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Developing a vape shop-based smoking cessation intervention: a Delphi study

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Abstract

Introduction

Providing access to a vape shop-based smoking cessation intervention may simultaneously increase e-cigarette use and increase the effectiveness of e-cigarettes for smoking cessation. The aim of this study was to identify the most important elements of vape shop-based smoking intervention to stakeholders who would be involved in delivering or accessing such an intervention.

Methods

We conducted a three-round Delphi study of vape shop staff (n=40), stop smoking professionals and tobacco control leads (n=30), and smokers, vapers and dual users (n=30) in the United Kingdom in May-August 2021. In each round participants were asked whether they agreed or disagreed statements related to vape shop-based interventions.

Results

Forty-six of 95 statements reached consensus in round one, 29 out of 49 in round two and eight out of 20 in round three. There was support for a vape shop-based intervention across stakeholder groups (96%). There was consensus that the service should comprise both product (98%) and behavioural support (97%), and that quitting vaping should not be a goal of the service (79%). Although there was consensus that there should be some free product provision, there was less consensus as to what this should involve. Views were mostly consistent across stakeholder groups.

Conclusions

There was broad consensus on how to deliver a vape shop-based smoking cessation intervention, providing a strong basis for future intervention development and implementation. Challenges around misuse of the service and misperceptions about vaping would need to be addressed for such an intervention to be feasible and effective.

Implications

Many smokers who make a quit attempt using e-cigarettes purchase their vaping products in vape shops. Delivering vape-shop based smoking cessation interventions could help to maximise the effectiveness of e-cigarettes for quitting smoking. This study used a Delphi approach to identify the most important elements of a vape shop-based intervention among stakeholders. The findings could be used to help develop future interventions.

Introduction

Electronic cigarettes (e-cigarettes) are currently used by an estimated 4.7 million adults in Great Britain.¹⁻³ Most adult (16+) e-cigarette users in England (referred to as 'vapers') are either ex-smokers, or smokers who also use e-cigarettes (referred to as 'dual users'); 57% of vapers are ex-smokers, and 35% are dual-users.³ Quitting smoking and remaining abstinent are the most frequently cited reasons for e-cigarette use.³ E-cigarettes are currently the most popular smoking cessation aid in England; among smokers who smoke and tried to stop or who stopped in the past year in England around a third used e-cigarettes.⁴ A range of new tobacco control measures and funding for smoking cessation in England was recently announced, highlighting the government's commitment to supporting the use of e-cigarettes for smoking cessation.⁵

A recent systematic review of the evidence on the health risks of nicotine vaping concluded that although vaping is not risk-free, it poses a small fraction of the health risks of smoking in the short and medium term.⁶ Evidence on longer term vaping (more than 12 months) is still needed. A Cochrane review concluded that e-cigarettes can be effective for smoking cessation⁷; however, their real-world effectiveness relies on them being accessed and used in a way that is conducive to smoking cessation. Providing access to a vape shop-based smoking cessation intervention (VSBI) may simultaneously increase e-cigarette use and increase their effectiveness for smoking cessation compared with unsupported e-cigarette use.

Data suggest that non-specialist shops, such as supermarkets and convenience stores, have overtaken vape shops as the most popular source of vaping products in England since 2021; however, specialist 'vape shops' remain a popular source of products, used by approximately one quarter of vapers aged 16 and over who smoke or who stopped in the past year.⁴ Given that vape shops provide access to an alternative to smoking which current evidence suggests is likely to be less harmful⁶ and the large number of shops in the UK – over 3600 in 2020,⁸ although this figure may have reduced during the COVID-19 pandemic – there is potential for them to play an important role in tobacco harm reduction.

The National Centre for Smoking Cessation and Training has highlighted the role of vape shops in supporting quit attempts and has published guidance on how to work with vape shops for cessation service providers and commissioners.⁹ Some stop smoking services in England have set up schemes whereby service users can receive discounts from specific vape shops, or have purchased e-cigarette products for service users from vape shops, which is one approach to ensuring that smokers who are trying to quit have access to e-cigarettes as well

as behavioural support.⁹ However, only a small proportion of smokers access specialist smoking cessation services, and many local authorities have cut their budgets for these services in recent years, or decommissioned them altogether.^{10,11} As an alternative, interventions could be based within or run through vape shops. Such interventions have already been run in some parts of the UK (such as Essex¹²) but to date few studies have explored the best way to deliver this type of support.

