Maximising the impact of local stop smoking services: latest evidence and best practice

NCSCT

This briefing identifies principles and evidence-based actions to increase the **impact** of Local Stop Smoking Services (LSSS). Informed by a review of evidence and best practice, it aims to assist with planning and delivery processes to ensure **decisions are based on evidence** to further maximise the impact of **services**.

The planning of stop smoking services should seek to target and maximise both the **reach** and **efficacy** of services to maximise overall **population impact**.

Importantly, **equity** and **cost-effectiveness** lenses are also key for appropriate planning of services. The equity lens considers reach and efficacy of service delivery among high priority groups. The cost-effectiveness lens considers how we can provide the greatest return for each pound invested in stop smoking services.

Planning should include the understanding that services targeted at high priority groups often require larger investment than those targeted at the general population. As such, it is critical that cost-effectiveness, and not purely costs, be examined when planning service delivery.

Impact = Reach x Efficacy

The overall **Impact** of stop smoking services is influenced by two key drivers:

- **Reach** – Engaging more people in services, with a focus on priority groups
- **Efficacy** – Optimising services based on the latest evidence to maximise return on investment

Recommended national priority groups include those experiencing any of the following:

- Socio-economic disadvantage and/or living in social housing
- Mental health conditions
- Substance misuse disorder and co-addictions
- Health conditions caused or made worse by smoking, including hospital inpatients
- Multiple or complex needs (homelessness, in contact with the criminal prosecution service, LGBTQ+)
- Pregnant women and those with children in the home

Principles

Appropriately funded services backed by local intelligence

Stop smoking services are highly cost-effective. There is an abundance of **gold standard evidence** to demonstrate that helping someone to stop smoking is not only cost-effective but also offers cost saving to localities and government. Appropriate investment in LSSS is needed to ensure services are delivered at scale.

Appendix A provides a checklist for effective service planning. The self-assessment checklist is designed to ensure robust service planning and delivery based on local intelligence.

Client led and client focused

The person who smokes should be at the centre of everything that we do. A person-centred approach assesses the needs of people who smoke and is responsive to those needs. Offering flexible support and minimising barriers to accessing support is essential. This includes adapting services to target groups (including how and where services are delivered) and individual tailoring of interventions.

Targeted and tailored approaches to service delivery

Ensuring populations with high rates of smoking are targeted in the planning of stop smoking services, and that interventions are tailored to the needs of priority groups, is essential. We have growing evidence of, and expertise in, how to target and tailor services to support equitable access, uptake and efficacy in key priority groups. It is important to ensure that this knowledge is reflected in service delivery and workforce training. See the **Target: increase efficacy of services** section for more information.

Work in partnership and collaborate across systems

Ensure services provide leadership, expertise and collaborate with partner organisations to maximise the reach, equity, and impact of stop smoking resources and support integrated models of service delivery. **Local strategies and service plans** should incorporate stop smoking and tobacco control measures especially where strategies relate to priority population groups (maternity services, housing strategy, Integrated Care Board (ICB) strategies, Joint Local Health and Wellbeing Strategy etc.). A **proactive Tobacco Control Alliance** that meets regularly and has representation from organisations that interface with key population groups is also integral to this work.

For the latest guidance on commissioning, delivering and monitoring local stop smoking services see: **www.ncsct.co.uk/publications/commissioning-delivery-monitoring**

Top actions for maximising the impact of stop smoking services

Here are the top actions to increase **reach** and **efficacy** of stop smoking services based on research and best practice. Each action is reviewed in more detail in the section that follows.

Increase reach

Engage more people in services, with a focus on priority groups.

1. **Provide a mix of person-centred, evidence-based service delivery models.**
2. **Build demand by having a visible presence in the community.**
3. **Use Cut-Down-to-Stop (CDTS) interventions to engage priority groups and those unable to quit abruptly.**
4. **Ensure easy, responsive referral pathways with quick response times and referral feedback loops.**
5. **Maximise opportunities for smoking cessation in settings with direct contact with priority groups. This includes ensuring all staff are trained in delivering Very Brief Advice on smoking (VBA+) on smoking tailored to the setting in which they work.**

Increase efficacy

Optimising services based on latest evidence to maximise return on investment.

1. **Employ a well-trained, well-led and motivated workforce.**
2. **Provide access to all first-choice stop smoking aids including combination Nicotine Replacement Therapy (NRT), nicotine vapes and nicotine analogues (varenicline and cytisine).**
3. **Ensure policies, protocols and training support the latest evidence on effective use of first-choice stop smoking aids, including tailoring dose and duration of treatment.**
4. **Match and tailor the level of behavioural support to the needs of people who smoke.**
5. **Optimise stop smoking services in inpatient and outpatient mental health services.**

Target: **Increase reach of stop smoking services**

1. Provide a mix of person-centred, evidence-based service delivery models.

Provide a range of accessible, identifiable and evidence-based behavioural support and stop smoking aids. Provide alternative options for those unlikely to participate in a Standard Treatment Programme (STP).

