NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Tobacco: treating dependence

NICE quality standard

Draft for consultation

11 July 2022

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| **This quality standard covers** support to stop smoking, stopping use of smokeless tobacco and harm-reduction approaches if people are not ready to stop in one go. It describes high-quality care in priority areas for improvement.  This quality standard will update and replace the existing quality standards on [smoking: supporting people to stop](https://www.nice.org.uk/Guidance/QS43) (published August 2013) and [smoking: harm reduction](https://www.nice.org.uk/guidance/qs92) (published July 2015). The topic was identified for update following a review of quality standards. The review identified:   * updated guidance on tobacco: preventing uptake, promoting quitting and treating dependence, and * that the quality standards on smoking: supporting people to stop and smoking: harm reduction should be combined.   For more information see [update information](http://www.nice.org.uk/guidance/qsXXX/chapter/Update-information).  This is the draft quality standard for consultation (from 11 July to 12 August 2022). The final quality standard is expected to publish in December 2022. |

# Quality statements

[Statement 1](#_Quality_statement_1:) People are asked at key points of contact with a healthcare professional if they smoke or use smokeless tobacco. **[2013, updated 2022]**

[Statement 2](#_Quality_statement_2:_1) People who smoke or use smokeless tobacco receive advice on quitting. **[2013, updated 2022]**

[Statement 3](#_Quality_statement_3:) People who want to stop smoking discuss the range of stop-smoking interventions available with a healthcare professional providing support or advice on quitting. **[2013, updated 2022]**

[Statement 4](#_Quality_statement_4:_1) People who do not want, or are not ready, to stop smoking in one go receive support to adopt a harm-reduction approach. **[2015, updated 2022]**

[Statement 5](#_Quality_statement_5:) People who smoke receive support to quit on admission to hospital. **[new 2022]**

In 2022 the quality standards on smoking: supporting people to stop and smoking: harm reduction were updated and combined. Statements prioritised in 2013 and 2015 were updated **[2013, updated 2022]** **[2015, updated 2022]** or replaced **[new 2022].** For more information, see [update information](#_Update_information_2).

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| Questions for consultationQuestions about the quality standard **Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?  **Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  **Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. Questions about the individual quality statements **Question 4** For draft quality statement 1: We have added a definition of ‘key points of contact’ as a guide to when people should be asked about their smoking as a minimum. Are there other key points of contact that should be included?  **Question 5** For draft statement 2: Is data collected around the use of smokeless tobacco, including provision of advice and support on quitting?  **Question 6** For draft statement 2: Is it feasible to measure quit rates in people who use smokeless tobacco using local data collection?  **Question 7** For draft statement 3: Is it appropriate to include people who use smokeless tobacco in the population for this quality statement?  **Question 8** For draft statement 4: Is the action in quality statement 4 appropriate for people who use smokeless tobacco?  **Question 9** For draft statement 4: The process measure for quality statement 4 measures the receipt of a harm-reduction approach to stopping smoking. Is this recorded by services currently, and if not, is it feasible to collect data on this?  **Question 10** For draft statement 5: Process measure a) measures receipt of behavioural support within 24 hours of admission to hospital. How achievable is this for the majority of services?  **Question 11** For draft statement 5: We have suggested measurement of the proportion of people who smoked on admission to hospital who received stop-smoking support for at least 4 weeks after discharge and abstinence at 4 weeks to support outcomes for this quality statement. Do you agree with the use of these outcome measures and are the data sources appropriate to support these? Local practice case studies **Question 12** Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form. |

# Quality statement 1: Identifying people who smoke or use smokeless tobacco

## Quality statement

People are asked at key points of contact with a healthcare professional if they smoke or use smokeless tobacco. **[2013, updated 2022]**

## Rationale

Identifying people who smoke or use smokeless tobacco gives healthcare professionals an opportunity to give advice about quitting and provide support or refer people to specialist tobacco cessation services if needed. Routinely asking people about tobacco use at key points of contact with healthcare services also gives opportunities to re-engage with people who previously did not want to stop, or who may have relapsed following a period of abstinence.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly. Some localities may want to focus on certain dimensions of equality dependent on local needs, for example socio-economic classification or family background.

