# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

# HEALTH AND SOCIAL CARE DIRECTORATE

# QUALITY STANDARD CONSULTATION

# SUMMARY REPORT

## 1 Quality standard title

Smoking: reducing tobacco use in the community

Date of Quality Standards Advisory Committee post-consultation meeting:
19 November 2014.

## 2 Introduction

The draft quality standard for smoking: reducing tobacco use in the community was made available on the NICE website for a 4-week public consultation period between 29 September and 27 October 2014. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 12 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary.

The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2 of this paper.

# 3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. For each quality statement what do you think could be done to support improvement and help overcome barriers?

Stakeholders were also invited to respond to the following statement specific questions:

1. For draft placeholder statement 6: Do you know of any evidence-based guidance that could be used to develop this placeholder quality statement? If so, please provide details. If not, would new evidence-based guidance relating to taking action against the illicit tobacco trade have the potential to improve practice? If so, please provide details.

# 4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- General support for the approach and improvement areas prioritised.
- Importance of the quality standard in addressing smoking as:
  - a cause of premature morbidity and mortality
  - a primary reason for the healthy life expectancy gap between rich and poor
- Equality and diversity considerations highlighted as particularly important in this quality standard.
- Need for referring to other smoking related behaviours among young people:
  - E-cigarettes
  - Shisha pens
  - Water pipes
  - Cannabis (used simultaneously with tobacco)
- Some concerns and criticism of the quality standard not addressing national policy and legislation; areas mentioned include:
  - national media campaigns;
  - minimum pricing
  - minimum pack sizes
  - standardised packaging
  - licensing of retailers and controlling licensing around schools
  - sentencing for tobacco smuggling – matching that for drug smuggling
  - preventing children and young people from exposure to tobacco marketing – films, you tube, social media, television programmes
  - film classifications (age restrictions) – limiting exposure to smoking in films

**Consultation comments on data collection**

- Data collection was felt to be feasible.
- Some concerns over:
  - local resource needed - both financial and human

  - data sharing protocols and agreements.
- Suggestion that the annual "Tobacco Control Survey, England: A report of council trading standards service activity" can provide useful data in support of this quality standard.

# 5 Summary of consultation feedback by draft statement

## *5.1 Draft statement 1*

Local commissioners and campaign planners develop local and regional mass-media campaigns to prevent children and young people under 18 from taking up smoking.

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 1:

- The draft quality statement accurately reflects the key areas for quality improvement.
- Need to define:
  - range of strategies
  - research evidence
  - campaign planners
- The statement is too broad – clear area for quality improvement need to be defined
- Need to recognise that:
  - local and regional campaigns should support and be complimentary with national campaigns
  - some mass media communication channels such as television paid advertising will only be affordable on a regional, and arguably, a national footprint
  - channels such as websites and social media cannot be confined to specific Local Authority boundaries.
- Data collection was felt to be feasible – additional suggestions included:
  - identifying the number of people from socially deprived areas and children and young people from poorer socioeconomic backgrounds that have contributed to and been engaged in these activities

**Responses to Questions 3**

- Main barriers to implementation identified:

  - funding and ensuring sufficient and recurring resources.
- Suggestions for implementation:
  - campaigns to be replicated across Local Authority areas / Regions in order to maximise the use of limited resources
  - contributions from a group of local authorities, to a campaign delivered over a regional footprint
  - provision of practical step-by-step guide on developing, implementing and evaluating mass-media campaigns
  - provision of guidance on effective use of resources are used effectively and economically across localities and regions. Local Authorities should be encouraged to work together to share resources in order to achieve better outcomes.

## *5.2 Draft statement 2*

Local authorities and their partners identify retailers that sell tobacco products to people under 18 and ensure that those who persist are prosecuted.