Not all people who smoke will be willing or able to participate in the standard six or 12 weekly behavioural support programme: some clients will benefit from more intensive and tailored support. Delivering person-centered, tailored interventions requires a range of evidence-based options from minimal to specialist support. All interventions should be evidence-based and appropriate to need. This includes ensuring access to first-choice stop smoking aids and behavioural support delivered by an NCSCT Certified Stop Smoking Practitioner in accordance with NICE guidance (NG209).

Appendix B provides an overview of evidence-based models. Whilst brief support ranks lower than structured multi-session support (the STP) for effectiveness, the availability of less intensive intervention models may assist with expanding the reach of services to people unable or unwilling to engage in more intensive forms of support. It is recommended that people with severe mental illness (SMI), pregnant women, those who are heavily dependent on tobacco or at high risk of relapse, those with complex needs including people who use substances and those experiencing homelessness be directed towards specialist support.

Face-to-face, virtual (telephone/video link), and group-based support are all effective. There is less evidence for digital interventions, but the use of digital support may be an effective way to extend the reach of behavioural support. There is some evidence that hybrid models of stop smoking support that combine personal (in-person or telephone) and digital forms of support may provide greater reach as well as effectiveness. The use of first-choice stop smoking aids alongside digital stop smoking support (smartphone apps or text messages) increases effectiveness compared to digital support alone. We know that digital interventions should be designed to deliver the same evidence-based behaviour change techniques (BCTs) to maximise their effect on smoking behaviours, in particular those that address cravings or anxiety. There is some data to suggest that interventions that are personalised and interactive are more effective.

Importantly, evidence suggests that stop smoking support provides the best outcome and is most cost-effective when provided as a single intervention, rather than as part of multi-component integrated lifestyle interventions.

2. Build demand by having a visible presence in the community.

Employ direct-to-public communications to promote services, trigger quit attempts and raise awareness of the support available for stopping smoking or reducing harm.

Direct-to-public communications are a highly effective behaviour change intervention that can motivate quit attempts and direct people to effective stop smoking support. It is important to ensure stop smoking services have a visible presence in the community and ensure that this presence is regularly reviewed and refreshed. Communications plans should be sufficiently extensive and sustained to have a reasonable chance of success. They should use a mix of communication channels such as local and social media, as well as working with community organisations and health care professionals where posters (e-posters), leaflets, forums and newsletters are used. Available evidence and best practice recommend that communications should aim to offer hope and help and resonate with target audiences. They should incorporate **how to stop** messages that are non-judgmental, empathetic and respectful. This includes the use of testimonials from local people who used to smoke. Targeting and tailoring of communication campaigns towards priority groups is recommended to ensure messages resonate. A single point of access (telephone contact/email) to all support services with a dedicated helpline, as well as digital access, is best practice.

3. Use Cut-Down-to-Stop (CDTS) interventions to engage priority groups and those unable to quit abruptly.

Individuals who feel unable to commit to stopping smoking abruptly can be supported to cut down the amount that they smoke towards a planned quit date.

The standard way to stop smoking is by quitting abruptly on a designated quit day. Abrupt quitting is the preferred approach to stopping smoking due to the immediate health gains. However, individuals who feel unable to commit to stopping smoking abruptly can be supported to cut down the amount they smoke. This can be achieved **with the help of NRT, a nicotine vape or varenicline** as part of a structured CDTS programme that includes **multi-session behavioural support from a trained practitioner** to set progressive smoking reduction goals, with a view to stopping completely over a specified period. CDTS programmes can be tailored to meet client needs but typically consist of 6 to 12 contacts and ideally continue for at least four weeks following stopping completely. This strategy is supported by NICE guidance. CDTS has been shown to be particularly useful for engaging people with SMI and people experiencing homelessness in stop smoking support. Therefore, staff who are working with these priority groups should be trained in supporting clients with a structured CDTS programme. CDTS is **not recommended for women who are pregnant** due to the significant risk of tobacco exposure to the foetus.

Any training delivered to front line staff working with SMI patients and people experiencing homelessness should promote the availability of a CDTS service so that VBA+ conversations can be pitched in a way that presents stopping smoking as more achievable through the application of a gradual approach to stopping.

4. Ensure easy, responsive referral pathways with quick response times and referral feedback loops.

Ensure clear referral pathways with quick response times are embedded throughout health and social care services and community.