### Process

Proportion of people who were asked if they smoke or use smokeless tobacco at a key point of contact with a healthcare professional.

Numerator – the number in the denominator who were asked if they smoke or use smokeless tobacco.

Denominator – the number of people attending a key point of contact with a healthcare professional.

**Data source:** Data on smoking and use of smokeless tobacco can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The [Quality Outcomes Framework indicator SMOK001, reported by NHS Digital’s indicators no longer in QOF (INLIQ)](https://digital.nhs.uk/data-and-information/publications/statistical/gp-contract-services/2019-20) reports the proportion of patients aged 15 and over whose notes record smoking status in the preceding 24 months. The [British Thoracic Society’s national smoking cessation audit](https://www.brit-thoracic.org.uk/quality-improvement/clinical-audit/national-smoking-cessation-audit-2021/) collects data on recording of smoking status in inpatient medical records.

## What the quality statement means for different audiences

**Service providers** (for example, primary care services and secondary care services) ensure that service specifications include asking people at key points of contact if they smoke or use smokeless tobacco and recording this.

**Healthcare professionals** (such as GPs, nurses, doctors, pharmacists, dentists and allied health professionals) ask people if they smoke or use smokeless tobacco at key points of contact and record this in patient records.

**Commissioners** (for example, local authorities and integrated care systems) ensure that they commission services in which people are asked if they smoke or use smokeless tobacco at key points of contact with a healthcare service.

**People using a healthcare service** are asked if they smoke or use smokeless tobacco at key points of contact with a healthcare professional, for example, after newly registering with a GP, at an NHS health check, before admission to hospital or after a long gap in contact.

## Source guidance

[Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209](https://www.nice.org.uk/guidance/ng209) (2021), recommendations 1.11.1 and 1.16.1.

## Definitions of terms used in this quality statement

### Smokeless tobacco

Any product containing tobacco that is placed in the mouth or nose and not burned and which is typically used in England by people of South Asian family origin. It does not include products that are sucked, like ‘snus’ or similar oral snuff products (as defined in the [European Union 2014 Tobacco Products Directive](https://eur-lex.europa.eu/legal-content/en/TXT/?uri=CELEX:32014L0040)).

The types used vary across the country, but they can be divided into 3 main categories based on their ingredients:

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

[[NICE’s guideline on tobacco](https://www.nice.org.uk/guidance/ng209), terms used in this guideline; smokeless tobacco]

### Key points of contact

Such as:

* a consultation with a newly registered patient
* a consultation about a condition related to smoking or use of smokeless tobacco
* NHS health check
* an annual review
* a preop appointment
* at the start of an inpatient episode
* outpatient appointment
* presentation after not being in regular contact with a healthcare professional.

[Expert opinion]

## Equality and diversity considerations

Smokeless tobacco is predominantly used by people from a South Asian family background. People should be asked if they use smokeless tobacco using the names that the various products are known by locally. If necessary, use visual aids to show them what the products look like.

## Question for consultation 4

We have added a definition of ‘key points of contact’ as a guide to when people should be asked about their smoking as a minimum. Are there other key points of contact that should be included?

# Quality statement 2: Advice

## Quality statement

People who smoke or use smokeless tobacco receive advice on quitting. **[2013, updated 2022]**

## Rationale

People who smoke or use smokeless tobacco should be advised to stop in a way that is sensitive to their preferences and needs. After advice has been given, it is important to act on the response by offering support to quit if the person wants this or ensuring the person knows where they can find support in the future.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly. The following process measure denominator uses a key point of contact for measurement purposes only. Some localities may want to focus on certain dimensions of equality dependent on local needs, for example socio-economic classification or family background.

### Structure

Evidence that healthcare professionals undergo training to give advice on how to quit smoking and using smokeless tobacco.

