



Tobacco: Harm-reduction Approaches to Smoking – Final Fieldwork Report

National Institute for Health and Clinical Excellence

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November 2021: NICE guidelines PH45 (June 2013) PH48 (November 2013) have been updated and replaced by NG209. The recommendations labelled [2013] or [2013, amended 2021] in the updated guideline were based on these evidence reviews. See www.nice.org.uk/guidance/NG209 for all the current recommendations and evidence reviews.

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National Institute for Health and Clinical Excellence

Report submitted by ICF GHK

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Executive summary

The Department of Health asked NICE to develop guidance on tobacco harm reduction approaches to smoking. The guidance is aimed at a wide range of stakeholders with harm reduction as a potential part of their remit, including: service providers, commissioners, managers, health and social care professionals; manufacturers and retailers of licensed nicotine-containing products; and members of the public.

ICF GHK was commissioned by NICE to field test the draft recommendations. The overall aim of this work was to capture the views of a diverse group of participants on the recommendations in terms of how clear, relevant and implementable they thought they were. Six specific questions were set by NICE:

1. *What are the views of commissioners, managers and practitioners, on the relevance and usefulness of the recommendations, to their current and future practice?*
2. *What factors could either help or hinder the effective implementation and delivery of the recommendations, as part of current or future practice?*
3. *What are the potential consequences of the recommendations for improving health and tackling health inequalities?*
4. *What is the potential impact of the recommendations on current policy, service provision or practice?*
5. *Which of the recommendations are both feasible and likely to make a difference to practice?*
6. *What would be the relative priority of each of the recommendations?*

Feedback was gathered from 125 participants across England, who participated in focus groups, telephone interviews and face-to-face interviews. A range of participants took part in the fieldwork, including public health specialists; primary and secondary care health professionals; manufacturers and retailers of NRTs; and representatives from local authorities and voluntary sector groups. This is the executive summary from the final report.

Participants supported harm reduction approaches primarily as a means to quitting

The approaches set out in the guidance recommended some potentially substantive additions to current practice. The vast majority of participants reported that current services are delivered with the sole focus of achieving quits – and are typically performance-managed against four-week quit targets.

For a significant minority of participants, the harm reduction approaches set out in the guidance represent a welcome new strategy for engaging with an increasingly hard to reach ‘hardcore’ of smokers who do not want to or are not able to quit. For these participants – a group including frontline advisors, manufacturers of licensed nicotine-containing products, and senior public health specialists – harm reduction approaches represent a new approach which may help to engage ‘hard to reach’ smokers.

Most participants, however, expressed very cautious support for harm reduction approaches per se. The clear message from the fieldwork was an endorsement of harm reduction approaches only in so far as cutting down will ultimately lead to a quit (which can be measured by the service). In particular, ‘smoking less’, as a harm reduction option, was not welcomed by the majority of participants.

Presenting ‘mixed messages’ to smokers was a key concern

While many participants commented positively on those parts of the recommendations that emphasised the primacy of abrupt quitting as the best way to improve smokers’ health, there were concerns about a potential negative impact of the recommendations as a whole. The ‘smoke less’ message, most thought, should not be presented in self-help literature or media campaigns because of the potential to blur the ‘quit message.’

Commissioning and monitoring arrangements were highlighted as key factors in enacting the recommendations

Services are typically commissioned and managed using four-week quit targets. For the recommendations to have an impact, participants thought that a change in commissioning arrangements would be required. However, in general terms, commissioners found the recommendation on commissioning (and the underlying evidence base) unconvincing, and considered that measuring harm reduction would be problematic – citing carbon monoxide breath testing as not suited to this purpose. Overall, there was little evidence in the consultations of commissioners intending to enact the guidance.

Participants debated the evidence base for the recommendations

The nature of the evidence base was raised as an issue by many participants. For some, the status of NICE as a respected authority guaranteed the robustness of the guidance; for others, significant concerns were raised over the extent to which the evidence supported the recommendations. For example, most commissioners thought that the evidence for the health benefits and cost-effectiveness of the new harm reduction approaches was insufficient to justify the changes that would be required to implement the recommendations.

Participants thought the recommendations were generally clear and understandable

Overall, participants thought that the recommendations were clearly written and relevant to their work. However, a number of suggestions for improved clarity were offered. These included calls for greater detail in some recommendations; a clearer and more comprehensive definition of temporary abstinence; and a clearer position on how long NRT products can safely be used.

The table overleaf presents the research team's overall summary of participants' views on the clarity, relevance and implementability of each recommendation. Green represents a positive response; yellow a mixed response; and red disagreement or a need for significant change. Further detail on each recommendation is set out in the main body of the report (Sections 4-19).

Table S1: Overview of fieldwork responses by recommendation

Recommendation	Clarity, detail and completeness	Relevance	Practicality of implementation	Overall likelihood of implementation
1: Raising awareness	Yellow	Green	Green	Yellow
2: Self-help support	Yellow	Green	Yellow	Red
3: Quit smoking in one step				Yellow
4: People not prepared to quit in one step				Yellow
5: Behavioural support	Yellow	Green	Red	Red
6: Carbon monoxide breath testing	Green	Green	Red	Red
7: Prescribing NRT for harm reduction	Yellow	Green	Yellow	Yellow
8: Advising on the use of nicotine-containing products				
9: Follow-up appointments	Yellow	Green	Yellow	Yellow
10: Temporary abstinence	Yellow	Yellow	Yellow	Yellow
11: People living in closed institutions	Yellow	Yellow	Red	Yellow
12: Staff working in closed institutions			Yellow	
13: Commissioning stop smoking services	Yellow	Green	Red	Red
14: Education and training	Yellow	Green	Yellow	Red
15: Promotion of licensed nicotine-containing products	Red	Red	Red	Red
16: Information on licensed nicotine-containing products	Red	Red	Red	Red

Key

	Positive response
	Mixed response
	Disagree / need for significant change

1 Introduction

1.1 Overview and purpose of the fieldwork

ICF GHK was commissioned by the National Institute for Health and Clinical Excellence (NICE) to field test draft recommendations for tobacco: harm-reduction approaches to smoking.

The aim of field testing is to gather the views of commissioners, managers and practitioners (for brevity, the report uses 'participants' as the overall term for this group) on whether and how the draft advice can be improved. This report presents the findings of the fieldwork to test the recommendations with a range of participants from public health; primary and secondary care; local authorities; private sector organisations, including retailers and manufacturers of licensed nicotine-containing products; and voluntary and community sector organisations. Detailed feedback from a series of focus groups, face to face and telephone interviews has informed the findings.

In this study, feedback was gathered from **125 participants** in England, who were asked questions **about the relevance, usability, acceptability, and implementability of the recommendations on tobacco: harm-reduction approaches to smoking.**

The views contained in this report and the conclusions derived from them are entirely based on the evidence given by participants. ICF GHK would like to thank all those who committed their time in order to give their views during this study.

1.2 Background and scope

The Department of Health asked NICE to develop guidance on tobacco harm reduction approaches to smoking. The guidance is aimed at a wide range of participants with harm reduction as a potential part of their remit, including: service providers, commissioners, managers, health and social care professionals, manufacturers and retailers of licensed nicotine-containing products, and members of the public.

The recommendations respond to the significant health risks associated with tobacco smoking; and recognise that those from routine and manual backgrounds are both more likely to smoke and more likely to take in more nicotine from cigarettes than more affluent people.

The draft recommendations therefore support the policy goal to reduce health inequalities – as set out in *Healthy lives, healthy people: our strategy for public health in England (DH 2011)* - and align with the *Tobacco Control Plan for England (DH 2011)*. The recommendations will support other key policy documents including (but not limited to): *Cancer Reform Strategy (DH 2007)*; *Equity and Excellence: Liberating the NHS (DH 2010)*; *the Health and Social Care Act 2012*; *National Stroke Strategy (DH 2007)*; *The NHS Outcomes Framework 2013/14 (DH 2012)*; *The Operating Framework for the NHS in England 2012/13 (DH 2011)*; and *the Public Health Outcomes Framework for England*.

1.3 Structure of this report

The remainder of this report comprises:

- **Methodology** (Section 2), describing the selection and characteristics of the sample, recruitment, and the analysis of data;
- **Feedback on the guidance as a whole** (Section 3), analysing the evidence given by participants that is relevant to the content and form of all the recommendations; and,
- **Feedback on the individual recommendations** (Sections 4 – 19), analysing responses to each individual recommendation.

2 Methodology

This section describes the aims and methodology used to carry out the fieldwork and analysis, including the aims and objectives, recruitment strategies employed, and a description of the resulting sample. The data analysis techniques employed are described at the end of the section.