For effective referral of all clients, and notably those in priority groups, it is important to ensure seamless pathways are established and integrated with various local health and social care networks. These include primary and secondary care, mental health and maternity services, homelessness and social housing groups. It is recommended that simple electronic referral systems are developed that support the principles for effective referrals and allow for analysis and reporting to commissioners and referrers. Working in partnership with health and community organisations to co-design referral pathways helps to provide a seamless loop with effective feedback mechanisms. Referrer feedback loops provide communication between health and social care professionals who are providing clinical care to patients. There is good evidence regarding the role of referral feedback loops in increasing referrals provided they are designed well. Depending on the volume of referrals, this can be done monthly or quarterly. Including statistical data, quotes from patients referred and recognition of top referring team/person can result in greater engagement and more, and better quality, referrals. Having a designated/named person in the stop smoking service who is the link with referring organisations is good practice.

Principles for maximising effective referrals:

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

5. Maximise opportunities for smoking cessation in settings with direct contact with priority groups. This includes ensuring all staff are trained in delivering VBA+ on smoking tailored to the setting in which they work.

Ensure tobacco dependence treatment and stop smoking support are embedded in key settings with direct contact with people who smoke, with a focus on priority groups. This includes community services, hospitals and other health and social care settings.

Training staff in VBA+ on smoking

Ensure all health and social care staff, with direct contact with the public, are trained and confident in delivering VBA+ on smoking tailored to the populations with whom they work. It is important to ensure that training is repeated periodically, with a frequency of every one to three years recommended.

Partnership, promotion and co-location with key community-based services

Take the service to people who smoke in locations such as housing association premises, homelessness services, judicial services and primary care settings. Fostering strong working relationships with local organisations and staff can facilitate access to target groups. Good practice includes training staff in VBA+, having trained stop smoking practitioners onsite, having regular offers of stop smoking support embedded into settings, offering harm reduction support and, for some settings, targeted campaigns, communications and incentives. Having a presence at community (e.g. social housing team meetings) and training events (e.g. GP training days) that allow for short presentations or promotional stands has been successfully used by LSSS to raise awareness and support partnership.

High quality Transfer of Care from acute and mental health trusts

One million people who smoke are admitted to hospital each year in England. Treating tobacco dependence in patients admitted to hospital (overnight) is now a **standard of care** in NHS acute and mental health trusts. In 2024, the NHSE **Standard Treatment Plan for Inpatient Tobacco Dependence**, structured around three Tobacco Dependence Treatment Care Bundles, was published. The STP provides a framework for embedding services into inpatient acute and mental health trusts.

There is strong evidence to show that tobacco dependence treatment initiated in hospital is effective and its efficacy can be increased by ensuring tailored follow-up support is provided for a minimum of one-month post-discharge. **Ensuring seamless referral pathways** are in place to link patients upon discharge from hospital to specialist stop smoking support is essential. Strong working relationships between the NHS and Local Authorities that include partnership agreements, establishing local referral pathways for Transfer of Care from inpatient support to LSSS, performance monitoring and quality improvement cycles are best practices. Best practices for effective referrals are described below.

Best practices for effective referral from inpatient settings:

- **Seamless support.** There is a need for well-coordinated, efficient pathways that provide seamless stop smoking support for people in the community following discharge.
- **Simple digital referral processes.** Try to make the process of referral through discharge pathways as easy and straightforward as possible, such as by using a one-click electronic referral method. Provide sufficient detail accompanying referrals to allow for seamless Transfer of Care.
- **Rapid follow-up following discharge.** This includes contact with the patient within 48 hours of discharge and multiple attempts to contact patients.
- **Adaptation of the service delivery model to support post-discharge follow-up.** The Standard Treatment Programme (STP) should be adapted to support Transfer of Care. A tailored, bespoke conversation is recommended at the initial post-discharge contact.
- **Flexible service delivery options.** Not all patients discharged from hospital will be mobile or in good health. This is particularly true in the early post-discharge period. Services should be prepared to modify service delivery options to ensure ongoing support is delivered. This includes telephone-based support and hybrid service delivery models.
- **Minimum of four weeks follow-up support.** Support should be provided for at least four weeks post-discharge for patients discharged from acute hospitals and 12 weeks for patients discharged from acute mental health hospitals.
- **Triage algorithms should be in place.** Criteria should be in place to ensure the most qualified community-based provider sees patients from groups at greatest risk of relapse, such as people who are heavily dependent on tobacco or people with an SMI.

Importantly, LSSS should include Transfer of Care clients **in their data returns** to NHS Digital, provided **clients receive their first appointment for behavioural support within 14 days** of their discharge from hospital, release from prison or referral from other treatment centres. Commissioning models which do not allow or disincentivise Transfer of Care from hospital to community should be updated as a priority to ensure that there is not an inequity created.

Resources

Inpatient Tobacco Dependence Treatment Resources
www.ncsct.co.uk/publications/category/inpatient-TDT-resources

Embedding tobacco dependence treatment into primary care settings and outpatient settings
Best practice includes embedding tobacco dependence treatment as a standard of care in general practice and outpatient services (e.g. pre-surgical clinics, lung health checks) which have regular contact with large numbers of people who smoke and are a key setting for generating referrals to LSSS.