**Data source:** Data on training to deliver advice on quitting smoking or smokeless tobacco can be recorded from information recorded locally by healthcare professionals and provider organisations, for example staff competency records. The [National Centre for Smoking Cessation and Training](https://www.ncsct.co.uk/pub_training-resources.php) have training resources containing information on delivery of advice on the most effective way of quitting.

### Process

Proportion of people recorded as currently smoking or using smokeless tobacco at a key point of contact, who received advice on quitting.

Numerator – the number in the denominator who received advice on quitting.

Denominator – the number of people recorded as currently smoking or using smokeless tobacco at a key point of contact.

**Data source:** Data on receipt of advice on quitting smoking or smokeless tobacco can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The [Quality Outcomes Framework indicator SMOK004](https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data) reports the proportion of patients aged 15 and over who are recorded as current smokers who have a record of an offer of support or treatment within the preceding 24 months. This offer of support includes brief intervention and smoking cessation education. The [British Thoracic Society’s national smoking cessation](https://www.brit-thoracic.org.uk/quality-improvement/clinical-audit/national-smoking-cessation-audit-2021/) audit collects data on evidence of provision of very brief advice for current smokers from inpatient medical records.

### Outcome

a) Quit rates.

**Data source:**[NHS Digital’s statistics on NHS stop smoking services in England](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england) collects and reports data on persons who smoke setting a quit date with an NHS stop-smoking service including self-reported and carbon monoxide-validated quit rates. No routinely collected national data for this measure has been identified for quit rates outside of NHS stop smoking services. Self-reported quit rates for people who use smokeless tobacco can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Smoking prevalence.

**Data source:** [NHS Digital’s statistics on smoking – England](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking) reports smoking prevalence among young people aged between 11 and 15 years. [Public Health Outcomes Framework 2019 to 2022 (Public Health Outcome Indicators 2019)](https://www.gov.uk/government/collections/public-health-outcomes-framework) includes indicators on smoking prevalence in 15 year olds (indicator number 2.09) and smoking prevalence in adults (indicator number 2.14).

## What the quality statement means for different audiences

**Service providers** (for example, primary care services and secondary care services) ensure that systems are in place for people who smoke or use smokeless tobacco and want to stop to be provided with advice on how to quit. They ensure that healthcare professionals receive training to deliver advice on quitting.

**Healthcare professionals** (such as GPs, nurses and, doctors, pharmacists, dentists and allied health professionals) are trained to deliver advice on quitting smoking and smokeless tobacco and provide it in a way that is sensitive to the person’s preferences and needs. They are aware of local referral pathways to stop-smoking support and can refer people if needed.

**Commissioners** (for example local authorities and integrated care systems) ensure that they commission services that can provide advice on quitting smoking and smokeless tobacco. They commission training on delivery of advice on quitting smoking and smokeless tobacco.

**People who smoke or use smokeless tobacco** are advised about the best way to quit and how they can be supported to do this.

## Source guidance

[Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209](https://www.nice.org.uk/guidance/ng209) (2021), recommendations 1.11.2, 1.11.4, 1.12.7,1.13.1 and 1.16.6.

## Definitions of terms used in this quality statement

### Advice on quitting

People who smoke should be advised that stopping smoking in one go is the best approach. Advice should include information on how stop-smoking support can help, and that varenicline, a combination of short-acting and long-acting nicotine replacement therapy or nicotine-containing e-cigarettes when combined with behavioural support are more likely to result in them successfully stopping smoking. There should be a discussion about any stop-smoking aids that the person has used before, and advice given on using nicotine-containing products including nicotine replacement therapy, nicotine-containing e-cigarettes and medication licensed for smoking cessation. Advice should be provided in a way that is sensitive to the person’s preferences and needs.

Ensure that people who use smokeless tobacco are aware of the health risks. They should be advised to stop using a brief intervention. This involves discussion, negotiation or encouragement. It is carried out when the opportunity arises, typically taking no more than a few minutes for basic advice.