2.1 Aims and objectives of the fieldwork

The overall aim of the fieldwork was to capture participants' views on the recommendations in terms of how relevant, usable, acceptable, and implementable they thought they were. Six specific questions were set by NICE to meet this overall aim:

1. *What are the views of commissioners, managers and practitioners, on the relevance and usefulness of the recommendations, to their current and future practice?*
2. *What factors could either help or hinder the effective implementation and delivery of the recommendations, as part of current or future practice?*
3. *What are the potential consequences of the recommendations for improving health and tackling health inequalities?*
4. *What is the potential impact of the recommendations on current policy, service provision or practice?*
5. *Which of the recommendations are both feasible and likely to make a difference to practice?*
6. *What would be the relative priority of each of the recommendations?*

This report is structured by recommendation, rather than by research question, so evidence relating to each question is presented throughout.

2.2 Sampling approach and achieved sample

2.2.1 Selection of fieldwork areas

The guidance applies to a wide range of practitioners across England. To reflect this, the following sampling criteria were used:

- **Regional spread.** In order to ensure the guidance is tested in a range of healthcare provider contexts participants were recruited from eight different regions.
- **High levels of deprivation.** Regions (and the cities within them) were selected which score highly on the English Indices of Deprivation.¹ Evidence shows that socioeconomic status is the most important variable explaining rates of smoking.²
- **Commissioning changes.** Ongoing reform of healthcare commissioning is likely to profoundly shape the provider landscape and the cessation services which are commissioned. The sample included early implementers of GP commissioning, selected from the GP pathfinder consortia.³

Focus groups were therefore conducted in the following regions (and cities):

1. West Midlands (Birmingham);
2. Yorkshire (Bradford);
3. London (Hackney);
4. East Midlands (Leicester);

¹ <http://www.communities.gov.uk/publications/corporate/statistics/indices2010>

² http://www.ash.org.uk/files/documents/ASH_93.pdf

³ http://www.dh.gov.uk/en/Aboutus/Features/DH_122384

5. East of England (Luton);
6. North West (Manchester);
7. North East (Newcastle); and
8. South West (Plymouth).

2.2.2 Selection of practitioners and professionals

In order to account for the diversity of the audience for the guidance, the fieldwork team aimed to consult with a wide range of professional groups. This included: those who play a planning and commissioning role (e.g. in local authorities); primary and secondary care professionals; voluntary sector organisation staff delivering cessation services; and manufacturers and retailers of licensed nicotine-containing products.

The total sample achieved was 125, against a target of 120. This comprised 83 focus group participants, 27 telephone interviewees, and 15 interviewees consulted face to face.

These respondents represented the following groups:⁴

- 89 (71%) primary and secondary care professionals and practitioners with smoking cessation or public health more generally in their remit. Most of these were smoking cessation advisors, including:
 - 27 employed by the NHS;
 - 20 employed in the voluntary and community sector;
 - 10 employed by the local authority; and
 - 4 private sector smoking cessation advisors.
 - Most participants were from primary care; 8 participants self-identified as secondary care practitioners.
- 37 (30%) NHS and local authority planners, managers and commissioners of public health services;
 - Of these, the majority (31) were employed by the NHS.
- 21 (17%) participants from third sector/community organisations who currently deliver smoking cessation services, or with a wider public health remit; and
- 25 (20%) manufacturers or retailers of non-tobacco nicotine-containing products.

Participants came from a variety of organisational settings, with NHS staff predominant:

- NHS public health managers and NHS smoking cessation advisors comprised just under half of the total number of respondents;
- The next most common were:
 - Community settings, employed in a third sector organisation;
 - Community pharmacists and pharmacy assistants; and
 - Local authority public/environmental health managers and smoking cessation advisors.

Across these settings, respondents had a range of roles. The largest proportion of participants self-identify as providing tobacco cessation services:

- Just under half of participants had a role providing services specific to preventing and stopping tobacco use;
- Adding these to those responsible for providing brief advice or referral, this figure increases to three quarters;
- About a fifth were commissioners. Of this group, most self-identified as commissioners of tobacco cessation services;
- Nine participants identified themselves as senior management for public health strategy and policy;

⁴ Some participants self-reported as belonging to more than one category. For example, community pharmacists were often both primary care professionals and retailers of NRT

- 11 participants self-identified as public health specialists, researchers or academics; and
- Nine participants had a community outreach or liaison role.

While many participants had a direct responsibility for tobacco control, the fieldwork team engaged with a diverse range of practitioners, including *inter alia*:

- (Assistant) Directors of Public Health;
- Dentists;
- Pharmacists;
- Opticians;
- Trading standards;
- Local authority environmental health staff;
- Prison health managers; and
- Secure mental health unit managers.

2.3 Recruitment methods

Recruitment was conducted using a purposive sampling process, designed to recruit a diverse group of participants with a remit likely to be affected by the guidance.

The recruitment process was carried out as follows:

- A letter of authority, explaining the purpose and format of the field testing, was sent to the stop smoking manager in each of the target areas. The fieldwork team then worked with them to identify a suitable date and venue for the focus groups.
- Suitable participants in each organisation were identified in consultation with the lead contact using a recruitment proforma highlighting the key groups that NICE wished to consult with. Where participants did not find it convenient to attend a focus group or did not attend, they were invited to participate in a telephone or face to face interview.
- After participants expressed an interest in taking part, the fieldwork team obtained the participant's informed consent as well as a completed recruitment proforma with information on their job role. Shortly before the field testing took place, the draft guidance was sent in full to all participants, along with a short pre-reading task designed to help structure their thoughts prior to attending.
- Participants who did not return consent forms were given the opportunity to complete them at the focus group or interview. At this point, all participants were asked to complete a sign-in sheet to collect information about their job roles and organisation.

2.4 Data gathering and analysis

Each focus group discussion was attended by two researchers: one took the lead facilitator role and the other was responsible for scribing and audio-recording the discussion. The scribe was responsible for writing up the discussion soon after the event. Telephone interviews were audio-recorded and written up. Write ups for focus groups and interviews were structured by the individual recommendations, supported by participant quotes, and themed according to the fieldwork aim and objectives, (see Section 2.1).

Once all the focus groups and interviews were completed, analysis took place using a content analysis approach. Using the fieldwork's key aim and questions, the fieldwork team identified core themes emerging from the data, defining concepts, providing explanations and finding associations and key differences between the views of different groups of participants. These were inserted into analytic templates, for an examination of summarised themes prior to reporting. Regular briefing and debriefing sessions took place throughout the fieldwork process, to agree themes and ensure that analysis was carried out in a robust manner.

3 Feedback on the guidance as a whole

This section examines participants' responses to the recommendations, and the implications for NICE are discussed in relation to feedback on the guidance as a whole.

Subsequent sections will then examine the responses to each of the recommendations individually.

3.1 Participants generally supported harm reduction approaches only as a means to ultimately quitting; there was debate as to the likely impact of the recommendations

It was widely reported that the tobacco harm reduction approaches set out in the guidance represented a substantive addition to current practice. For the vast majority of participants, current services are delivered on the basis of achieving quits – and typically performance-managed against four-week quit targets. The use of NRT as part of a programme of support to achieve this quit is largely in agreement with the recommendations' guidance on prescribing and advising on the use of NRT. In current practice, however, the extent of 'harm reduction' approaches is to cut down to quit – not to cut down indefinitely, as participants interpreted some parts of the guidance as endorsing. This harm reduction option – set out in the third bullet point in Box 1 on page eight of the guidance – was the key focus of discussion throughout the fieldwork, as it represented the significant addition to existing practice.

"I think this [guidance] is incredibly radical and would really stir things up in a big way." – NHS commissioner

For a significant minority of participants, the harm reduction approaches set out in the guidance represent a welcome new strategy for engaging with an increasingly hard to reach 'hardcore' of smokers who do not want to or are not able to quit. For these participants – a group including frontline advisors, manufacturers of licensed nicotine-containing products, and some senior public health specialists – harm reduction approaches represent a novel method to address this issue.

Most participants, however, expressed very cautious support for harm reduction approaches. The clear message from the fieldwork was an endorsement of the current practice described above – that is, to promote harm reduction approaches only in so far as cutting down will ultimately lead to a quit (which can be measured by the service). Reducing smoking indefinitely – participants' interpretation of the third harm reduction option – was not welcomed by the majority of participants.

Another key concern was that of presenting 'mixed messages'. While many participants commented positively on those parts of the recommendations that emphasised the primacy of abrupt quitting as the best way to improve the health of people who smoke, there were nonetheless widespread concerns about a potential negative impact of the recommendations as a whole.

Some thought that presenting smokers with an option to 'cut down indefinitely', as they understood it, rather than quit, presented an 'easy way out'. Many thought that at best, this should be offered as an option only by a trained advisor after the abrupt quit message has been seen to have failed (acknowledging that currently, quitters may take six or seven attempts before successfully quitting). The 'smoke less' message, most thought, should therefore not be presented in self-help literature or media campaigns because of the potentially negative impact of blurring the 'quit message'.

In addition to these 'in principle' issues, two important concerns were raised regarding:

- commissioning and monitoring arrangements; and
- the evidence base for harm reduction.