A mixed-methods study of vape shops in the East Midlands region of England and their customers found that vape shops contribute to customers' positive experiences of vaping, but that in general they are not regarded as a place in which smokers can access smoking cessation advice.^{13,14} Similarly, a qualitative study investigating the role of the vape shop environment in supporting smoking abstinence in East Anglia found that providing traditional smoking cessation support is not perceived as the main role of vape shops by either vapers or vape shop staff.¹⁵ In the East Midlands study, however, many participants – both vape shop staff and customers - suggested that vape shops could be an appropriate setting for delivering smoking cessation advice.^{13,16} In a more recent qualitative study, we found that stop smoking service providers, local tobacco control leads, smokers and vapers and vape shop staff recruited from across the UK were positive about the idea of a VSBI (*manuscript under review*). Most participants agreed that this should be primarily delivered by trained vape shop staff with support from SS, that a VSBI should be flexible in terms of the type, duration and frequency of support provided, and that the intervention should comprise both technical guidance on using a vape and behavioural support to prevent a return to smoking.

This paper describes a subsequent Delphi study which aimed to identify the most important elements of VSBI to stakeholders who would be involved in delivering or accessing such an intervention.

Methods

Design

The Delphi method was developed to reach consensus of expert opinion.^{17,18} Typically, the Delphi survey involves a series of rounds of questionnaires to expert 'panellists' whereby participants rate and rerate these ideas after seeing panellists' responses from previous rounds, until consensus is reached, or a predetermined endpoint is reached. Our survey was conducted over a series of three rounds, which is typical for the approach, between May and August 2021.¹⁹

In each round participants were asked whether they agreed or disagreed with a series of statements related to VSBI. Development of statements for each round was iterative, with the first round informed by the findings of a previous qualitative study (*manuscript under review*). Statements covered all key aspects of the intervention design including the purpose of the intervention, format, duration of support to be provided, who should deliver and content of advice. Statements that reached a consensus (agree or disagree) in each round were removed from the subsequent round.

The study was approved by the University of Nottingham's School of Medicine Ethics committee (reference number 404-1910).

Recruitment and sampling

The purpose of the Delphi study was to reach consensus on how to deliver a VSBI based on the views of key stakeholders who would be involved in delivering and accessing such an intervention. Therefore, stakeholders comprising vape shop staff, smokers and vapers (including dual users) and stop smoking professionals were invited to participate in the study. Smoking, vaping and dual use were self-reported. A stop smoking professional was defined as someone listed as a trained provider of smoking cessation services, as identified by tobacco control leads who facilitated recruitment of this group

We recruited participants by contacting individuals who consented to be contacted about the Delphi study during recruitment to a qualitative study that preceded this work²⁰ (109 stop smoking professionals; 123 smokers, vapers and dual users; 36 vape shop staff).

Recruitment methods varied depending on the stakeholder group. Smoking cessation training providers and individuals working in Tobacco Control at Public Health England (England's Public Health Agency at the time of the study) circulated study information to their contacts working as stop smoking professionals (SSP) and Tobacco Control Leads (TCL) on our behalf (purposive), and participants were also asked to forward this on to others who worked in the same capacity (snowballing). Smokers, vapers, and dual users (SVD) were recruited using a convenience approach, via Facebook adverts (over 6-weeks). Those interested in participating completed a short online survey to check eligibility: Over 18 years old, able to participate in an English language study, and identifying as one of our stakeholder groups.

Vape shops were contacted directly by the researcher. This group was recruited from a diverse sample of bricks and mortar vape shops by mapping postcodes for UK vape shops (~2500 of which, including online shops, are listed in a national directory -

ecigdirectory.co.uk) to geographical area, index of deprivation (IMD) and rurality measures (MB and TL checked mapping of 10%). For maximum variation, vape shops from different geographical areas, with differing IMD classifications were contacted about the study. Additional participants were recruited using snowball sampling.

There is no agreed sample size for online Delphi surveys and no criteria against which a sample size choice can be judged. Some studies have had success with around 20 panel members; however, given the diversity of the sample and to ensure a sufficient sample size even in case of attrition, we aimed to recruit 100 respondents, with broadly similar representation from each of our different stakeholder groups.

Data collection and measures

Data collection was undertaken via Online Surveys (formerly Bristol Online Surveys). Delphi survey participants were offered £5 vouchers for the first two rounds and £10 upon completion of all three. Email and text reminders were sent to participants to maximise retention. Each round was open for four weeks (round one May, round 2, June/July, round 3 August, 2021), and each survey took approximately 15 minutes, 10 minutes and 7 minutes to complete, respectively.

