section will be

4 deleted after consultation. The lead editor will make the necessary changes.]

Recommendation in 2008 guideline	Recommendation in current guideline	Reason for change
Recommendation 3 bullet 3 • Staff who offer counselling should be trained to at least level two (individual behavioural counselling) and preferably, they should hold an appropriate counselling qualification. Training should comply with the 'Standard for training in smoking cessation treatments' or its updates.	1.4.3 Staff who offer counselling should be trained to at least NCSCT level 2 (individual behavioural counselling) and preferably, they should hold an appropriate counselling qualification. Training should comply with the 'Standard for training in smoking cessation treatments' or its updates.	Amended to take account of change in training standards.
Recommendation 7 • Offer brief advice or, preferably, behavioural support from the local NHS Stop Smoking Service and prescriptions of NRT, varenicline or bupropion, according to clinical judgement.	1.5.1 Offer people with cardiovascular or respiratory disease who smoke behavioural support from the local specialist stop smoking service or brief advice in primary care. Also offer prescriptions of NRT, varenicline or bupropion, according to clinical judgement.	Amended to reflect that local authorities are responsible for commissioning stop smoking services and to include brief advice as an option.
Recommendation 14, bullet 2 • Develop and deliver communications strategies	1.9.2 Develop and deliver communications strategies in partnership with the NHS,	Amended to take into account changes in the external sources

in partnership with the NHS, regional and local government and non-governmental organisations. The strategies should: – use the best available evidence of effectiveness, such as reviews by the Cochrane Collaboration and the Global Dialogue for Effective Stop Smoking Campaigns. – be developed and evaluated using audience research – use 'why to' and 'how to' quit messages that are non-judgemental, empathetic and respectful. For example, testimonials from people who smoke or used to smoke can work well – 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 – consider targeting and tailoring campaigns towards low income and minority ethnic groups to address inequalities.	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' quit messages that are non-judgemental, empathetic and respectful, for example, 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. • Consider targeting and tailoring campaigns towards low income and some minority ethnic groups to address inequalities.	referred to and that smoking prevalence may be higher in some minority ethnic groups.

1

Changes to recommendation wording for clarification only (no change to meaning)

Recommendation numbers in current guideline	Comment
All recommendations except those labelled [new 2018]	Recommendations have been edited into the direct style (in line with current NICE style for recommendations in guidelines) where possible. Yellow highlighting has not been applied to these changes.
1.6.4, 1.7.2, 1.8.3	Wording updated to take into account changes in service structure since the original guideline. Yellow highlighting has not been applied to these changes.
1.6.1	The wording has been updated to use more person-centred language and to fit current NICE style. Yellow highlighting has not been applied to these changes.
1.6.2	Contact details for the helpline updated. Yellow highlighting has not been applied to these changes.

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