Services are commissioned and managed to a set of targets – typically measured by four-week quits. For the recommendations to have an impact, participants thought that a change in commissioning arrangements would be required. For this reason, Recommendation 13 was a key focus of discussion (discussed further in section 16). Yet in general, commissioners found this recommendation (and the underlying evidence base) unconvincing, and ultimately there was little evidence in the consultations of commissioners intending to enact the guidance.

The robustness of the evidence base was raised as an issue by many participants. For some, the status of NICE as a respected authority guaranteed the robustness of the guidance. For most, however, significant concerns were raised over the extent to which the evidence justified the recommendations made.

Most commissioners thought that the evidence for the health benefits and cost-effectiveness of harm reductions was insufficient to justify the significant changes that would be required to implement the recommendations. There would likely be significant cost associated with reform, and this concern was exacerbated for commissioners by uncertainty on how long-term NRT would be paid for, and how harm-reduction approaches might be paid for within 'payment by results' contracts (where payment is typically attached to a quit).

Furthermore, many expressed the view that measuring harm reduction would prove problematic: the use of carbon monoxide testing was considered unsuitable for this purpose (fuller detail on this is available in the chapter dealing with recommendation six).

3.2 Participants thought the guidance was generally clear and understandable; some changes were suggested

Overall, participants thought that the recommendations were clearly written and relevant to their work. However, a number of suggestions for improved clarity were offered, the most commonly mentioned being that:

- A few of the recommendations would benefit from greater detail if they are to be enacted (detailed in Sections 4-19 below);
- The definition of 'temporary abstinence' was the subject of debate for many participants; this is in part because it is a relatively new proposition for services (see Section 13 below);
- A significant minority of participants was confused by the statements in the guidance on how long NRTs can be used for. These participants reported that NRT is sometimes referred to as for use for as long as necessary, and elsewhere as safe for up to five years;
- The language used in recommendation headings could be made clearer and more 'active'. For example, Recommendation 9 could read "*Offering follow-up appointments*," with similar changes made to other recommendations;
- Recommendation 13 was seen as of central importance; accordingly a few participants suggested it be placed as the first recommendation; and
- Many participants raised concerns regarding the dangers of promoting harm reduction approaches in self-help literature (see above in relation to 'mixed messages'). A few suggested that this recommendation be moved towards the back of the document.

Suggestions were also made regarding gaps in content. These were that:

- A significant minority of participants thought that the pharmacy role was insufficiently recognised in lists of who should take action throughout;
- Many commented on the importance of behavioural approaches; a significant minority thought that they should be more prominent throughout the guidance;
- A few participants thought the draft guidance missed opportunities to link with the Smokefree agenda; and
- A few thought that each recommendation should link directly to its relevant evidence statements in a way which is easy to follow.

4 Recommendation 1: Raising awareness of nicotine-containing products to reduce the harm from smoking

Recommendation summary

This recommendation is intended for professional bodies such as the British Medical Association and the Royal Medical and Nursing Colleges; regional tobacco control organisations; stop smoking services; statutory agencies, such as health and wellbeing boards and local authorities; and voluntary and community sector organisations.

The recommendation focuses on raising awareness among the public of the harm caused by smoking and second-hand smoke. In this recommendation there is an emphasis on providing information in a range of formats and languages for different target groups. It is advised that this information should cover facts such as: the types of diseases smoking causes; the reason why nicotine is addictive; and the safety of NRT products. Information on licensed nicotine-containing products should cover type, effective usage and where to obtain them; and outline the cost compared to smoking cigarettes.

4.1 There was general agreement with the recommendation, with some qualifications

Participants saw this recommendation as largely describing current practice in the way their services promote licensed nicotine-containing products. Nonetheless, the recommendation was welcomed as a means of raising awareness across public health and primary care professionals, as around half of stop smoking specialist staff reported that not all health and social care practitioners in their local areas have a full understanding of the nature of nicotine-containing products. For example, Stop Smoking Services staff in one group commented that their service has to 'undo' the messages smokers receive from other, non-specialist health professionals on the dangers of licensed nicotine-containing products.

Stop smoking advisors strongly welcomed the inclusion of an action to provide information on licensed nicotine-containing products. Many thought that smokers can struggle to understand the variety of products available, the relative benefits of each and how to use them effectively. The majority view was that this information is best provided face-to-face by an advisor where possible – as is current practice in many Stop Smoking Services.

There were mixed views on providing information in a range of formats and languages for different target groups. Some practitioners said that this was current practice; for others the decision had been made that this is not a cost-effective approach. The reason given for this was that if the smoker does not speak English, they are also likely to be illiterate in their own language.

Discussion of Recommendation 1 often first raised a theme that would then be raised throughout – the issue of who should pay for nicotine replacement therapy and how long it should go on for. Participants made it clear that this could have significant resource implications and would be a key factor in the likelihood of the recommendations being enacted.

4.2 Views on providing information on e-cigarettes varied across participant groups

There was lively debate on the action regarding providing information that *“little is known about the effectiveness, quality and safety of unregulated nicotine-containing products (such as electronic cigarettes) however, they are likely to be less harmful than cigarettes.”*

Frontline advisors often noted that many of the smokers they see are aware of electronic cigarettes and sometimes ask whether they should use them. The common view received from advisors across the fieldwork is that as an unlicensed product, electronic cigarettes should not be actively promoted. However, several advisors reported having told interested

smokers that electronic cigarettes are 'likely to be less harmful' than cigarettes. In this context, most frontline advisors – as well as Stop Smoking Service managers – welcomed this part of the recommendation as a recognition of the 'reality' of smokers' knowledge of and interest in e-cigarettes, prior to the Medicines and Healthcare products Regulatory Agency (MHRA) licensing decision.

A few participants, on the other hand, were opposed to the 'endorsement' of electronic cigarettes. This was because of: a fear of 're-normalising' smoking behaviour (e-cigarettes were seen as not breaking the habits associated with smoking); or because these participants would be more comfortable waiting for a robust evidence base before making a recommendation.

Manufacturers of licensed nicotine-containing products were strongly opposed to the inclusion of this statement in the recommendation. Their view was that NICE should not be 'endorsing' – or perhaps even mentioning – any product which has not yet demonstrated its safety and effectiveness.

4.3 Participants expressed mixed views about long-term NRT use

There was no single, coherent view from participants about long-term supply of NRT in principle. Some supported this option as a safer alternative to smoking, while others objected, mainly on the grounds that this would maintain an addiction to nicotine and so present a greater risk of relapse.

This was an area in which the discussion sometimes turned to the underlying evidence base, with some participants remaining unconvinced that longer-term use of NRT as a substitute for smoking was an effective method of helping smokers to ultimately quit (as noted above, for many participants cessation should always be the 'end goal').

A significant minority of participants were confused by the juxtaposition of statements firstly endorsing lifetime use of NRT, and then stating that NRT products have been demonstrated to be safe to use for up to five years.

5 Recommendation 2: Self-help support

Recommendation summary

This recommendation is directed at a wide range of participants including: national, regional and local organisations responsible for public health and tackling tobacco use; organisations providing practitioners with training to reduce the harm caused by smoking; telephone helplines and internet support sites aimed at helping people to quit smoking; manufacturers of licensed nicotine-containing products; retailers; and social media websites.

It recommends the provision of self-help materials in a range of formats and languages to meet the needs of different groups. It states that materials should advise people to stop smoking cigarettes altogether - or to smoke less if they do not want to quit. Information should also be provided on the benefits of using licensed nicotine-containing products; the type of products available; guidance on usage and where to obtain products; as well as how to get further help and support.

5.1 Generally there was strong opposition to this recommendation, particularly due to a perceived risk of 'mixed messages'

The view from most stop smoking advisors was that harm-reduction messages are not currently delivered through self-help materials.

"This recommendation would likely lead to a need for new sets of materials around smoking less and would need to be tailored to different types of smoker – at the moment the literature would be too generic." – Public health consultant

With current approaches focussed on achieving quits, the majority of participants thought that this recommendation could present smokers with mixed messages – that, contrary to the prevailing message, it was 'acceptable' to continue smoking. A few participants even suggested that recommending harm reduction in a leaflet could have the result of encouraging smoking.

"As an ex-smoker, you need that push to really stop. If a middle ground is offered, you'll take it" – Stop Smoking Advisor

Furthermore, there was a view among many frontline advisors that specialist and personalised support is required to help smokers through the options available to them; the recommendation should be careful not to overstate the benefits of self-help support.

Beyond these specific concerns, many participants considered that self-help support is the least successful way to give up smoking cigarettes. They thought that this recommendation may be suitable for smokers who are confident in giving up, while for more vulnerable groups, or those needing additional support, self-help support would be less effective.

5.2 Participants made suggestions to improve the recommendation

Participants suggested that:

- Clarity was needed on where to obtain NRTs and how long people can access them on prescription;
- The Royal Pharmaceutical Society should be listed under 'who should take action';
- 'Self-help' should extend to smokers' wider personal support network – to include families and communities supporting smokers to quit; and
- Finally, participants welcomed the reference to social media websites, particularly as a means of engaging with young people.