In November 2021, varenicline was unavailable in the UK. See the [MHRA alert on varenicline.](https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103160)

[Adapted from [NICE’s guideline on tobacco](https://www.nice.org.uk/guidance/ng209), recommendations 1.11.2 to 1.11.4, 1.12.7 and 1.16.2, and [NICE’s glossary](https://www.nice.org.uk/glossary); brief intervention]

### Key point of contact

Such as:

* a consultation with a newly registered patient
* a consultation about a condition related to smoking or use of smokeless tobacco
* NHS health check
* an annual review
* a preop appointment
* at the start of an inpatient episode
* outpatient appointment
* presentation after not being in regular contact with a healthcare professional.

[Expert opinion]

## Equality and diversity considerations

People who smoke or use smokeless tobacco should be given advice that they can easily understand themselves, or with support, so they can communicate effectively with healthcare services. Advice should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed. Smokeless tobacco is predominantly used by people from a South Asian family background. People should be asked if they use smokeless tobacco using the names that the various products are known by locally. If necessary, visual aids should be used to show them what the products look like. People who use smokeless tobacco should be referred to specialist tobacco cessation services, including services specifically for South Asian groups where they are available. These services should take into account the needs of different South Asian communities, for example by using staff with relevant language skills or translators and by providing translated materials or resources in a non-written format.

For people with additional needs related to a disability, impairment or sensory loss, communication support should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

## Question for consultation 5

Is data collected around the use of smokeless tobacco, including provision of advice and support on quitting?

## Question for consultation 6

Is it feasible to measure quit rates in people who use smokeless tobacco using local data collection?

# Quality statement 3: Stop-smoking interventions

## Quality statement

People who want to stop smoking discuss the range of stop-smoking interventions available with a healthcare professional providing support and advice on quitting. **[2013, updated 2022]**

## Rationale

People who want to stop smoking should be told about the range of options to help them stop, including behavioural support, pharmacotherapy and nicotine-containing e-cigarettes so that they can make their own choice of intervention based on their preferences, health and social circumstances, and previous experience of stop-smoking aids. Although a combination of behavioural support with varenicline, short-acting and long-acting nicotine replacement therapy or nicotine-containing e-cigarettes are more likely to result in a successful quit attempt, individual factors and preferences are also likely to be important.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly. The following process measure denominator uses a key point of contact for measurement purposes only. Some localities may want to focus on certain dimensions of equality dependent on local needs, for example socio-economic classification or family background.

### Process

Proportion of people who want to stop smoking when asked at a key point of contact who had a discussion with a healthcare professional about the range of stop-smoking interventions available.

Numerator – the number in the denominator who had a discussion with a healthcare professional about the range of stop-smoking interventions available.

Denominator – the number of people who want to stop smoking when asked at a key point of contact.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

### Outcome

a) Quit rates.

**Data source:**[NHS Digital’s statistics on NHS stop smoking services in England](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england) collects and reports data on persons who smoke setting a quit date with an NHS stop-smoking service including self-reported and carbon monoxide-validated quit rates. No routinely collected national data for this measure has been identified for quit rates outside of NHS stop smoking services.

b) Smoking prevalence.

**Data source:** [NHS Digital’s statistics on smoking – England](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking) reports smoking prevalence among young people aged between 11 and 15 years. [Public Health Outcomes Framework 2019 to 2022 (Public Health Outcome Indicators 2019)](https://www.gov.uk/government/collections/public-health-outcomes-framework) includes indicators on smoking prevalence in 15 year olds (indicator number 2.09) and smoking prevalence in adults (indicator number 2.14).

## What the quality statement means for different audiences

**Service providers** (for example, primary care services, secondary care services and stop-smoking services) ensure that systems are in place for people who want to stop smoking to have a discussion with a healthcare professional about the range of stop-smoking interventions available. They ensure that people have access to the range of stop-smoking interventions available.