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 2:

- Comments on terminology :
  - use ‘sanction’ rather than ‘prosecution’
  - it is not correct to say that retailers may "expect" training and support from local trading standards - there is no capacity to deliver this level of support
- Comments on partnership work between local authorities and retailers:
  - general support for partnership work
  - the statement fails to acknowledge the work of retailers in reducing access to tobacco for under 18s through sales restrictions, intelligence gathering and awareness raising
  - need for effective communication about test purchasing activities
  - enforcement activity by local authorities needs to be evidence led
  - substantial reduction in Trading Standards activity in test purchasing and work force
- Concerns about the draft quality statement:
  - too focused on enforcement and prosecution instead of recognising the contribution of preventative measures, such as awareness raising, to stopping underage sales of tobacco
  - lack of other interventions to close down routes to obtaining tobacco than underage sales in shops
  - no recognition of the difference between established persistent negligent or criminally motivated practices from one offs, and mistakes
  - 2 concepts that should be brought together better; suggested alternative: Local authorities identify and sanction retailers that persistently sell tobacco products to people under 18

- Comments on data collection:
  - data relevant to this statement available - annual survey of tobacco control activities undertaken by trading standards services
  - data and intelligence sharing - essential but hindered by legislation and organisational protocol
- Comments on forthcoming changes to legislation that may affect the quality standard:
  - legal age limit for purchasing e-cigarettes
  - proxy sales as an offence

**Responses to Questions 3**

- Main barriers to implementation identified:
  - funding - to provide sufficient financial and human resources to allow local authorities and partners to identify, investigate and prosecute those retailers selling tobacco to underage people.
- Suggestions for implementation:
  - Sharing good practice between Trading Standards, police, voluntary and community groups and local retailers.
  - Improving knowledge and awareness among the public including young people may reduce proxy purchasing and provide other sources of intelligence.
  - Specific recognition of shisha bars as being retailers of tobacco and inclusion of information specific to these establishments would be beneficial
  - Developing practical solutions to this is desirable but should be undertaken at national level rather than relying upon individual Local Authorities to develop their own arrangements locally.

## *5.3 Draft statement 3*

Educational establishments have an organisation-wide smokefree policy that is coordinated with the local tobacco control strategy.

**Consultation comments**

- general support for the statement
- comments on the focus of the statement:
  - emphasis should be on the delivery of an organisation-wide smokefree policy
  - having a strategy should not be the outcome
- the statement should be more specific/stronger
  - focus on 1 implementing of the elements within the strategy
  - specify minimum standards for some of the elements of the strategy

**Responses to Questions 3**

- Suggestions for implementation:
  - Ofsted and other educational regulators should ensure that a review of adherence to this policy is part of their inspection process and consequences if the policy is not adhered to.
  - Identification and sharing good practice on organisation wide smokefree policies as per definitions.

## *5.4 Draft statement 4*

Employers encourage employees who smoke to access smoking cessation support during working hours without loss of pay.

**Consultation comments**

- general support for the statement
- change “encourage” to “allow”
- need to define “employees are offered support by smoking cessation services”
- Comments on joint working between employers and local stop smoking services.
  - importance of working in partnership
  - importance of targeting businesses employing people from routine and manual socio-economic group
- Comments on workplace policies:
  - policies to encourage referrals are ineffective
  - initiatives encouraging employers to go smoke-free (remaining abstinent from smoking in the workplace, supported by cessation) need to be recommended

**Responses to Question 3**

- Suggestions for implementation:
  - Ensure staff are aware of the availability of smoking cessation support during working hours it should be regularly advertised internally.
  - If the smoking status of the employee is known, these employees are reminded/invited regularly of the free access during working hours of the smoking cessation service
  - The business case for this statement needs to be made strongly - particularly important in relation to engaging with small and medium size businesses and especially those employing people from routine and manual socio-economic group.

## *5.5 Draft statement 5*

Acute, maternity and mental health secondary care services implement a smokefree site policy.

**Consultation comments**

- comments on the focus of the statement:
  - emphasis is on policy whilst it should be on practice
  - monitoring should focus on action rather than words - establishing process measures in relation to the communication, implementation and enforcement smokefree policies in an effective and equitable way
  - suggested wording: Acute, maternity and mental health secondary care services have smokefree grounds/are smokefree sites

**Responses to Questions 3**

- Suggestions for implementation:
  - Commissioners and regulators such as NHSE, CQC, CCG, Monitor, TDA, assist Trusts enforce this quality standard, holding Chief Executives and Trust Boards to account with penalties for non-adherence.
  - Being smoke-free should be a condition of NHS commissioning, with financial penalties for failure to implement. This needs leadership at national as well as local level.
  - Support and guidance needs to be made available to secondary care services on a local and regional basis. Comments on:
    - variable support from public health teams and local stop smoking services
    - few hospitals seeking guidance from other hospitals
  - Mass media campaigns should be used to ensure that patients and visitors are made aware of smokefree policies and that support is available to abstain from smoking while in the secondary care settings (including the hospital grounds) and in the community.