6 Recommendation 3: People who want to quit smoking in one step

Recommendation summary

This recommendation is directed at frontline health and social care practitioners, such as those working in primary and secondary healthcare (including GPs, practice nurses, pharmacists and health trainers) and residential and domiciliary care. In addition, this recommendation targets telephone helplines and internet support sites aimed at helping people to quit smoking.

This recommendation is focused on helping those people who want to quit smoking in one step. It is advised that services should offer support for quitting smoking in one step by recommending pharmacotherapy and if able, offer to supply or prescribe it. In addition, practitioners should provide advice and targeted activities through one-to-one or group sessions. Referrals to a stop smoking service for pharmacotherapies and more intensive behavioural support should also be offered.

In addition, the recommendation advises the use of licensed nicotine-containing products for as long as necessary after a smoker has stopped smoking.

6.1 Participants supported the message of quitting in one step; they were generally sceptical of presenting smokers with other options

There was strong support for this recommendation's action point to identify smokers and advise them to quit smoking as the best option.

By contrast, many thought that presenting smokers with an option to 'smoke less indefinitely', as they interpreted it, rather than quit, presented an 'easy way out'. Many thought that, at best, this option should be offered only by a trained advisor after the abrupt quit message has failed (acknowledging that quitters may require six or seven attempts before successfully quitting).

While participants generally support the endorsement of pharmacotherapy in this recommendation, around half commented that there should be a stronger emphasis on behavioural support. For these participants, the placement of pharmacotherapy above behavioural support in this recommendation suggests a 'too medical' approach.

6.2 Participants raised practical concerns regarding the long-term use of NRT, as well as specific points for improving the recommendation

Despite the overall support for this recommendation, there was some concern about the mention of long term NRT usage:

"The recommendation may ultimately lead to there being too much choice for some people – they would choose the easy option of not quitting" – Stop Smoking Service Manager

A key issue concerned who should prescribe or supply pharmacotherapy and for how long NRT use might last (and be funded for). Greater clarity was called for on these points which may act as key barriers to enacting the recommendation.

Many stop smoking service staff thought the recommendation would be improved by a stronger emphasis on referral into their services. In addition, the list of who should take action should be widened to include stakeholders such as children centres, schools, acute care, and voluntary and community sector workers.

7 Recommendation 4: People who are not prepared to quit smoking in one step

Recommendation summary

This recommendation is intended for frontline health and social care practitioners, such as those working in primary and secondary healthcare (including GPs, practice nurses, pharmacists and health trainers) and residential and domiciliary care. In addition, this recommendation targets telephone helplines and internet support sites aimed at helping people to quit smoking. Stop smoking advisers are also included.

The recommendation advises services identify clients' smoking behaviour and their triggers for smoking. Using this information and their own professional judgement, practitioners and services should work through the harm-reduction approaches outlined in the guidance to find the most suitable approach for that smoker.

Services should also advise people that using licensed nicotine-containing products may be more effective to cut down to quit or to smoke less.

Should the smoker need more intensive support, practitioners and services are asked to offer a referral to stop smoking services.

7.1 Participants expressed general support for the specific actions, qualified by concerns over the risks inherent in some harm reduction approaches

The general response to this recommendation can be summarised as qualified support. Firstly, frontline advisors generally welcomed the action to use professional judgment to work through the harm reduction options, based on the person's smoking behaviour. This fits with participants' concerns regarding the appropriateness of using self-help materials to guide smokers through what might be seen as a complicated series of options; and also with the general support for the usefulness of behavioural support approaches. Frontline advisors were also familiar with the guidance on recommending one or more NRT product, and this fits closely with current and accepted practice.

Advisors currently offer a 'cut down to quit' approach where smokers do not want to quit abruptly, and welcome the emphasis on using NRT products to support this. However, there was significant concern expressed regarding the acceptance of the 'smoke less' option, which participants interpreted as accepting that smokers may smoke less indefinitely.

As with other recommendations, participants raised questions regarding the evidence base on the safety and effectiveness of long-term NRT use. A significant minority questioned why this recommendation endorses indefinite use of licensed NRT, while other recommendations note that NRT has been proven to be safe for only five years.

"We need strong guidance on how to implement this recommendation. At the moment, you need six or seven sessions with someone to help them quit. What's the impact for cutting down? How many sessions are required and how is success measured?" – Tobacco Control Alliance Co-ordinator

A few participants commented that they would welcome a statement in the guidance on the role of Champix in harm reduction approaches.

It was also noted that the voluntary and community sector should be added to the list of who should take action.

8 Recommendation 5: Behavioural support for harm reduction

Recommendation summary

This recommendation is directed at stop smoking advisers; frontline health and social care practitioners who are trained to provide behavioural support to help people who smoke to quit; and telephone helplines and internet support sites aimed at helping smokers to quit.

It advises that these practitioners should find out more about the person's smoking habits and level of dependence. This information should be used to help people set goals, discuss reduction strategies and develop a schedule detailing how much they will aim to cut down (and by when).

For those aiming to quit, it is recommended that a quit date should normally be within 6 weeks from the start of receiving structured support. For those aiming to smoke less but not currently intending to quit smoking, a date should be set for when they will have achieved their reduction goal. The recommendation stresses that services should advise people on how to use licensed nicotine-containing products where necessary.

Practitioners should follow up with those receiving behavioural support to see whether they have achieved their goal(s).

8.1 Participants welcomed the inclusion of behavioural approaches

The majority of participants were pleased to see the guidance support behavioural approaches. Many frontline advisors expressed the view that behavioural support is integral to an effective service of helping someone to quit or to cut down with an intention of quitting smoking. A significant minority of participants commented in relation to other recommendations that behavioural approaches should feature more prominently.

"There is a lack of focus on behaviour change in the guidelines in general." – Stop Smoking Specialist Advisor

Most frontline advisors were familiar with the 'heaviness of smoking index' as a tool for diagnosing a smoker's behaviour and level of dependence. However, this is not currently used as part of harm reduction strategies and some questioned how useful this index would be as a harm reduction tool.

Most participants supported the action point of following up with smokers to determine whether goals have been achieved. In particular, this was seen as a valuable opportunity to re-engage with smokers and move them 'up' to a cut down to quit or abrupt quit approach.

8.2 Many were uncomfortable with the option of smoking less

Most participants again raised concerns with the perceived message of 'setting a goal of smoking less indefinitely'. This was how most participants interpreted the third harm reduction option presented in Box 1 on page eight of the guidance; this general debate was often raised during discussion of the action point in this recommendation to help people who are aiming to smoke less to set a date for their reduction goal.

"Cutting down is fine as long as you do then quit." – Stop Smoking Specialist Advisor

As with throughout the recommendations, many participants had significant concerns regarding the lack of evidence on the potential health benefits of a harm reduction approach; the possible diversion of resources away from services for those who want to quit; and the practical challenge of commissioning for cutting down:

"I am unclear on how you assess a behavioural change properly and how you could commission services and training which are tailored to the individual." – Public Health Consultant

8.3 Participants raised practical concerns with the recommendation

The following points were raised as practical concerns with this recommendation in particular:

- There were mixed views on setting quit dates. While some participants welcomed the inclusion of a definite deadline, others thought that within the tight 12-week window of current support arrangements, setting a quit date within six weeks would be too late. This issue partly came down to a variation in participants' interpretation of the action point – whether the action point is to set a date for quitting that is within six weeks of the start of receiving support; or to take the action of setting a quit date within six weeks of the start of receiving support.
- A significant minority called for greater clarity on how frequently services are expected to see people leading up to a quit date. Moreover, as support to people who are aiming to smoke less would represent a relatively new offer for most services, participants felt this action in particular would require detail on how often support should be provided. Many suspected this ongoing support over a longer term would be prohibitively expensive for services; a few suggested this is likely to reduce the potential impact of this recommendation among GPs and pharmacies due to a lack of time to deliver this intervention. Related challenges for commissioning were also raised.

9 Recommendation 6: Carbon monoxide breath testing

Recommendation summary

This recommendation targets stop smoking advisers and frontline health and social care practitioners, in particular those working in primary and secondary healthcare (including GPs, practice nurses, pharmacists and health trainers).

The recommendation suggests that carbon monoxide breath testing should be conducted to establish a baseline before someone starts to smoke less (whether they are intending to quit smoking or not). Progress should be monitored by conducting further tests, and practitioners should provide positive feedback at appropriate intervals.

Services should ensure that staff conducting carbon monoxide breath testing have been trained to do it correctly. Staff should be able to interpret the results for people who are aiming to smoke less, as well as for people who are cutting down to quit.

9.1 Most participants strongly disagreed with this recommendation

Carbon monoxide breath testing was well-known and accepted by Stop Smoking Service managers and advisors across the statutory, private and voluntary sectors. Currently it is used to validate quit attempts to meet audit requirements; for providers under payment by results contracts, it is a requirement for being paid.