Measures

In each round participants were asked whether they agreed or disagreed with a series of statements related to VSBI. Development of statements for each round was iterative, with the first round informed by the findings of a previous qualitative study (*manuscript under review*). Statements covered all key aspects of the intervention design including the purpose of the intervention, format, duration of support to be provided, who should deliver and content of advice. Statements that reached a consensus (agree or disagree) in each round were removed from the subsequent round. Details regarding the number of items for each round are outlined below:

Round one: Participants were asked to select how much they agreed, or disagreed, with 96 statements using a five-point Likert scale: *strongly agree; agree; uncertain; disagree; strongly disagree*. Participants were also invited to give feedback on questions if they felt the wording of any statements was ambiguous.

Round two: Forty-six statements that did not reach consensus in round one were included in round two, with two questions being slightly reworded as per participant feedback. The results

from round one for these statements were also included, so each statement was presented with information on how many participants had strongly agreed, agreed, were undecided, disagreed or strongly disagreed, with the statement during round one. A free text comment box was also added as per participant feedback.

Round three: Twenty statements that did not reach consensus in round two were included, along with the results for each statement from round two. No further amendments were made to the statements.

Analysis

Survey responses were imported into SPSS 28. Ratings of '*strongly agree*' and '*agree*' were combined into a single '*agree*' category. Ratings of '*disagree*' and '*strongly disagree*' were combined into a single '*disagree*' category'. Descriptive analysis was used to assess whether a statement had reached consensus (*agree* or *disagree*); a consensus point of $\geq 70\%$ was selected in line with previous Delphi studies. (17-19) Chi-squared tests were carried out on all statements that reached consensus to explore any differences between stakeholder groups.

All statements that reached consensus were ranked according to strength of consensus. Values were assigned according to whether participants rated a statement as '*strongly agree*', '*agree*', '*undecided*', '*disagree*', or '*strongly disagree*'. If a statement reached consensus as '*agree*', the scoring was Strongly Agree = +2, Agree = +1, Undecided = 0, Disagree = -1, Strongly Disagree = -2. If the statement reached consensus as '*disagree*', the scoring was reversed. The data were then analysed to calculate the mean score of each statement, producing a number between 2 and -2. A higher score was deemed to indicate a greater strength of consensus on the statement. Data was missing for one participant for one statement, in the final round of the survey; however, this did not affect the conclusions of the study as this statement failed to reach consensus (*Local stop smoking services should be responsible for monitoring, overseeing and managing the vape shop service*).

Results

A total of 100 participants representing vape shop staff (n=40), smokers/vapers or dual users (30) and SSP (30) took part in round one, with 78 retained in round two and 63 in round three (Figure 1; Table 1), resulting in attrition rates of 22% and 19% from Rounds 1 to 2 and 2 to 3 respectively. Attrition figures were higher among younger age groups, vapers and vape shops (Table 1). The results for each statement are summarised in Table S1. Forty-six of 95 statements reached consensus in round one, 29 out of 49 in round two and

eight out of 20 in round three. Responses were generally consistent across the three stakeholder groups. Across the three rounds there were differences between the groups on only nine statements which reached consensus overall; these differences are described below. Table 2 summarises the key recommended characteristics of a VSBI based on the three rounds of the Delphi survey. A summary of statements reaching consensus by Delphi round and a summary of those not reaching consensus are provided in supplementary tables S2 and S3 respectively.

General views

Participants generally held positive views about vaping; there was consensus that it is safer than smoking and an effective aid to smoking cessation (91% agreed). Nearly all participants agreed that offering stop smoking support in vape shops is a good idea (96% agreed).

Accessing the service

There was consensus that access to the service should be via several routes, including referral from a variety of health care professionals, and that referral should not be the only way to access the service. For example, 90% or more participants agreed that GPs, consultants and pharmacists should be able to refer smokers to the service.

Information provided

There was consensus that a VSBI should provide product information – such as about different types of products and how to use them (98% agreed) – as well as behavioural support, such as how to cope with cigarettes cravings (97% agreed).