**Healthcare professionals** (such as GPs and stop-smoking advisors) are aware of the full range of stop-smoking interventions available and can provide information on their use, effectiveness and how to access them, including referral pathways to local stop-smoking services if needed. They can give advice on nicotine-containing products on general sale including nicotine replacement therapy and nicotine-containing e-cigarettes and how to use them properly. They give advice on nicotine-containing e-cigarettes that is clear, consistent and up-to-date.

**Commissioners** (for example, local authorities and integrated care systems) ensure they commission services that can provide information on and access to a range of stop-smoking interventions.

**People who want to stop smoking** are given information on a range of approaches to help them quit. They discuss these and their circumstances and preferences with their healthcare professional to help them to choose the approach that is right for them.

## Source guidance

[Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209](https://www.nice.org.uk/guidance/ng209) (2021), recommendations 1.12.1 and 1.12.2

## Definitions of terms used in this quality statement

### Range of stop-smoking interventions

Ensure the following are accessible to adults who smoke:

* behavioural interventions:
  + behavioural support (individual and group)
  + very brief advice
* medicinally licensed products:
  + bupropion (see [BNF information on bupropion hydrochloride](https://bnf.nice.org.uk/drugs/bupropion-hydrochloride/))
  + nicotine replacement therapy (NRT) – short and long acting
  + varenicline (see [NICE's technology appraisal guidance on varenicline for smoking cessation](https://www.nice.org.uk/guidance/ta123) and the [BNF information on varenicline](https://bnf.nice.org.uk/drugs/varenicline/))
* nicotine-containing e-cigarettes.

In November 2021, varenicline was unavailable in the UK. See the [MHRA alert on varenicline.](https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103160)

For young people aged 12 and over who are smoking and dependent on tobacco consider NRT, which should be offered with behavioural support.

[Adapted from [NICE’s guideline on tobacco](https://www.nice.org.uk/guidance/ng209), recommendations 1.12.2 and 1.12.3]

### Key point of contact

Such as:

* a consultation with a newly registered patient
* a consultation about a condition related to smoking or use of smokeless tobacco
* NHS health check
* an annual review
* a preop appointment
* at the start of an inpatient episode
* outpatient appointment
* presentation after not being in regular contact with a healthcare professional.

[Expert opinion]

## Equality and diversity considerations

People who want to stop smoking should be provided with information during the discussion that they can easily understand themselves, or with support, so they can communicate effectively with healthcare services. Information given should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, communication support should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

Nicotine replacement therapy should be considered alongside behavioural support to help women stop smoking in pregnancy and for young people aged 12 and over who are dependent on tobacco. Varenicline and bupropion should not be offered to pregnant or breastfeeding women or people under 18.

People who use smokeless tobacco who want to quit should be referred to local specialist tobacco cessation services, including services specifically for South Asian groups, where they are available.

## Question for consultation 7

Is it appropriate to include people who use smokeless tobacco in the population for this quality statement?

# Quality statement 4: Harm-reduction approach

## Quality statement

People who do not want, or are not ready, to stop smoking in one go receive support to adopt a harm-reduction approach. **[2015, updated 2022]**

## Rationale

Stopping smoking in one go reduces the risks of developing smoking-related illnesses or worsening conditions affected by smoking, however some people may not want, or be ready, to stop smoking in one go. It is important that they are encouraged and supported to adopt a harm-reduction approach to smoking, such as smoking less or stopping temporarily. People who reduce their smoking are more likely to stop smoking in the future. Harm-reduction approaches should not detract from approaches to stop smoking, but should support and extend the reach and impact of stop-smoking support.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly. The following process measure denominator uses a key point of contact for measurement purposes only. Some localities may want to focus on certain dimensions of equality dependent on local needs, for example socio-economic classification or family background.

### Process

Proportion of people given stop-smoking advice at a key point of contact who do not want, or are not ready, to stop smoking in one go who received support to adopt a harm-reduction approach to smoking.

Numerator – the number in the denominator who received support to adopt a harm-reduction approach to smoking.