Most participants disagreed with this recommendation. They suggested that it was likely to be ineffective or, at worst, potentially harmful. This was because levels of carbon monoxide vary significantly depending on when the most recent cigarette was smoked, rendering this approach a poor indicator of an overall reduction in smoking. Furthermore, the inaccuracy of the reading might cause harm to the smoker's health prospects as they could think their harm reduction progress is better or worse than it actually is, causing them to alter their behaviour accordingly (and inappropriately).

“Good as a population screening method, but has no place as a measure of harm reduction.” – Head of Tobacco Control

Participants' disagreement with this recommendation subsequently affected their responses to other recommendations, and Recommendation 13 in particular. With carbon monoxide breath testing rejected as a potential means of measuring harm reduction, commissioners especially were not able to see how outcomes could be reliably measured for a harm reduction approach.

10 Recommendation 7: Prescribing NRT for harm reduction

Recommendation summary

This recommendation is directed at stop smoking advisers, GPs, and nurse prescribers.

The recommendation states that NRT products should be offered to people who smoke, as part of a harm reduction strategy. All types of NRT should be on offer, either separately or in combination, according to their preference and level of dependence.

People should be advised to replace each cigarette with an NRT product – for example, a lozenge or piece of gum. Ideally this should be taken just before the person would normally have a cigarette, to allow for the slower nicotine release from NRT products.

NRT products should be offered to help prevent a relapse among people who have quit smoking and those who have reduced the amount they smoke.

10.1 There was broad support for providing NRT products; though only qualified support for the use of NRT as part of harm reduction approaches

The recommendation to offer a range of NRT products – either singly or in combination and according to preference and level of dependence – was welcomed by participants and considered to be broadly descriptive of current practice, particularly in Stop Smoking Services. Frontline advisors noted that smokers have a wide range of preferences for different nicotine replacement products and it is important that these preferences be taken into account when offering NRT. Current practice in prescribing NRTs singly or in combination varied, but generally the view was that combinations are prescribed for smokers with a higher level of dependency.

As with previous recommendations, most participants qualified their support for this recommendation with the view that any harm reduction approach should be framed as a means to an eventual quit. In this context, most did not agree with the recommendation to prescribe NRT to those who have decided to smoke less without the intention of setting a quit date. Furthermore, a significant minority of participants commented that indefinite use of NRT may fail to break smokers' dependency on nicotine, increasing the risk of relapse.

10.2 Many participants had concerns regarding the practicalities of prescribing NRT

The primary concern from many participants was who should pay for NRT products. They thought it is important that the recommendation should be clear on who should pay – and for how long. The immediate objection for many – and particularly commissioners – was of a potentially unmanageable cost implication of prescribing NRT for those who have reduced the amount they smoke. This would be particularly problematic if services are intended to support smokers taking a harm reduction approach for a longer time period than is currently taken with 'quitters' (often 12 weeks).

While most participants agreed with the importance of offering a range of NRTs in principle, for some this would prove challenging in the context of tightening resource constraints. Expanding access to these products to smokers who wish to cut down without the intention to quit would, on this view, create an added financial strain.

“We find it hard enough to get the full range of NRT for those who want to quit, let alone those who are cutting down indefinitely.” – Director of Public Health

Finally, a few participants suggested that, since NRT can be supplied without a prescription, the use of “prescribing” in the recommendation title should be reconsidered.

11 Recommendation 8: Advising on the use of nicotine-containing products

Recommendation summary

This recommendation is intended for frontline health and social care practitioners, such as those working in primary and secondary healthcare (including GPs, practice nurses, pharmacists and health trainers) and residential and domiciliary care. In addition, this recommendation targets telephone helplines and internet support sites aimed at helping people to quit smoking. Stop smoking advisers are also included.

The focus of this recommendation is to advise people on the use of nicotine containing products. Practitioners should offer reassurance to smokers that licensed nicotine-containing products are a safe and effective way of reducing the harm from cigarettes. The advice should also include that licensed nicotine products can be used separately or in combination; using more than one product is more likely to be successful.

Advice should be given on how to use licensed nicotine-containing products correctly, for controlling cravings, preventing compensatory smoking and achieving quit, reduction or temporary abstinence goals.

The recommendation makes reference to unregulated nicotine-containing products (for example, electronic cigarettes). It states that although such products are not currently regulated by the MHRA meaning their safety and quality cannot be assured – however, they are likely to be less harmful than cigarettes.

11.1 Participants welcomed the broad messages of the recommendation

As with Recommendation 1, participants generally welcomed the recommendation's support for licensed nicotine-containing products as safe and effective means of reducing the harm from cigarettes. While this is already current practice across most services, participants welcomed the message being reiterated for the benefit of health and social care practitioners who may not have received this message.

Stop smoking advisors' current practice of advising on the use of NRT singly or in combination matches the wording of the recommendation; again participants welcomed this recommendation in raising awareness of this practice across the wider health and social care sector.

11.2 Support for the recommendation was qualified with concerns about the long-term safety of NRT products and 'endorsement' of electronic cigarettes

Responses to this recommendation often revisited recurrent themes raised during discussion of earlier recommendations – namely concerns on clarity regarding NRT safety and the appropriateness of NICE being seen to 'endorse' non-licensed products.

A significant minority of participants were confused that the recommendation states both that NRT products have been demonstrated to be safe for up to five years and that licensed nicotine-containing products can be used 'indefinitely', if necessary. For these participants, this uncertainty would prevent them from enacting this recommendation.

As noted previously, frontline advisors often noted that many of the smokers they see are aware of electronic cigarettes and sometimes ask whether they should use them. The common view received from advisors across the fieldwork is that as an unlicensed product, electronic cigarettes should not be actively promoted. However, informally, several advisors reported being comfortable telling interested smokers that electronic cigarettes are 'likely to be less harmful' than cigarettes. In this context, most frontline advisors – as well as stop smoking service managers – welcomed this part of the recommendation as a recognition of

the 'reality' of smokers' knowledge of and interest in e-cigarettes, prior to the MHRA licensing decision.

A few participants, on the other hand, were opposed to 'endorsement' of electronic cigarettes: this was because of a fear of 're-normalising' smoking behaviour; and because e-cigarettes do not alter the behavioural habits of smoking – a technique important to helping people quit. A few other participants wanted to see the evidence base before taking a position. Manufacturers of licensed nicotine-containing products were strongly opposed to the inclusion of this statement in the recommendation. Their view was that NICE should not be 'endorsing' – or perhaps even mentioning – any product which has not yet demonstrated its safety and effectiveness.

Participants were generally satisfied with the wording of the recommendation, but participants in one focus group agreed that "*experts believe that lifetime use of NRT...*" was poorly worded as it suggests that the recommendation is not evidence-based.

12 Recommendation 9: Follow-up appointments

Recommendation summary

This recommendation is directed at stop smoking advisers, and frontline health and social care practitioners who are trained to provide behavioural support to help people who smoke quit.

The recommendation is to offer follow-up appointments to review the progress of people who have adopted a harm-reduction approach to smoking. Smokers who have not reached or maintained their quit or smoking reduction goals should be encouraged to try again.

Practitioners should also have a discussion with people aiming to quit or cut down about whether they would like to continue using the same licensed nicotine-containing product or would like to try a different one (or a different combination of products).

12.1 This recommendation was welcomed in principle, although practical concerns were raised

Participants welcomed the most general messages of this recommendation. Follow-up support was widely considered as good practice and an integral part of a quality service. Furthermore, this re-engagement with smokers was seen as a positive opportunity to reintroduce the service to smokers. The recommendation to discuss with the smoker whether they wish to change their goals was received positively (particularly since this was seen as an opportunity to revise goals 'upwards' towards quitting rather than a permanent harm reduction approach).

The key barrier identified to enacting the recommendation was the potentially prohibitive cost of ongoing support for smokers who have adopted a harm reduction approach. Where no clear quit date has been defined or agreed upon, services reported that they would be unlikely to be able to fund support without changes to commissioning arrangements.

Participant views were mixed on the perceived lack of clear guidance on when services should follow up. Some thought that the lack of prescription would allow them to accommodate this within existing practice; others expressed a desire to see greater precision on timing.

13 Recommendation 10: Temporary abstinence

Recommendation summary

This recommendation is aimed at stop smoking advisers; frontline health and social care practitioners who are trained to provide behavioural support to help people who smoke to quit; and telephone helplines and Internet support sites that help people to quit smoking.

The recommendation focuses on supporting those people who want to abstain temporarily on a short-term, medium-term or longer-term basis. The recommendation's target groups should provide information about the different types of licensed nicotine-containing products and how to use them. Where possible, they should prescribe NRT as advised in recommendations 7 and 8.

Behavioural support should also be offered to those who want or need to abstain temporarily. Information should be offered on reasons to reduce the harm caused by smoking and advice on how to do this via one-to-one or group sessions.

Services should also assess the motivations of those smokers who have successfully abstained on a temporary basis to do so again on other occasions (or for longer periods); smoke less; or quit smoking.