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

Multi-component interventions, that combine several strategies, to address barriers and increase uptake of VBA+ in primary care are most effective.

Best practices for embedding VBA+ into primary care and outpatient services:

- **Co-develop referral pathways.** GP and outpatient surgery pathways should be developed, with named responsibility for delivering each element of VBA+.
- **Training.** Primary care and outpatient staff should have the skills to deliver VBA+ and to provide accurate information to patients on the benefits of smoking cessation and the value of stop smoking aids and support. Training providers increases delivery of VBA+ and results in more patient referrals. Training as part of the GP Vocational Training Scheme (VTS) and at doctor change over dates can be transformative. Refresher training and performance coaching increases rates of delivery.
- **Champions.** As seen in other areas of quality improvement, having a smoking cessation champion within each primary care and outpatient setting can significantly improve rates of VBA+ delivery and rates of referral to LSSS.
- **Electronic prompts and referral tools.** Automated medical record prompts and simple electronic referral tools can increase delivery of VBA+.
- **Patient engagement, including carbon monoxide (CO) testing.** Offering CO monitoring alongside VBA+ and facilitating access to free or low-cost stop smoking aids can increase patient motivation to quit.
- **Automated referrals.** Automated referrals should be made for patients with a new diagnosis of a smoking related condition to discuss stopping and available support.
- **Co-promotion of services and prompt quit attempts.** Ensure visual presence in GP waiting rooms (e.g. screens in waiting rooms, GP websites, patient portals) or use of GP technology such as AccuRX to auto message patients.
- **Co-location of services.** There has been success with co-location of stop smoking support in GP and outpatient surgeries.

- **Performance feedback and coaching.** Regular feedback reports directed to both GPs and GP surgery champions on patients referred, stop smoking aids used and outcomes (e.g. 4 week quit) is good practice. There is good evidence that referral rates can be increased via performance coaching and referrer feedback. Specifically, after initial training, GPs and RNs can be supported with a coaching and feedback visit to reinforce training, address any challenges, and share positive feedback. This can be done as a group lunch and learn at the GP surgery or one to one.

Employ best practices for engaging and supporting pregnant and post-partum women and their partners in stopping smoking

The NHS has now embedded tobacco dependence treatment into maternity care services, however, there remains an important role for LSSS to support the maternity care pathway to ensure optimal outcomes. Embedding the latest evidence on best practice for engaging women and their partners in stop smoking support requires working with maternity care services. Some LSSS may be responsible for providing behavioral support to pregnant woman via a specialist advisor in the community and supporting women in the post-partum period. All services will have a key role to play in supporting spouses and family members in accessing stop smoking support.

Best practices for tailoring services include:

- Opt-out referral pathways for pregnant women **as early in pregnancy as possible** from maternity services and primary care.
- Carbon monoxide (CO) testing at antenatal appointments.
- Behavioural support delivered by a specialist stop smoking practitioner trained in working with pregnant women.
- A rapid, flexible behaviour support programme that includes home visits and co-location at family centres/hubs.
- Direct access to, and support with use of, free combination NRT or nicotine vapes.
- Offer of pregnancy financial incentive schemes. Local services should mobilise the new financial incentive scheme for women within locally available services.
- Offering support, and access to stop smoking aids, to partners and significant family members to create a social norm and motivate the pregnant client to attempt and maintain a quit attempt.
- Follow up care throughout pregnancy and into the postnatal period with relapse prevention support. This should include continuation of stop smoking behavioural support and stop smoking aids in the post-partum period where appropriate due to high risk of relapse.
- Training provided to maternity care teams as well as Health Visitors and family support teams.

Target: **Increase efficacy of stop smoking services**

1. Employ a well-trained, well-led and motivated workforce.

Investment in a well-trained, highly qualified workforce will have a direct impact on service delivery outcomes.

Stop smoking practitioners are the key asset within stop smoking services. There is a direct association between the skill level of stop smoking practitioners and treatment outcomes. Appropriate salaries and work environments, resources (mobile phones, laptops) and structures that support staff, including training, practice supervision and continuing professional development, should be a minimum quality standard. A core team of specialist staff that provide intensive support to the most complex clients, combined with community-based staff who provide less intensive stop smoking support as an adjunct to their day job, will provide a cost-effective workforce that makes the best use of limited budgets.

It is recommended by NICE guidance that all staff who deliver support to quit attempts, in both specialist stop smoking and community settings, should be NCSCT Certified Stop Smoking Practitioners. To maintain the effectiveness of interventions, it is important that those providing support receive face-to-face (in person or virtual) training in line with the NCSCT training standard, receive support and practice supervision, have access to continuing professional development and participate in update training at least once a year. Stop smoking practitioners who are NCSCT Certified have significantly better quit rates than untrained practitioners. Practitioners delivering specialist support to priority groups should receive additional appropriate training to ensure they have the knowledge, skills, and confidence for tailoring support to the needs of the population to maximise efficacy.