Denominator – the number of people given stop-smoking advice at a key point of contact who do not want, or are not ready, to stop smoking in one go.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

## What the quality statement means for different audiences

**Service providers** (such as primary care services, secondary care services and stop-smoking services) ensure that harm-reduction approaches are available for people who do not want, or are not ready, to stop smoking in one go. They ensure the availability of self-help materials that include advice on choosing a harm-reduction approach and details of where to find more help and support. They ensure that medicinally licensed nicotine-containing products are available if possible and have referral pathways to local stop-smoking support services.

**Healthcare professionals** (such as GPs and stop-smoking advisors) are aware of harm-reduction approaches to smoking. They discuss the approach that might be most suitable for the person, based on their smoking behaviour, previous attempts to stop and health and social circumstances, and preferences. They provide advice on the use of medicinally licensed nicotine-containing products and, if possible, prescribe or supply them. They are aware of local referral pathways to local stop-smoking support services.

**Commissioners** (such as local authorities, and integrated care systems) ensure they commission services that provide support for people who do not want to stop smoking in one go to adopt a harm-reduction approach and that offer medicinally licensed nicotine-containing products on a long-term basis. They should ensure that harm-reduction approaches support and extend the reach and impact of stop-smoking support.

**People who do want, or are not ready, to stop smoking in one go** receive advice on reducing the amount they smoke or temporarily not smoking. They are offered stop-smoking products that contain nicotine such as patches, gum, tablets for under the tongue, lozenges or sprays, or are told where they can get them.

## Source guidance

[Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209](https://www.nice.org.uk/guidance/ng209) (2021), recommendations 1.15.2 to 1.15.7 and 1.22.7 to 1.22.9

## Definitions of terms used in this quality statement

### Harm-reduction approach

Approaches that aim to reduce harm to people who smoke by smoking less or abstaining from smoking temporarily. The following approaches should be discussed to determine which might be most suitable.

Cutting down before stopping smoking:

* with the help of 1 or more medicinally licensed nicotine-containing products (the products may be used as long as needed to prevent relapse to previous levels of smoking)
* without using medicinally licensed nicotine-containing products.

Smoking reduction:

* with the help of 1 or more medicinally licensed nicotine-containing products (the products may be used as long as needed to prevent relapse to previous levels of smoking)
* without using medicinally licensed nicotine-containing products.

Temporarily not smoking:

* with the help of 1 or more medicinally licensed nicotine-containing products
* without using medicinally licensed nicotine-containing products.

[[NICE’s guideline on tobacco](https://www.nice.org.uk/guidance/ng209), box 1]

### Key point of contact

Such as:

* a consultation with a newly registered patient
* a consultation about a condition related to smoking or use of smokeless tobacco
* NHS health check
* an annual review
* a preop appointment
* at the start of an inpatient episode
* outpatient appointment
* presentation after not being in regular contact with a healthcare professional.

[Expert opinion]

## Equality and diversity considerations

People should be provided with advice that they can easily understand themselves, or with support, so they can communicate effectively with healthcare services. It should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, communication support should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

## Question for consultation 8

Is the action in quality statement 4 appropriate for people who use smokeless tobacco?

## Question for consultation 9

The process measure for quality statement 4 measures the receipt of a harm-reduction approach to stopping smoking. Is this recorded by services currently, and if not, is it feasible to collect data on this?

# Quality statement 5: Stop-smoking support in hospital

## Quality statement

People who smoke receive support to quit on admission to hospital. **[new 2022]**

## Rationale

Admission to hospital brings people who smoke into contact with healthcare professionals who can provide advice and help to stop smoking. Hospitals are smoke-free environments without the usual cues and prompts to smoke and so admission to hospital offers an opportunity to quit. The [NHS Long Term Plan](https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/smoking/) includes an action that all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services by 2023/24.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

Evidence of local arrangements to ensure that people who smoke have access to a hospital or community-based smoking cessation service when admitted to hospital.