13.1 Participants had no direct objections to the recommendation, but did express a desire for greater clarity

This recommendation was seen as something of a new approach. Frontline advisors reported that it was not common to be approached by smokers for temporary abstinence support. Indeed, most participants associated the concept of temporary abstinence with 'Stoptober' – a campaign which many expressed support for.

Because of this unfamiliarity with temporary abstinence, participants sought greater clarity on its definition. For example, a few advisors reported being unsure as to whether long-haul flights should qualify as 'temporary abstinence'. These participants requested more clarity regarding the minimum length of time required to constitute a temporary abstinence. Similar questions were raised for whether smokers' pre- and post-operation periods might qualify as temporary abstinence.

Regardless of this lack of clarity, participants' responses to the core messages of the recommendation mirrored those given elsewhere in the guidance. For example, advisors would offer NRT to smokers who are going on holiday to support a reduction of smoking, and would also offer behavioural support.

Participants welcomed the action point to assess smokers' motivation to move on to other harm reduction approaches; again, this was framed as a step towards the 'end goal' of a quit.

One representative of a manufacturer of licensed nicotine-containing products raised the point that regulation limits the potential to advertise temporary abstinence approaches:

"If you look at licenses for NRT, we don't have temporary abstinence in our indication – we have to be careful how to communicate because we have to stick within legislation." – Manufacturer of licensed nicotine-containing products

13.2 The recommendation could be better linked to others, and to wider policies

A significant minority of participants thought that this recommendation in particular would benefit from explicit alignment with and references to policies on workplace smoking and Smokefree homes and cars. Within the document, a few commented that the recommendation might also explicitly refer to Recommendation 5 (after mentioning behavioural support) and Recommendation 9, to provide follow-up support.

14 Recommendation 11: People living in closed institutions

Recommendation summary

This recommendation is directed at managers of services where smoking is not permitted, such as secure mental health units and custodial sites such as prisons and police stations.

Members of staff providing harm-reduction advice in situations where smoking is not permitted should be trained to the same standard as NHS stop smoking advisers. This includes people working in mental health and prison health services.

Staff working in closed institutions should understand and recognise that smoking can be an integral part of some people's lives. Staff should recognise the issues arising from enforced smoking cessation and how the environment may restrict the quitting techniques and coping mechanisms that would be typically used.

It is advised that staff must understand that if someone reduces the amount they smoke (or quits completely), this can affect their need for psychotropic medication. Arrangements should be in place to adjust their medication accordingly.

Managers should provide the support required for successful temporary abstinence from smoking as outlined in recommendations 5-8, including prescribing or supplying NRT products.

14.1 The recommendation was generally supported by staff working in closed institutions

The 'tone' of the recommendation – of recognising the different context for people living in closed institutions and trying to quit – was generally welcomed by participants, particularly those working in prisons. The vast majority of participants from prison health and secure mental health unit staff were pleased to see recognition from NICE of smoking being 'an integral part' of some people's social lives. For these smokers, enforced withdrawal from smoking can have significant negative impacts.

"Smoking in a mental health hospital is a society, it's somewhere they can go, talk and feel understood" – CEO, mental health charity

Many participants operating in secure institutions responded positively to the recommendation's action point on ensuring staff understand the potential impacts on the need for psychotropic medication. These participants reported that many are unaware of the relationships between smoking and psychotropic medication, and so further guidance and/or support materials would be required to assist staff in adjusting medication accordingly.

Managers and advisors based in secure institutions generally agree with offering NRT products along the lines suggested in recommendations 5-8. However, this was largely with the caveats mentioned in the summary of those recommendations – that smoking cessation services are commissioned to achieve four-week quits, and so a significant move to a 'pure' harm reduction approach was considered to be unlikely. There were also concerns regarding potential abuse of the system – for example that prisoners may adopt a harm reduction approach in order to 'sell on' NRT products.

A few participants suggested that as a recommendation for temporary abstinence, this should link directly to Recommendation 10. There was also a suggestion from one focus group that the use of 'peer support' may be usefully referenced in the list of who should take action for this recommendation.

14.2 Practical constraints will limit the scope for implementation

Participants reported that the nature of prison services prohibits services from following some of the action points of the recommendations. For example, prison staff reported varying practice in offering NRT. In one prison NRT is not allowed as it could be used as

currency; in another gum cannot be offered (as it can be placed in locks), but other products – including inhalators, lozenges, tabs and clear patches – are provided.

There were mixed views on ensuring all staff are trained to the same standard as NHS stop smoking advisors. Resource constraints mean that some participants argued for a system of generalists referring smokers to trained specialists.

15 Recommendation 12: Staff working in closed institutions

Recommendation summary

This recommendation targets managers of services where smoking is not permitted, such as secure mental health units and custodial sites such as prisons and police stations. It is also aimed at workplace managers of enclosed premises.

Managers and workplace managers should provide staff who smoke with advice and guidance on how to quit smoking in one step, as detailed in recommendation 3. If, after discussion, the person does not want (or does not feel able) to do this, they should be asked whether they would like to consider a harm-reduction option. Staff working in closed institutions who are reluctant to quit should be encouraged to use licensed nicotine-containing products.

Temporary abstinence from smoking should be enforced for the full period of duty for staff that have health and social care responsibilities in settings where people are not allowed to smoke.

15.1 Participant views on this recommendation were mixed

Current practice on this recommendation varied significantly across participants. For example, one service reported piloting a smoking cessation service for health staff based within the prison, which will be spread to wider prison staff if take-up is high. For another, the view was that smokers within the prison are the priority, not the staff, and resources should be allocated accordingly. Similarly, policies on workplace smoking for staff with health and social care responsibilities varied.

“You can’t smoke on the premises and, being a prison it’s not easy to get out... harm reduction is a viable strategy with many staff already using patches during the day.” – Clinical Services Manager at a prison

Going beyond current practice, views on the likelihood of implementing the recommendations were also mixed. Some saw the value of offering harm reduction approaches to staff in these services, while others thought they are not in a significantly different position to other NHS staff – and so the scope of the recommendation should be broadened.

For those that disagreed with the imposition of a temporary abstinence policy, a risk of losing the trust of staff was cited as a key barrier. The view was that as long as they are not smoking on wards, it is important that staff do not feel ‘nannied’ by their managers. Some cautiously supported enforced abstinence, while recognising it would require a significant cultural change to be accepted.

Either way, many participants agreed that if this recommendation were to be enacted, it would be important to make it into a more positive message of support for staff, rather than of enforced abstinence.

Ultimately, there was little evidence from managers of smoking cessation services in closed institutions that action was likely on the basis of this recommendation. The reasons given were that service targets (and, in some cases, payment by results contracts) are based on quits, and the priority is inmates rather than staff.

As in Recommendation 11, this was seen by a few participants as closely related to the recommendation on temporary abstinence, and so Recommendation 10 might be referenced here.

16 Recommendation 13: Commissioning stop smoking services

Recommendation summary

This recommendation is directed at commissioners of Stop Smoking Services within health and wellbeing boards; local authorities and their directors of public health; clinical commissioning groups; and the NHS Commissioning Board.

The recommendation states that commissioners should ensure that investment in harm-reduction approaches to smoking does not detract from, but supports and extends the reach and impact of, existing stop smoking services.

Commissioners should also ensure that service specifications include requirements that stop smoking services offer licensed nicotine-containing products; and staff working in Stop Smoking Services are trained to National Centre for Smoking Cessation and Training level 2, or the equivalent.

The recommendation suggests outcome measures to help manage the performance of service providers that support people who want to cut down on their smoking before quitting, or who want to smoke less.

Commissioners are advised to monitor service delivery and uptake to identify the points of contact when and where longer-term use of licensed nicotine-containing products is offered and its outcomes. This information should be used to inform future commissioning.

16.1 This recommendation was seen as of central importance to the guidance

Participants were clear that smoking cessation services, delivered across the statutory, private and voluntary sectors, are commissioned and managed to quit targets. There was awareness among participants in a few areas of a broader policy shift to services commissioned on payment by results contracts, which is likely to further emphasise the importance of quits within contracting arrangements.

Furthermore, with the broader organisational changes across the health landscape – senior stakeholders in particular highlighted the shift of responsibility for public health from NHS to local authorities – any significant changes in the way services are delivered (such as those contained in this guidance) would need to be clearly and persuasively communicated to a new set of commissioners. As a result, most participants saw this recommendation as critical to the implementation of the recommendations more broadly.

16.2 Commissioners raised questions about the robustness of the evidence base

Most commissioners raised concerns about the extent to which the evidence base for harm reduction approaches can justify the resources required to develop new activity and outcome measures for harm reduction. They also cited costs in ensuring that harm reduction approaches are integrated within services – as well as the costs associated with delivering harm reduction services as detailed in other recommendations.

“I would need to understand from the policy and evidence whether it is cost-effective. It’s all very well saying harm reduction is a good thing – and I agree with that. But it is in competition with quitting, and we don’t currently provide a comprehensive quitting service.” – Commissioner

The current financial context, where savings are being sought, means that there is an increased emphasis for commissioners on an economic evidence base and the need to justify the cost-effectiveness of any new approach.