Designing the service

A range of statements reflecting the need for the intervention to be flexible and tailored to each individual (86%), and offer support when the person needs it (81%), achieved consensus. Some slightly conflicting statements achieved consensus, for example that support should be provided for 12 weeks (82% agreed) and that support should be provided for as long as needed (75% agreed); however, overall this reflects that there was consensus on support being provided for an extended period. Vape shop respondents were more likely to agree that a person using the service should have unlimited support until they feel they no longer need it ($p=0.02$). Vape shops were also more likely to agree that the service should be delivered on a one-to-one basis. They were less likely to agree that *'The service should offer online/virtual support as well as in person support'* ($p<0.001$); of the 12% who were either undecided or disagreed, all were vape shops.

Who delivers the service

The statements *'This service should be delivered by trained stop smoking professionals with support from vape shop staff'* (82% agreed) and *'This service should be delivered by the vape shop staff, with support from trained stop smoking professionals'* (83% agreed) both achieved consensus, suggesting agreement that the service should be jointly delivered by staff and stop smoking professionals.

Managing the service

There was consensus that participating shops should not be owned by tobacco companies (83%) and should agree not to work with tobacco companies (72%). There was also consensus that shops delivering the service should adhere to clear guidance (93% agreed) and rigorous data collection (76% agreed). Although there was consensus that there should be a mix of shop styles to choose from, it was also agreed that non-clinical looking shops would be most appropriate (80% disagreed with statement that *'A shop that has clinical-looking aesthetic (like a pharmacy) would be most appropriate'*). Although it reached consensus overall, vape shops were more likely to disagree with the statement *'It is important that vape shops have a private room to speak with people wanting to stop smoking with this service'*: ($p=.039$). Of the 11 participants who disagreed, 8 were vape shops. There was overall consensus on that statement that *'Vape shops should comply with the same data gathering and management as stop smoking services'*; however vape shops were less likely to agree with this statement ($p=009$). Of the 24 who were either undecided or disagreed, 17 were vape shops.

Safety considerations

While it was agreed that groups such as pregnant women (74% agreed) and people with respiratory conditions (90% agreed) should be permitted to access the service, there was also consensus that people with an underlying condition should receive a letter from their GP to access the service (73%). There was consensus on the need for vape shop staff to understand and advise on any interactions nicotine may have on pre-existing medications (78%).

Vape shops

There was agreement that a VSBI would be cost-effective if it was effective (93% agreed), and that there would be benefits to the shops involved (88% agreed). There was consensus that vape shops should be paid to deliver the service (87% agreed), but also consensus that this should not be linked to successful quits (84% disagreed). There was consensus that

'Vape shops have a moral duty to support people to quit smoking with vapes'; however, vape shops were more likely to agree with this statement ($p=.006$). Of the 26 participants who were either undecided or disagreed, only 3 were vape shops.

Product provision

Product provision was the domain with the lowest proportion of statements achieving consensus. In particular, there was no consensus on the statement that vouchers/starter kits should only be free if people are referred into the service (54% agreed), and that people should purchase their own device and liquid out of their own money (35% agreed). There was consensus that some free product provision was appropriate, either in the form of vouchers and/or a starter kit (83%). There was consensus that the service should offer other forms of nicotine replacement therapy (such as patches) alongside vapes (74%); however, vape shops were more likely to disagree with this statement ($p=0.01$). Of the 20 participants who disagreed with this statement, 13 were vape shops.

Potential barriers

There was consensus that many of the potential barriers presented to participants would not exist, such as conflicts of interest for participating shops (78% disagreed). There was consensus that false information about vaping could be a barrier and that clients might misuse the service (91% agreed). There was overall consensus disagreeing (71%) with the statement *'A vape shop's primary goal is to make sales, not support smoking cessation'*; however vape shops were less likely to agree with this statement ($p=0.004$). Of the 16 participants who agreed, none were vape shops.

Quitting vaping

While there was consensus that clients should receive advice on quitting vaping (75% agreed), there was also consensus that quitting vaping should not be a goal of the intervention (79% disagreed). There were differences between the groups, however: SSP were more likely to agree with the statement that *'It is important people quit vaping within 12 months of quitting smoking through this service'* ($p=0.020$). Of the 13 who agreed with this statement, nine were SSP.

Discussion

We found support for a VSBI across stakeholder groups. There was consensus that the service should be flexible and comprise both product and behavioural support, and that quitting vaping should not be a goal of the service, although SSP were less likely to agree with this statement than other stakeholder groups. Although there was consensus that

there should be some free product provision, there was less consensus as to what this should involve. Views were mostly consistent across stakeholder groups.