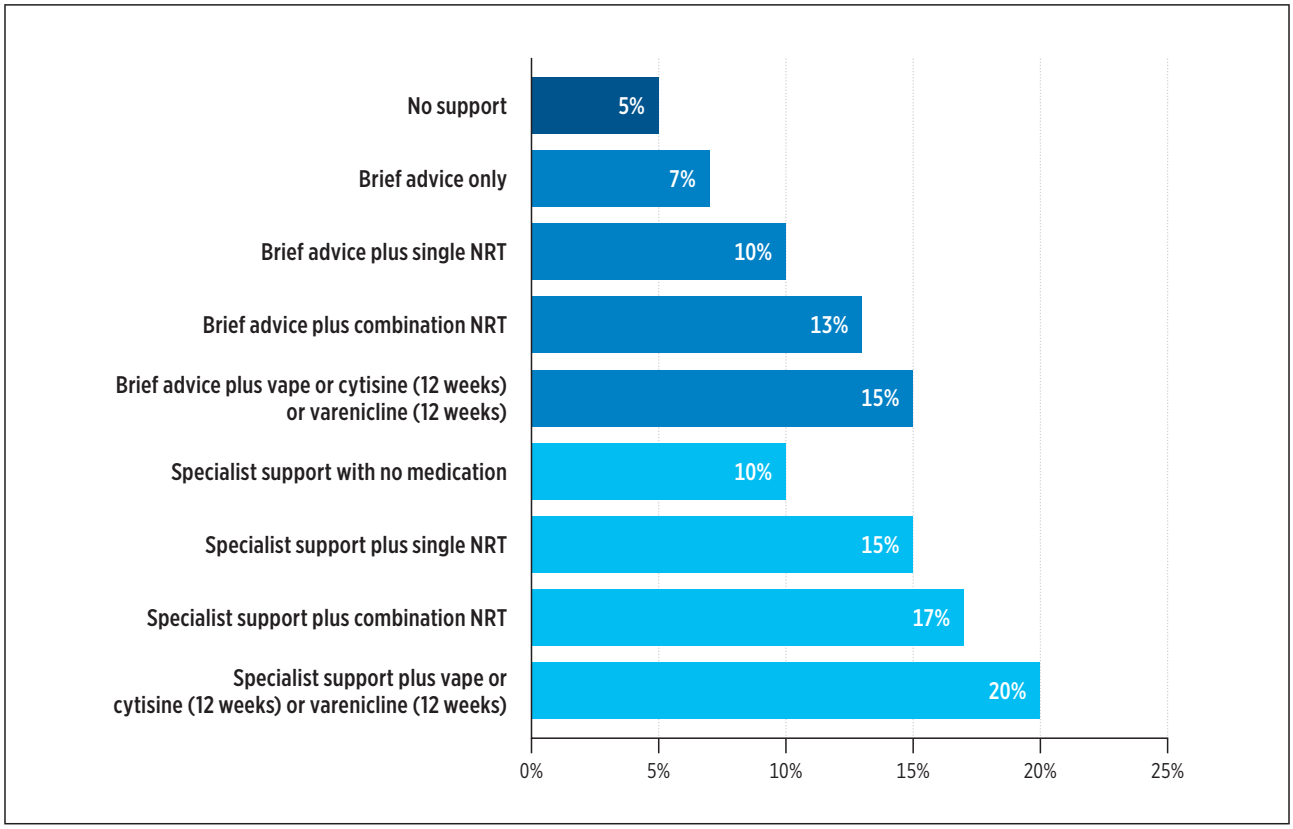
2. Provide access to all first-choice stop smoking aids, including combination NRT, nicotine vapes and nicotine analogues.

Supporting access to all first-choice stop smoking aids via stop smoking services for the full treatment course is best practice.

The latest NICE guidance provides the current standard for first-choice stop smoking aids. These aids are: combination NRT, nicotine vapes and nicotine analogues (varenicline and cytisine). First-choice stop smoking aids have been shown to increase rates of stopping long-term when used alone and further increases are seen when they are combined with behavioural support from a trained practitioner (see **Figure 2**).

Best practice includes ensuring stop smoking aids are easy to access by removing barriers and being low in cost. The provision of free stop smoking aids has been shown to increase use of treatment, compliance and rates of stopping. To ensure barriers to access and use of stop smoking aids are minimised, direct supply (having processes and protocols in place to provide stop smoking aids directly to clients at their appointment) is best practice.

Figure 2: Long-term (6 – 12 months) quit rates for stop smoking aids when used alone or in combination with behavioural support



Source: Lindson N, Theodoulou A, Ordóñez-Mena JM, et al. Pharmacological and electronic cigarette interventions for smoking cessation in adults: component network meta-analyses. Cochrane Database of Systematic Reviews 2023, Issue 9. Art. No.: CD015226.