## *5.6 Placeholder statement 6*

Preventing access to, and supply of, illicit tobacco.

**Consultation comments**

- Comments welcoming the placeholder statement and recognition of the need for evidence based guidance in this area.
- Comments on wording within the rationale
- Any activity must be delivered at a supra-local level. The aim of any action in this area is to eliminate the trade in illicit tobacco, rather than move it from place to place, as can happen when levels of enforcement differ from locality to locality.
- Sources of information on the prevalence of illegal trade in particular areas were highlighted:
  - local HM Revenue and Customs officers
  - 'pack swap' data that is commissioned by tobacco companies
  - Trading Standards Institute can provide data for the level of activity undertaken by Local Authority trading standards in respect of tackling illicit tobacco supply - data is collected via the annual survey and includes types of illicit product that are seized, and the quantity. This data is shared routinely with HMRC
  - The annual "Tobacco Control Survey, England: A report of council trading standards service activity"
- Programmes of work already carried out:
  - The Tackling Illicit Tobacco for Better Health website, http://www.illegal-tobacco.co.uk/ (The report by the UKCTAS)

# 6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements:

- people who are not in work
- closing down routes to obtaining tobacco other than underage sales in shops

# Appendix 1: Quality standard consultation comments table

| ID | Stakeholder | Statement No | Comments[1] |
|---|---|---|---|
| 1 | Association of School and College Leaders | General | ASCL supports the aim of this work and, so far as it intersects with our area of expertise, agrees with the approach. |
| 2 | British Thoracic Society | General | BTS fully support the development of a Quality standard Smoking- reducing tobacco use in the community |
| 3 | NHS England | General | Thank you for the opportunity to comment on the above quality standard. I wish to confirm that NHS England has no substantive comments to make regarding this consultation. |
| 4 | Pfizer Ltd | General | Pfizer supports and welcomes this latest Quality Standard, Smoking: reducing tobacco use in the community. Given the part smoking plays as a leading cause of premature morbidity and mortality, as well as well as a primary reason for the healthy life expectancy gap between rich and poor, we believe this is a hugely important set of recommendations. |
| 5 | Royal College of Nursing | General | This is just to let you know that there are no comments to submit on behalf of the Royal College of Nursing in relation to the stakeholder engagement exercise the for the Draft Smoking: reducing tobacco use in the community quality standard. Thank you for the opportunity to participate. |
| 6 | Royal College of Physicians | General | The RCP is grateful for the opportunity to respond to this consultation. Although we have no specific criticism of the contents of the draft QS we are extremely concerned that it omits to include the power of national strategies in preventing tobacco use in the community, such as:<br>• National media campaigns (which are far more cost-effective than those at the local and regional level). We believe that it is vital that NICE should be able to make recommendations to the national government.<br>• Preventing exposure of children and young people to dark marketing of tobacco – promotion through films, youtube music videos, social media, television programmes<br>• Minimum prices for tobacco - to remove the budget brands that young people and the socially disadvantaged tend to choose<br>• Minimum pack sizes (coming with the EU Tobacco Products Directive)<br>• Licensing of retailers<br>• Standardised packaging |