“As a commissioner I would read the first bullet of this guidance and disregard the rest. In terms of the resources we have available, there is no point doing this” – NHS Commissioner

Most commissioners thought that the recommendations and the evidence base presented in the draft guidance did not present adequate grounds for a change in services. For example, a few commissioners commented that there is no detail given on the extent to which a 50% reduction in cigarettes smoked would result in a health gain, or how this varies by the overall number of cigarettes smoked. Overall, commissioners expressed reluctance to invest in what they saw as a new and unproven approach.

“It says early on we don’t know the health benefits of smoking less and yet it’s mentioning it as almost as good as quitting.” – NHS Commissioner

A few commissioners questioned the status of the draft guidance document as a whole and NICE’s status, given what they considered to be a weak evidence base.

“This could create a credibility problem for NICE. I think it goes too far without evidence.” – NHS Commissioner

16.3 The indicators suggested were considered to be unhelpful

Many commissioners thought that the list of outcome measures included in the recommendation contradicted the spirit of ‘harm reduction’ in the draft guidance document, as only one of the four referred to smoking less. As the ‘smoke less’ option represented the most significant addition to current practice, more detail on commissioning and monitoring associated services would be required. By contrast, most participants thought that there is no need for guidance on commissioning services on the basis of achieving quits. As noted in the discussion of Recommendation 6 above, most thought that carbon monoxide breath testing was not an appropriate measure of reduction, and so measurement of this target would be problematic. At best, some commissioners considered this target of a 50% reduction in cigarettes smoked as a potential ‘soft target’ to be used for performance management. They also noted that measurement would most likely rely on smokers self-reporting, with associated problems of recall and accuracy.

Participants agreed that a means of measuring harm reduction would be required if services are to be commissioned that are in keeping with the harm reduction agenda. To this end, a few participants called for a closer alignment of this NICE draft guidance and the DH targets (currently based on 4-week quits) which drive the commissioning and management of services.

“Harm reduction has to lead to a quit or we can’t get it commissioned.” – Health Improvement Specialist

This difficulty is compounded for services operating on payment by results tariffs, as a tariff would need to be calculated for harm reduction goals.

16.4 This recommendation appears unlikely to be implemented

Some elements of the recommendation reflect current practice. It was reported, for example, by most Stop Smoking Service managers and advisors, that training to National Centre for Smoking Cessation and Training Level 2 standard is common practice for their services – though this is not always included in service specifications. Similarly, it is common practice for services to work in the community.

However, the cost implications, lack of appropriate outcome measures, and lack of compelling evidence suggesting significant health benefits of tobacco harm reduction approaches all contributed to a reluctance among commissioners to follow this recommendation.

“This would be impossible with the staff we have – to manage, monitor, deliver, provide training to everyone, offer harm reduction to everyone as well as hosting a stop smoking service.” – Stop Smoking Service Co-ordinator

16.5 Participants made suggestions to improve the clarity of the recommendation

The recommendation as a whole was considered clear, however suggestions for improvement were made by a few participants:

- The last action point was cited as unclear;
- This recommendation should be brought to the front of the document (to become Recommendation 1), because it underpins all the other recommendations;
- The NHS Commissioning Board and the Department of Health should be added to the list of who should take action.

17 Recommendation 14: Education and training for practitioners

Recommendation summary

This recommendation is aimed at Health Education England; organisations providing training on the harm caused by smoking; and commissioners, providers and managers of Stop Smoking Services (including health and wellbeing boards, local authorities and their Directors of Public Health).

The recommendation suggests that these bodies should include the principles and practice of tobacco harm reduction, as outlined in the tobacco harm reduction guidance, within all relevant curricula.

These organisations should also ensure that service specifications and service-level agreements state that staff are trained to National Centre for Smoking Cessation and Training level 2 (or the equivalent) and undertake regular continuing professional development. The aim is to ensure that staff are qualified to help people quit or cut down on their smoking.

17.1 Participants agree with the importance of training and continuing professional development, particularly if harm reduction approaches were to be adopted

Regardless of their views on tobacco harm reduction approaches to smoking, most participants agreed on the importance of training – and particularly welcomed the endorsement of continuing professional development. There was a familiarity with the National Centre for Smoking Cessation and Training and most stop smoking specialists consulted were qualified to Level 2 or equivalent.

There was broad agreement that changes in training curricula would be necessary if services were to adopt the principles and practice of tobacco harm reduction as outlined in the draft guidance. This is because harm reduction approaches are not widely practised by existing services and would represent a significant cultural shift from the 'quit' message.

However, as most participants did not agree with the effectiveness of the 'smoke less' harm reduction approach, this specific recommendation is unlikely to be enacted (by commissioners and managers of Stop Smoking Services). Indeed, a few managers and commissioners noted that training for practitioners would add additional costs to the programme of reforms associated with this guidance, further increasing the need for evidence of cost-effectiveness.

A significant minority of participants expressed confusion regarding which of the action points relates to which of the participant groups listed in 'who should take action'. Additionally, a few thought it unrealistic that Royal Colleges would take on these responsibilities given their other commitments.

18 Recommendation 15: Point-of-sale promotion of licensed nicotine-containing products

Recommendation summary

This recommendation is targeted at tobacco retailers and manufacturers of licensed nicotine-containing products.

It recommends that these participant groups: encourage people who smoke to consider the harm-reduction options outlined in the guidance; display licensed nicotine-containing products in shops and supermarkets, and on websites selling cigarettes and tobacco products; and ensure products are clearly priced.

18.1 Responses to harm reduction approaches varied by participant group

Manufacturers of licensed nicotine-containing products supported the recommendation's action point to encourage people who smoke to consider harm-reduction options. Providing NRTs as a safer alternative to smoking was reported as being within the license and indications for these products (although possibly not specifically for temporary abstinence). Some manufacturers welcomed this recommendation as representing an endorsement from NICE, as this contributes to the credibility and legitimacy of harm reduction as a public health strategy.

Stop smoking advisors working in retailers of nicotine-containing products generally expressed views similar to those of advisors in other settings: that the prevailing monitoring arrangements incentivised encouraging smokers to quit; and that without a change in how their services are commissioned, the likely impact of the recommendations on the service they provide is likely to be limited.

18.2 Participants varied in their interpretations of the recommendation for clear pricing

Manufacturers and retailers varied significantly on how they interpreted the action to “ensure products are clearly priced.” Some interpreted the point as asking retailers to make sure the price is clearly displayed on the shelf – a response to a problem these participants did not believe was significant. For one major retailer, this recommendation was said to be in the right spirit but that it carried no practical implication, as retailers are already required by law to price clearly. Others interpreted the action as a call for pricing to allow more transparent comparisons between NRT products – for example by displaying the cost per mg of nicotine. According to one representative of a manufacturer of NRT, this may require regulatory intervention. This is because different products have different dosages and different lengths of effectiveness (e.g. 18 hours or 24 hours), making consumer comparisons more difficult.

18.3 More clarity was called for on displaying licensed NRTs; barriers may exist

Participants called for clarity on the action point to display licensed nicotine-containing products in shops and supermarkets, and on websites selling cigarettes and tobacco products. Participants expressed a desire for greater detail on where these licensed products should be placed relative to cigarettes, and questioned how this recommendation might fit with changes to rulings on the display of cigarettes.

Most manufacturers and retailers of licensed nicotine-containing products thought that NICE guidance was unlikely to have an impact on what will ultimately be decided as a set of commercial decisions between retailers, tobacco manufacturers and manufacturers of licensed nicotine-containing products.

“If the retailers have an available space it has a commercial value and it would be a commercial negotiation.” – Manufacturer of licensed nicotine-containing products

Ultimately the lack of detail and the perceived lack of status of NICE in the retail arena caused most manufacturers and retailers to doubt the likely impact of this recommendation.

18.4 Participants were unsure as to the status of NICE in relation to retailers

A common view expressed on this recommendation across participant groups was that NICE guidance may not have influence over retailers and manufacturers of licensed nicotine-containing products. This view was supported, to some extent, by interviews with a number of retailers and manufacturers – who cited the MHRA and commercial decisions as more significant drivers of behaviour.

“Not sure why retailers are included in a document from NICE. Most healthcare people have a real arms length from tobacco retail.” – Retailer

On a wider point, around half of participants thought that the recommendation should target retailers more generally. The issue underpinning this suggestion is that by targeting the recommendation at ‘retailers of tobacco,’ the draft guidance misses out pharmacists.

Pharmacy was noted by a significant minority of participants as a key target group for the recommendation as they are a key retailer of NRT, and are also in a position to support smokers using their medical expertise. Finally, a significant minority of participants added that the recommendation should encourage retailers (including pharmacists) to refer or signpost to specialist stop smoking advisors.

19 Recommendation 16: Information on licensed nicotine-containing products

Recommendation summary

This final recommendation is directed at manufacturers of licensed nicotine-containing products.