Combination NRT (combining the NRT patch with a faster-acting NRT product) provides superior relief of withdrawal symptoms and urges to smoke, and is more effective in helping people quit than using just one form of NRT. High-quality randomised controlled trials have found nicotine vapes to be an effective aid to quit smoking. Advice regarding the nicotine concentrations used by clients who are stopping or cutting down should follow the same principles as NRT.

Nicotine analogues (varenicline and cytisine) are among the most effective stop smoking aids, with proven efficacy and a good side effect profile. Cytisine was approved for use as a prescription-only stop smoking aid in the UK in January 2024. Whilst supply and quality issues forced the withdrawal of Champix, generic varenicline returned to the market in the autumn of 2024. Ensuring the rapid introduction of nicotine analogues into the STP will maximise clients' chances of quitting successfully. In local authorities, governance processes should be used to reinforce return on investment for treatment models/aids, that may on the face of it seem cost and resource intensive, but in the long run will pay dividends.

3. Ensure policies, protocols and training support the latest evidence on effective use of first-choice stop smoking aids including tailoring dose and duration of treatment.

Stop smoking aids should be provided at sufficient doses and durations, to optimise their value as a treatment and to prevent relapse.

Combination NRT

Combination NRT (patch + faster acting product) is recommended for all clients who smoke more than 10 cigarettes per day.

Clients who are more dependent

Tailoring nicotine dosage to the client's level of tobacco dependence is recommended. The two-item Heaviness of Smoking Index (HSI), or the six-item Fagerstrom Test for Nicotine Dependence (FTND), are recommended for the assessment of tobacco dependence. People who are more dependent on tobacco generally benefit from higher doses of NRT or nicotine vapes and these higher doses are well tolerated and safe for this client group. Higher dose NRT patches (42/44 mg – two patches) are more effective in managing withdrawal symptoms in those who are **highly tobacco-dependent** compared to a single NRT patch (21/25 mg) and this should always be combined with a faster acting NRT product or vape to allow clients to self-manage. There is also evidence that varenicline is more effective than NRT in those who are more tobacco dependent. Some people who smoke, especially if more dependent on tobacco, may benefit from the use of stop smoking aids for extended periods of time (3 to 12 months). This is safe practice and recommended as a relapse prevention strategy. Client needs assessments should guide the treatment plan and funding for extended use of products should be viewed as an investment that is grounded in evidence for this group of clients. Services may decide to fund for certain clients for a limited time.

Nicotine vapes

It is recommended that all clients who choose to use a vape to stop smoking tobacco use nicotine-containing vapes and that sufficient nicotine is used to manage cravings and withdrawal. Those who are more dependent may initially benefit from vaping 20 mg/ml nicotine e-liquid in combination with a nicotine patch, using the vape as their faster-acting nicotine product.

Combining first-choice stop smoking aids

Combining drugs with different mechanisms of action, such as varenicline and NRT, has increased quit rates in some studies compared with use of a single product. The combination of varenicline and NRT has the strongest evidence of increased rates of smoking abstinence and may be particularly useful among people with higher tobacco dependence, those who continue to experience urges to smoke and/or withdrawal symptoms, and those who have reduced their cigarette consumption but not stopped completely with monotherapy. While there is limited research regarding the combining varenicline with nicotine containing vapes we would expect this combination to have similar efficacy given vapes are another form of NRT. There is also limited research looking at combination of cytisine and NRT or vapes; however, we expect similar efficacy to that seen with varenicline given these are both nicotine analogues.

Clients who are pregnant

NRT is safe and effective in supporting pregnant women to quit smoking. Combination NRT can be used for pregnant women who smoke and might be particularly helpful to those who are more dependent on tobacco or who are struggling with withdrawal symptoms and/or urges to smoke. In pregnancy, combination NRT may be particularly important because pregnant women have increased nicotine metabolism.

Nicotine vapes have been shown to be an accepted treatment among pregnant women who are unable to stop smoking during pregnancy. While very little research exists on the safety of vaping during pregnancy, a recent study found that vaping nicotine has a similar safety profile to NRT. The study also found that nicotine vapes were more effective than NRT in preventing low birth weight and helping those who are pregnant to quit smoking. While licensed NRT is the recommended option, if pregnant women choose to use a vape, and if that helps them to quit smoking and stay smokefree, they should be supported to do so with our priority being to always ensure that they do not return to smoking tobacco.

Resources

NCSCT briefing: Combination NRT
www.ncsct.co.uk/publications/combination_nrt_briefing

Royal College of Midwifery. Position Statement: Support to stop smoking in Pregnancy
rcm_position-statement_conference_2024_smoking_in_pregnancy_digital.pdf

4. Match level of behavioural support to priority groups and tailor to the needs of people who smoke.

Everyone who smokes should have access to evidence-based stop smoking support, with more intensive specialist services for those with greatest need. Support should be adapted to the needs of priority groups, tailored to individual needs and grounded in best practice.