Discussion of findings

The extent to which the potential benefits of e-cigarettes for smokers are borne out in practice relies to a large extent on how the products are regulated and marketed²¹; offering a VSBI which facilitates access to e-cigarettes and provides evidence-based smoking cessation support is an intuitive way to maximise their real-world effectiveness and thus realise their potential benefits. This Delphi study provided insights into how this might best be delivered.

The study confirms the key findings from the earlier qualitative study which informed the statements included in the Delphi survey.²⁰ The need for the service to be flexible in terms of access and the nature and duration of the intervention was often mentioned in the qualitative study and there was strong consensus on this in the current study. Currently only around 2% of smokers who make a quit attempt in England report accessing behavioural support.⁴ Offering an easily accessible and highly flexible vape shop-based service may help to overcome some of the barriers to attending traditional smoking cessation services, which are only accessed by a small proportion of smokers.

In the qualitative study most participants felt such an intervention should be delivered by trained vape shop staff with the support of local stop smoking services. In the current study, there was consensus on both the statement that the service be delivered by vape shop staff with support from SSPs, and also the reverse. While this is conflicting to some extent, it highlights an overall preference for such a service to be delivered collaboratively between vape shops and professional stop smoking advisors. This reflects a further point on which consensus was clear: that such a service should provide both product advice – which may be better delivered by vape shop staff - and behavioural support – which vape shop staff are likely to have limited experience of, and the delivery of which may therefore be best supported by professional stop smoking advisors. There is a need to consider whether it would be appropriate for vape shop staff to provide advice on interactions between nicotine and medications; given the potential risks, it is likely that this information would be better provided by a health professional.

Overall there was agreement that there should be some free product provision, either in the form of vouchers and/or a starter kit. There was also consensus that some people might misuse the services e.g. by signing up even though they had already quit smoking, or by

signing up to multiple services, indicating the need to carefully manage free provision. There was consensus that a VSBI should offer other forms of nicotine replacement therapy (such as patches) alongside vaping products. The NCSCT states that e-cigarettes and NRT can be combined, and that there may be benefits from combining patches, which deliver nicotine slowly but steadily, with e-cigarettes which deliver nicotine more rapidly.²² There is, however, limited research on combining NRT with vaping. A randomised controlled trial found that combining nicotine-e-cigarettes with nicotine replacement products such as patches improves smoking cessation rates²³; however, real-world data from the English stop smoking service suggests that quit rates with a vaping product and licensed medication concurrently are similar to those for vaping products and e-cigarettes alone.²⁴

Although findings were generally consistent across stakeholder groups, there were some noteworthy differences. Vape shops were more likely than other groups to agree that the service should be delivered on a one-to-one basis. This might reflect that vape shops may regard group sessions as being more difficult to arrange and deliver. Vape shop staff were also more likely to disagree that participating shops should have a private room in which to speak with clients, perhaps an indication such a stipulation would preclude some vape shops from participating. They were also more likely to disagree that the service should offer online/virtual support as well as in person support, perhaps indicating that offering both methods of support would create an additional challenge.

While current evidence on the short- and medium-term risks of vaping suggest that it is likely to be much less harmful than combustible tobacco use, there is increasing evidence of the addictive potential of e-cigarettes.^{25,26} Many vapers may wish to quit and the risk of dependence may be a deterrent to using e-cigarettes in a quit attempt, despite their harm reduction potential.^{27,28} In our study there was consensus that clients should be given advice on how to quit vaping. Although there was also consensus that it would not be important for clients to quit vaping at the end of the intervention, SSP were less likely to agree with this, and some caution may be needed in the interpretation of this finding due to the overall positive attitudes towards e-cigarettes in this sample. While vape shop-based interventions may help people who smoke to quit, a VSBI should also provide advice on gradually reducing and ultimately ceasing all nicotine product use to clients who wish to quit vaping. This may be particularly important to maximise uptake of a VSBI among current non-vapers, as it may help to address concerns around vaping dependence.

There was consensus that myths around vaping could be a barrier to the service, which could be particularly challenging in relation to encouraging access among non-vapers.

Previous evidence indicates that smokers' perceptions of the harmfulness of vaping products predicts the use of these products in attempts to quit smoking.²⁹ Despite increasing evidence that vaping poses a fraction of the risks of smoking, at least in the short and medium term,⁶ four in ten adults in Britain believed vaping to be more or equally harmful than smoking in 2023, reflecting a high level of misinformation about vaping in the general population.³ There was also consensus, however, that offering a vape shop-based service might make the use of vapes more acceptable and make shops be perceived as more legitimate. Thus the provision of such a service in itself might mitigate concerns that some smokers have about switching to vaping.