### Data source: Data can be collected locally by provider organisations, for example from service specifications. The [British Thoracic Society’s national smoking cessation audit](https://www.brit-thoracic.org.uk/quality-improvement/clinical-audit/national-smoking-cessation-audit-2021/) collects data on whether hospital trusts have a hospital-based smoking cessation service on the premises or access to a community-based smoking cessation service. It also collects data on whether there is a formal referral pathway to a hospital or community-based smoking cessation service and whether a hospital has a dedicated smoking cessation practitioner.

### Process

a) Proportion of people who smoked on admission to hospital who received behavioural support to quit within 24 hours of admission.

Numerator – the number in the denominator who received behavioural support to quit within 24 hours of admission.

Denominator – the number of people who smoked on admission to hospital.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. [NHS Digital’s data collection on tobacco dependence](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/tobacco-dependence) collects data on whether current smokers aged 16 and over admitted for an overnight stay to a provider with an inpatient tobacco dependence treatment service had referral to an in-house tobacco dependence service, date of the referral, date of attendance at an in-house service and the tobacco control plan which includes quit attempt with behavioural intervention.

b) Proportion of people who smoked on admission to hospital who received stop-smoking pharmacotherapy.

Numerator – the number in the denominator who received stop-smoking pharmacotherapy.

Denominator – the number of people who smoked on admission to hospital.

**Data source:** [No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. NHS Business Services Authority’s secondary care medicines dataset](https://opendata.nhsbsa.net/dataset/secondary-care-medicines-data) collects data on hospital prescribing, including stop-smoking pharmacotherapies. The [British Thoracic Society’s national smoking cessation audit](https://www.brit-thoracic.org.uk/quality-improvement/clinical-audit/national-smoking-cessation-audit-2021/) collects data from inpatient medical records of evidence that people who smoke were offered the use of licensed pharmacotherapy for tobacco addiction and the pharmacotherapy received (single NRT, combination NRT, varenicline, bupropion, or decline of pharmacotherapy). [NHS Digital’s data collection on tobacco dependence](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/tobacco-dependence) collects data on whether current smokers aged 16 and over admitted for an overnight stay to a provider with an inpatient tobacco dependence treatment service had referral to an in-house tobacco dependence service, date of the referral, date of attendance at an in-house service, the tobacco control plan which includes quit attempt with licensed medication, with nicotine and the type of pharmacotherapy received.

### Outcome

a) Proportion of people who smoked on admission to hospital who received stop-smoking support for at least 4 weeks after discharge.

Numerator – the number in the denominator who received stop-smoking support for at least 4 weeks after discharge.

Denominator – the number of people who smoked on admission to hospital.

**Data source:**No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The [British Thoracic Society’s national smoking cessation audit](https://www.brit-thoracic.org.uk/quality-improvement/clinical-audit/national-smoking-cessation-audit-2021/) collects data on attendance at a follow-up smoking cessation service upon discharge.

b) Proportion of people who smoked on admission to hospital who were abstinent at 4 weeks after discharge.

Numerator – the number in the denominator who were abstinent at 4 weeks after discharge.

Denominator – the number of people who smoked on admission to hospital.

**Data source:**No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The [British Thoracic Society’s national smoking cessation audit](https://www.brit-thoracic.org.uk/quality-improvement/clinical-audit/national-smoking-cessation-audit-2021/) collects data on whether patients are abstinent at 4 weeks after discharge (chemically validated or self-reported).

## What the quality statement means for different audiences

**Service providers** (for example, acute services, maternity services and inpatient mental health services) ensure that systems are in place to provide stop-smoking support to people who smoke when they are admitted to hospital. They ensure that staff in secondary care are trained to give advice and interventions for quitting and there are referral pathways to behavioural support.

**Healthcare professionals** (such as doctors, nurses and stop-smoking advisors) offer stop-smoking support to people who smoke when they are admitted to hospital. They undergo training to give advice and interventions for quitting and are aware of referral pathways to stop-smoking support within the hospital setting and when people are discharged. Those who are trained to provide behavioural support to stop smoking undertake regular continuing professional development. They offer to measure people’s exhaled carbon monoxide level during each contact to motivate and provide feedback on their progress.