People from more deprived communities and priority groups will need more support to achieve the same outcomes as the general population. Intensive (longer and more frequent sessions) and/or extended support (for 12 weeks post-quit and longer) may increase rates of quitting, especially in some high-priority populations. It is recommended that this support is made available to pregnant women, people with SMI, those who are heavily dependent on tobacco, those who face multiple barriers to quitting and those who are at high risk of relapse. Stop smoking practitioners should be trained in how to target and tailor interventions to these client groups.

Interventions should be adapted to address individual physical and mental health needs. Adapting the intervention (e.g. shorter, longer or more frequent consultation times), using outreach models in community settings, and home or remote services, have been shown to assist with the ability of people with SMI or other mental and physical health conditions to engage in support.

Establishing relationships between practitioners and these priority groups can be more challenging but has been shown to increase compliance and efficacy of treatment. The ability to provide consistent care (i.e. one practitioner supports client) has been identified as being particularly important for some priority groups (e.g. persons with SMI, young pregnant women, persons experiencing homelessness). Support provided to pregnant women may need to be more flexible and of longer duration compared to the general population. Continued support throughout the pregnancy, up to the date of delivery, is recommended, as relapse is common and often occurs late into pregnancy. There is good evidence that financial incentive schemes can double rates of quitting among pregnant women, both at the end of pregnancy and post-partum, and are cost effective.

5. Optimise stop smoking services in inpatient and outpatient mental health services.

People with mental illness need, and deserve, high-quality, evidence-based support tailored to their individual needs to give them the best possible chance of quitting smoking.

People with mental illness, including SMI, are a priority group due to high smoking prevalence and the established benefits to physical and mental health associated with quitting. Although just as likely to want to stop smoking as people who do not have SMI, this client group typically face significant barriers and challenges to quitting smoking. They therefore require flexibility and time. Attempting to fit them into rigid treatment protocols will be unlikely to meet their needs. The recommendations focus on a person-centered approach using a flexible service delivery model, designed to promote engagement of people with SMI, guided by the client's individual needs.

Best practices for tailoring services for people with SMI include:

- Ensuring pathways are in place for delivering VBA+, with referral to specialist tobacco treatment support in all mental health settings. The procedures for delivering VBA+ need to be defined in the treatment pathway, reflected in clinical records systems and assessed in quality assurance checks. Ensuring rapid response times promotes engagement, when motivation to quit or cut down on smoking is high.
- Ensuring all mental health staff have been trained in VBA+ for people with SMI and have strong working relationships with stop smoking advisors.
- Ensuring specialised teams of stop smoking practitioners are embedded in community and inpatient mental health services and have sufficient time to meet local needs. Practitioners working with people with SMI should complete specialised training.
- Facilitating access to NRT, nicotine vapes or nicotine analogues prior to quitting and for extended periods after quitting to prevent relapse.
- Ensuring people with SMI receive an appropriate amount of NRT, given they are typically more nicotine dependent and likely to require a higher dose than people who smoke in the general population.
- Offering quitting in one step (abrupt quit) as the first-choice option, with flexibility to offer CDTS for those not interested, or able, to stop in one step.
- Providing person-centred support that is tailored to the individual, including flexible appointment venues, more frequent contacts and tailored duration of support.
- Addressing common barriers to quitting (i.e. urges to smoke, boredom, peer groups who smoke) and facilitating alternative activities.

- Mechanisms to ensure the client's clinical care team are updated on quit attempts (starts and stops) and other information that may impact on the need for a medicines review. Particular attention should be paid to dose adjustment for patients taking some psychotropic medications such as Clozapine.
- Offering support with stopping to family/caregivers.
- Being ready for setbacks and building these into the treatment plan. This may include allowing for breaks in quit attempts. Following such a break or relapse it is important to both make re-engagement easy and to provide regular follow up to reassess interest in stopping.

Resources

Standard Treatment Plan for Tobacco Dependence Treatment in Mental Health Hospitals
www.ncsct.co.uk/publications/STP-inpatient-mental-health

Smoking Cessation Intervention for People with Severe Mental Ill Health: SCIMITAR+ Trial
www.ncsct.co.uk/library/view/pdf/SCIMITAR.pdf