Several participants in the previous qualitative study highlighted concerns around conflicts of interests related to vape shops' primary goal to make sales and make a profit. This was not borne out in the current study: there was overall consensus that there is not a conflict of interest, with most participants also disagreeing that a shop's primary goal is to make sales rather than support quitting, although this may reflect the favourable attitudes of the sample towards vaping. The study did confirm the previous finding that tobacco industry involvement is a concern; it was agreed that participating shops should not have any links to the tobacco industry, which may be a challenge given high levels of tobacco industry involvement in the e-cigarette market. The feasibility of only providing non-tobacco industry vaping products as part of the intervention should be considered.

Limitations

The study had some limitations. 37% of the first-round participants did not participate in the final Delphi round, and the response rate in vape shop participants was lower in Round 3 than in the other stakeholder groups; however, given that consensus was reached on a high proportion of statements in the first two rounds, this is unlikely to have had a significant effect on the overall findings.

A significant majority of participants held favourable opinions on e-cigarettes and towards having a VSBI which may in part be related to the convenience and snowballing sampling approaches used in this study which may bias our findings; however, those involved in delivering/accessing a VSBI would be expected to hold favourable views and as such, this sample is representative of those who would use or deliver VSBI.

Conclusions

This study demonstrates that there is broad consensus on how to deliver a vape shop-based smoking cessation intervention among key stakeholders, providing a strong basis for future

intervention development and implementation. Future research should aim to test the feasibility and effectiveness of vape shop-based interventions. Challenges around misuse of the service and misperceptions about vaping would need to be addressed.

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Declaration of interests

None to declare.

Data availability

Ethical approval did not cover making the data available beyond this project.

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Table 1. Characteristics of the Delphi panel (n=100)

	Round 1 - n (%)	Round 2 - n (%)	Round 3 - n (%)
Age			
18-24	9 (9)	5 (6.4)	4 (6.3)
25-34	28 (28)	17 (21.8)	13 (25.4)
35-44	27 (27)	22 (28.2)	18 (23.1)
45-54	21 (21)	20 (25.6)	17 (21.8)
55+	15 (15)	14 (17.9)	11 (17.5)
Gender			
Male	49 (49)	32 (41)	27 (42.9)
Female	51 (51)	46 (59)	36 (57.1)
Smoking status			
Smoker	5 (5)	6 (7.7)	2 (3.2)
Vaper	60 (60)	41 (52.6)	36 (57.1)
Dual user	9 (9)	5 (6.4)	5 (7.9)
Non-smoker	26 (26)	26 (33.3)	20 (31.7)
Stakeholder group			
Smoker/Vaper	30 (30)	28 (35.9)	25 (39.7)
Stop smoking professionals	30 (30)	24 (30.8)	20 (31.7)
Vape shops	40 (40)	26 (33.3)	18 (28.6)
Total participants	100 (100)	78 (100)	63 (100)
Lost to follow up	-	22 (22)	15 (19.2)

Table 2. Summary of key characteristics of a vape shop-based smoking cessation intervention based on Delphi consensus

Domain	Key features
Access	<ul style="list-style-type: none"> • Via self-referral, clinical referral, stop smoking services • Promotion via social media
Intervention content	<ul style="list-style-type: none"> • Product advice – type, maintenance, nicotine reduction • Behaviour change advice • Advice on quitting vaping (but not an intervention goal)
Service design	<ul style="list-style-type: none"> • Flexible service: Time, duration, in-person and online, group & individual, walk-ins • Duration: 12 weeks or as long as needed
Service delivery	<ul style="list-style-type: none"> • Vape shop staff and stop smoking service staff together
Service management	<ul style="list-style-type: none"> • No tobacco industry links • Vape shops receive payment per client who receives support • Robust data monitoring • CO monitoring • Delivery in private room
Safety	<ul style="list-style-type: none"> • Pregnant women can access service • People with pre-existing conditions should receive referral letter from GP • Vape shop staff should receive training on interactions of nicotine with medications
Product provision	<ul style="list-style-type: none"> • Free starter kits • Vouchers / free e-liquids to support continued vaping • Provision of NRT
Potential barriers/challenges	<ul style="list-style-type: none"> • Myths around vaping • Misuse of service • E-cigarette advertising restrictions