It recommends that manufacturers should provide simple, clear instructions on how to use licensed nicotine-containing products to support the harm-reduction options outlined in the guidance. Manufacturers should provide information on the outside packet as well as on the inner leaflet. They should also package products in a way that makes it as easy as possible for people to take the recommended dose, and provide safety information, including details on long-term use.

19.1 Participants welcomed the recommendation; however greater detail and wider stakeholder involvement is needed

Stakeholders welcomed this recommendation as a means of making licensed nicotine-containing products as easy as possible to be correctly used. Frontline advisors in particular often noted that smokers can find products difficult to use, and many added that it is well-known that many users of NRT do not take the recommended dose. For these reasons, these stakeholders were pleased to see this recommendation to encourage action to simplify products and encourage effective use.

Furthermore, it was noted by many stakeholders that the multiplicity of NRT products could confuse users. The lack of standardisation across manufacturers means that NRT products vary by price, strength, and pack size. According to one retailer, *“It is hard for the customer to know where to start.”*

However, participants from manufacturers and retailers of licensed nicotine-containing products were sceptical of the ability of this recommendation to affect change. One reason is that the recommendation lacks detail for manufacturers to act upon.

“If there are specific examples that the team behind the guidance could highlight, that would make it much easier for us to action.” – Manufacturer of licensed nicotine-containing products

Another reason given was that bringing clarity and simplicity to the range of NRT products available will require a co-ordinated effort across the industry – most likely via a regulatory intervention. In its current format, the recommendation is interpreted to apply to individual manufacturers; some manufacturers suggested the MHRA would need to be involved if this recommendation was to be enacted.

“To some extent there will need to be dialogue between MHRA and manufacturers to determine the extent to which we can act on Recommendation 16.” – Manufacturer of licensed nicotine-containing products

19.2 The status of NICE guidance in relation to manufacturers’ practice was questioned

All manufacturers consulted welcomed the recommendation. In particular, it was seen as positive that the harm reduction approach was being supported by NICE and this was considered to lend the agenda further credibility, compared with the message being conveyed by manufacturers or retailers alone. Some retailers and manufacturers gave the view that the commercial sector has already recognised a harm reduction approach and is developing and marketing products with this in mind.

“In reality customers are already behaving like this.... they are using [products] all year round, in situations like holidays, travelling on a plane, an office environment.”
– Retailer

A few of these participants also noted that the guidance document may have value when discussing licensed nicotine-containing products with other stakeholders in the NHS and public health more widely. However, manufacturers' activity in relation to this recommendation will largely be driven by the MHRA.

"We are bound by MHRA regulation so whatever we can do, we have to make sure it is in line with medicines legislation and endorsed by the MHRA. We're not necessarily free to respond to these [recommendations] as others might choose." –
Manufacturer of licensed nicotine-containing products

Annex 1 Participant sign-in sheet

Participant sign-in sheet

Please fill in **both sides** of this sheet so we can know a little more about the professional backgrounds of people attending today.

Your name: _____

Your role: _____

Your organisation: _____

Q1. Please tick **one or more** categories which best describe your current role:

Primary care practitioner in a clinical or community setting (e.g. stop smoking advisor, community pharmacist, dental nurse)	
Secondary care practitioner in a hospital setting (e.g. clinical staff, ward staff, senior management)	
Local authority officer/practitioner in a community setting (e.g. stop smoking advisor or appropriately trained youth workers, community development workers, or other council officers)	
NHS planner, manager and/or commissioner of public health services (e.g. CCG/PCT commissioner, NHS manager)	
Local authority planner, manager and/or commissioner of public health services (e.g. environmental health, councillor, HWB rep)	
Third sector/community organisation staff currently delivering or managing smoking cessation services	
Third sector/community organisation staff who do not currently deliver or manage smoking cessation services	
Private sector staff currently delivering or managing smoking cessation services (Other than community pharmacists)	
Retailer of non-tobacco nicotine-containing products (e.g. nicotine gums, patches, lozenges and sprays)	
Manufacturer of non-tobacco nicotine-containing products (e.g. nicotine gums, patches, lozenges and sprays)	
Other, please describe:	

Q2. Please tell us if your role covers the following responsibilities – **please tick all that apply:**

Commissioner of smoking cessation or tobacco control services	
Commissioner of public health services	
Providing services specific to stopping or reducing tobacco use	
Providing brief advice and/or referral for smoking cessation/tobacco use (e.g. in your role as a primary health care professional or community development officer)	
Primary or secondary health care provision without any responsibility for advice (brief or specialist), and/or referral for smoking cessation/tobacco use	
Outreach and community liaison	
Public health specialist, researcher or academic	
Provider of smoking cessation/tobacco use training for practitioners	
Senior management role responsible for public health strategy design and policy-making	
Other leadership role, such as a role which mainly involves coordinating services, clinical care or commissioning	
Other not mentioned above (please give brief description):	

Thank you.

Annex 2 Recruitment templates

Invitation letter

Date

Dear Colleague

Subject: National Institute for Health and Clinical Excellence (NICE) fieldwork on public health draft guidance – Tobacco: harm-reduction approaches to smoking

ICF GHK (an independent social research company) has been commissioned by the National Institute for Health and Clinical Excellence (NICE) to undertake fieldwork on their draft public health guidance on Tobacco: harm-reduction approaches to smoking.

NICE is committed to improving the quality of its guidance by listening to the views of experienced, knowledgeable people in local areas across England. Testing the recommendations with relevant professional groups through fieldwork is an important part of the process through which NICE public health guidance is tested and produced.

Your participation in this fieldwork will help to examine the relevance, usability, acceptability and implementability of the NICE draft guidance and recommendations on tobacco harm reduction.

As part of the process, we are carrying out fieldwork in **Location**. We are keen to involve a wide range of professional groups in this work, which will ensure that recommendations in the final guidance are relevant, appropriate, useful, feasible and implementable and informed by your opinions. We are seeking to recruit a sample which covers four broad professional groups relevant to tobacco harm reduction. These four groups are:

- 1) Primary and secondary care staff working in the NHS, local authorities or the private sector;
- 2) NHS and local authority planners, managers and commissioners;
- 3) Third sector providers of smoking cessation services; and
- 4) Manufacturers and retailers of non-tobacco nicotine-containing products;

The focus group will be held at:

Location

Date

If you would like to participate in this focus group please contact Oliver Jackson at oliver.jackson@ghkint.com or 0121 233 6995. We can then confirm your place and provide you with a copy of the draft guidance.

The final report which outlines the fieldwork findings will be used by NICE to inform a final version of its recommendations. The report may be published on the NICE website.

Your identity will not at any point be revealed in the fieldwork or any final products. although ICF GHK may quote participants, all comments will be anonymised and **will not identify you or your organisation** within the report.

If you have any questions regarding this fieldwork or your rights as a participant, you can contact Oliver on the email address or telephone number provided above.

Yours sincerely,

Oliver Jackson

Consent letter

Date

Dear Colleague

Subject: National Institute for Health and Clinical Excellence (NICE) fieldwork on public health draft guidance – Tobacco: harm-reduction approaches to smoking

Consent to participate in research – PLEASE SIGN AND RETURN

Location and address

Date and time

As part of the National Institute for Health and Clinical Excellence (NICE – www.nice.org.uk) fieldwork process, we are carrying out fieldwork in **Location**. We would like to know your views so that NICE's recommendations on tobacco harm reduction are relevant, appropriate, useful, feasible and implementable.

NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Conducting fieldwork with professional groups who may be affected by the recommendations is an important part of the process in the production of this NICE guidance.

The fieldwork is being carried out by ICF GHK on behalf of NICE, alongside the wider public consultation being managed by NICE. Participation in this fieldwork is being requested on the basis that participants share their **personal views as professionals in the field**; we are not asking participants to represent their organisations in this fieldwork. Organisational responses can be submitted through the formal stakeholder consultation process. This can be done by visiting the NICE website at: <http://www.nice.org.uk/>.

If you agree to participate in the fieldwork, you will be asked to take part in a focus group or interview, which will be recorded using a digital recorder. The recordings and transcripts will be handled and stored securely on encrypted servers and destroyed after five years in accordance with best practice. The focus group will last no longer than the allotted time, but you have the right to end early if it is inconvenient, or talk for longer if you wish.

The final report produced as a result of the analysis will be used by NICE to inform a final version of its recommendations to the field, and the report may be published on the NICE website.

Your identity will not be revealed at any point in the final report. Although ICF GHK may quote you, all comments will be anonymised and will not be identifiable to yourself or your organisations.

ICF GHK will provide you with a copy of the draft NICE guidance closer to the focus group.

If you have any questions regarding this fieldwork or your rights as a research participant, you can contact **Oliver Jackson** at oliver.jackson@ghkint.com or 0121 233 6995.

Placing your signature below indicates that you have read and understood the information provided above, that you willingly agree to participate, that you understand your right to discontinue participation at any point, and that you have received a copy of this form.

Printed Name _____ **Organisation** _____

Signature _____ **Today's Date** _____

Phone Number _____ **Email** _____