Appendix A
Checklist for effective stop smoking service planning

Question	Action required	When / Who
Intelligence Led: Local prevalence, need and demand		
Is there sufficient tobacco control **commissioning capacity and expertise?**		
Is there a **local tobacco control strategy or alliance** with cross-sector input?		
Does the **local needs assessment** include a comprehensive section on tobacco control that addresses smoking-related harm and health inequalities, and acknowledges the impact of tobacco control activity across the Public Health Outcomes Framework and NHS Outcomes Framework?		
Is there a shared understanding of the local level of smoking prevalence, and service need, based on a range of local and national data across a range of public services?		
Has a **Joint Strategic Needs Assessment (JSNA)** been completed or recently updated?		
Is local data on tobacco control interventions provided within hospitals, primary health care and other settings collected and analysed to **inform the needs assessment?**		
Do commissioners own and analyse local stop smoking service treatment data to assess quality, including specific breakdown by gender, age, postcode, condition, route of referral and treatment outcome, so that treatment provision can be aligned with need?		
Does the needs assessment incorporate a methodology such as asset-based community development to consider the availability and potential for development of existing community support networks and other local assets?		
Has **an Equity Impact Assessment** been completed and shared?		
Is data available and regularly examined regarding the **impact of tobacco control and stop smoking interventions** on hospital admissions, length of stay and social care activity?		
Does **analysis of tobacco-related hospital admissions** inform the targeting of local interventions?		

Question	Action required	When / Who
Intelligence Led: Local provision of stop smoking services		
Has a **CLeaR local tobacco control assessment** been completed along with CLeaR Deep Dives?		
Has an **analysis of the gaps** in access, reach and outcomes of the current service been undertaken?		
Is there equity of access to current stop smoking services for national and local priority populations (such as routine and manual workforce, people living in social housing or experiencing homelessness, people with mental illness, people with smoking related illness, prison populations and lesbian, gay, bisexual, transgender, queer (LGBTQ) people)?		
Has support provided been weighted in terms of deprivation and does this include priority groups?		
How are the **needs of priority groups met?**		
Person-centred support:		
Is the local community involved in **co-designing support**?		
Are interventions and services **geographically and culturally appropriate** to the people for whom they are designed? How do you know?		
Are **barriers** to accessing stop smoking services identified and removed?		
Is **marketing and communication** of support offer accessible and attractive to all people who smoke?		
Will the **service model** meet demand and needs whilst being responsive to changes?		
Is there a patient-centred pathway in place for **Transfer of Care** between the NHS Tobacco Dependence Service and Local Stop Smoking Services?		

Question	Action required	When / Who
Evidence-based support:		
Do interventions commissioned for tobacco control and tackling smoking-related harm take an **evidence-based approach** based on NICE NG209 and latest 2024 National Centre for Smoking Cessation and Training (NCSCT) guidance?		
Is there systematic provision of VBA+ and routine referral written into providers contracts and supported by appropriate training and established referral pathways and systems?		
Are all of the Health and Social Care workforce receiving training on the VBA+ model and routinely referring people who smoke to either inhouse or local stop smoking support?		
Are **formalised electronic referral systems** in place to facilitate timely and efficient referral as well as supporting identification of areas where referral rates could be improved?		
Are a mix of evidence-based **service delivery models** available to meet the needs of clients and expand the reach of services?		
Is easy access to low-cost **first-choice stop smoking aids** (combination NRT, varenicline, cytisine and nicotine vapes) available to patients via the Local Stop Smoking Service?		
Are policies in place to allow for extended treatment for patients at risk of relapse?		

Question	Action required	When / Who
Quality outcomes and indicators:		
Do **contracts for commissioned services specify performance indicators** and are these regularly measured, monitored, evaluated and reviewed towards key service outcomes?		
Do performance indicators promote service design to meet quality standards and reduce the risk of gaming?		
Is **formal system-wide evaluation of the range of tobacco control support** featured in the commissioning strategy?		
Have a **wide range of measures of success been included within the contracts** to reflect the three roles of LSSS and of commissioning targets?		
How do overarching outcomes **fit within the Quality and Outcomes Framework?**		
How are outcomes **verified** as part of quality assurance monitoring?		
Are providers required to undergo an **independent audit** and review as well as conducting **internal quality assurance checks?**		
Are the consequences of failure to achieve outcomes clear?		
Are client satisfaction indicators included and monitored?		

Are the following in service specification scope?	Y/N	Action
Is the **service model** clear?		
Aims of service?		
Objectives of service?		
Funding and delivery of marketing and communication?		
Transfer of Undertakings (Protection of Employment) (**TUPE**)?		
What data, IT infrastructure and telecoms is required, how will these be implemented, and what is their maintenance plan?		
Supply and maintenance of CO monitors and ongoing supply of consumables?		
Practitioners trained to **NCSCT Standards?**		
Is **harm reduction support** included in support provision?		
Are all **first-choice stop smoking aids** available to all clients?		
How will stop smoking aids be provided to **remove barriers** to clients?		
Are **service review and auditing practices** clearly defined?		

Appendix B

Stop smoking service delivery models ranked based on evidence of effectiveness

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

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

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

NCSCT | NATIONAL CENTRE FOR SMOKING CESSATION AND TRAINING