**Commissioners** (such as integrated care systems) ensure that they commission services in which people who smoke are offered support to quit when admitted to hospital.

**People who smoke and are admitted to hospital** receive help to quit on admission. This includes information, practical advice and encouragement, and medicines that can help them to quit.

## Source guidance

[Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209](https://www.nice.org.uk/guidance/ng209) (2021), recommendations 1.14.5, 1.14.13 and 1.14.15

## Definitions of terms used in this quality statement

### Support to quit

Support includes:

* discussion about current and past smoking behaviour and development of a personal stop-smoking plan
* information about the different types of stop-smoking options and how to use them
* information on the types of behavioural support available
* offer and supply of prescriptions of medicines licensed for smoking cessation or nicotine replacement therapy
* offer to measure exhaled carbon monoxide level during each contact to motivate and provide feedback on progress.

People admitted to hospital who smoke should be offered behavioural support and stop-smoking pharmacotherapy to stop smoking during their inpatient stay. Behavioural support should be provided immediately, if necessary, or within 24 hours of admission for an inpatient. Stop-smoking pharmacotherapy should be provided immediately.

[Adapted from [NICE’s guideline on tobacco](https://www.nice.org.uk/guidance/ng209), recommendations 1.14.5 to 1.14.11, 1.14.13, 1.14.15 and 1.14.17]

### Hospital

All acute, maternity and mental health services inpatient admissions. It covers emergency care, inpatient care for severe mental illness in hospitals, psychiatric and specialist units and secure hospitals and planned specialist medical care or surgery. It also includes maternity care in hospitals and in maternity units.

[Adapted from [NICE’s guideline on tobacco](https://www.nice.org.uk/guidance/ng209), section 1.14 and terms used in this guideline; secondary care]

## Equality and diversity considerations

People who smoke who are admitted to hospital should be provided with stop-smoking information that they can easily read and understand themselves, or with support, so they can communicate effectively with healthcare services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

People with severe mental health conditions who may need additional support to stop smoking should be offered support by a specialist adviser with mental health expertise that is tailored in duration and intensity to the person’s needs.

Nicotine replacement therapy should be considered alongside behavioural support to help women stop smoking in pregnancy and for young people aged 12 and over who are dependent on tobacco. Varenicline or bupropion should not be offered to pregnant or breastfeeding women or people under 18.

## Question for consultation 10

Process measure a) measures receipt of behavioural support within 24 hours of admission to hospital. How achievable is this for the majority of services?

## Question for consultation 11

We have suggested measurement of the proportion of people who smoked on admission to hospital who received stop-smoking support for at least 4 weeks after discharge and abstinence at 4 weeks to support outcomes for this quality statement. Do you agree with the use of these outcome measures and are the data sources appropriate to support these?

# Update information

**July 2022:** This quality standard updates and replaces NICE’s quality standards [QS43 on smoking: supporting people to stop](https://www.nice.org.uk/Guidance/QS43) and [QS92 on smoking: harm reduction](https://www.nice.org.uk/guidance/qs92) Statements prioritised in 2013 and 2015 were replaced. The topic was identified for update following a review of quality standards. The review identified:

* updated guidance on tobacco
* that the quality standards on smoking: supporting people to stop and smoking: harm reduction should be combined.

Statements are marked as:

* **[new 2022]** if the statement covers a new area for quality improvement
* **[2013, updated 2022]** if the statement covers an area for quality improvement included in the 2013 quality standard on smoking: supporting people to stop and has been updated
* **[2015, updated 2022]** if the statement covers an area for quality improvement included in the 2015 quality standard on smoking: harm reduction and has been updated.

# About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See our [webpage on quality standards advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10153).

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [resource impact report](https://www.nice.org.uk/guidance/ng209/resources) for the NICE guideline on tobacco to help estimate local costs.

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10153) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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