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

| | | | |
|---|---|---|---|
| 7 | Trading Standards Institute | General | The annual "Tobacco Control Survey, England 2013/14: A report of council trading standards service activity" can provide useful data in support of this quality standard. |
| 8 | UK Centre for Tobacco and Alcohol Studies | General | The document does not address preventing promotion of smoking to children through the media. Local authorities license cinemas so are able to limit exposure to films containing smoking, but the film classification is a national issue (and scandal) whilst youtube and other online video content is another level of problem. However, whilst important, this issue isn't mentioned in the standard but needs both local and national action. Raising the price of tobacco, and particularly the low budget brands of manufactured cigarettes and hand-rolling tobacco, is vital to ensure that economic incentives to quit remain strong. Again, this is an effective but national policy not touched on in this document. Standardised packaging will reduce uptake of smoking and promote quitting. Again, a national policy not touched on. So overall this quality standard is weak in terms of outcomes, objectives and scope. It will achieve little. We would recommend substantial revision. |
| 9 | UK Centre for Tobacco and Alcohol Studies | General | This quality standard falls seriously short of what is required to prevent smoking in the community as a result of its focus on local instead of local and national policy. |
| 10 | Health Equalities Group | Question 1 | Yes. The draft quality standard accurately reflects the key areas for quality improvement. Equality and diversity considerations are particularly important and should be emphasised at every opportunity. |
| 11 | Public Health England | Question 1 | Yes we do believe that the key areas for quality improvement have been identified, with one notable exception being, the inclusion of standards around engaging people who are not in work. |
| 12 | Royal College of Paediatrics and Child Health | Statement 1 | Would be useful to define somewhat further the phrase "a range of strategies" as this seems a somewhat nebulous concept in isolation. It may be more useful to specify the number of different strategies that would need to be implemented for inclusion in the numerator. |
| 13 | UK Centre for Tobacco and Alcohol Studies | Statement 1 | Mass media campaigns are one of the most effective and cost-effective means of reducing smoking, yet no mention is made of national campaigns. Local campaigns can of course be effective, and necessary to communicate information relevant at local level, but the headline messages and effect are best achieved through national campaigns. These approaches are complementary, but with national campaigns being far more powerful. Why is there no recommendation on national media campaigns? |
| 14 | British Thoracic Society | Statement 1 - question 1 | Yes |
| 15 | British Thoracic Society | Statement 1 - question 2 | Yes |

| | | | |
|---|---|---|---|
| 16 | Health Equalities Group | Statement 1 - question 2 | The three quality measures: (a) Proportion of local or regional mass-media campaigns to prevent people taking up smoking that are based on research evidence; (b) Proportion of local or regional mass-media campaigns to prevent people taking up smoking that were developed in partnership with children and young people and; (c) Proportion of local or regional mass-media campaigns to prevent people taking up smoking that used a range of strategies, are important. However, collecting and analysing data for the proposed quality measure may prove difficult. A precise definition of 'research evidence' is needed to make this workable in practice. It is important to determine what counts in relation to research evidence. Is it evidence presented in a peer-reviewed journal? Is it evidence obtained by a marketing agency? Is it evidence obtained from an informal focus group to determine the appropriate look and content of a leaflet? If agreement could be reached about the definition of research evidence, would all forms of evidence carry the same value? Qualitative research should be considered together with quantitative data. |
| 17 | Public Health England | Statement 1 - question 2 | From the information given we see no reason why it would not be possible to collect the data for this quality measure. Considering that, "Smoking is more common in socially deprived areas and children and young people from poorer socioeconomic backgrounds take up smoking at an earlier age". The process section might identify the number of people from these backgrounds that have contributed to and been engaged in these activities. There is always the possibility that this kind of activity only 'engages the engaged' and this should be understood and mitigated against in the planning stages of these campaigns. |
| 18 | British Thoracic Society | Statement 1 - question 3 | The greatest barrier is funding. Ensuring sufficient and recurring resources for the development of local and regional mass-media campaigns. |
| 19 | Health Equalities Group | Statement 1 - question 3 | The support of the quality statement would be improved by the provision of a practical step-by-step guide that explains how to develop, implement and evaluate mass-media campaigns by using social marketing and other appropriate behaviour change approaches. This information already exists in other public heath related guidance. Guidance and examples of good practice should especially be available in relation to targeting children and young people from poorer socioeconomic backgrounds. Guidance should also be provided to ensure that resources are used effectively and economically across localities and regions. Some mass media communication channels such as television paid advertising will only be affordable on a regional, and arguably, a national footprint. Local Authorities should be encouraged to work together to share resources in order to achieve better outcomes. Other channels such as websites and social media cannot be confined to specific Local Authority boundaries.If campaigns are going to engage young people, they need to be developed in partnership with them. They also need to be mixed mass-media campaigns over an extended period and should include social media. |
| 20 | Public Health England | Statement 1 - question 3 | Contributions from a group of local authorities, to a campaign delivered over a regional footprint, will be less than the cost of developing and delivering these campaigns at a local level, which may be cost effective for local authorities. |

| | | | |
|---|---|---|---|
| 21 | Trading Standards Institute | Statement 1 - question 3 | Where possible, campaigns should be capable of being replicated across Local Authority areas / Regions in order to maximise the use of limited resources; these should support any National campaigns. The experience of "Smoke free" revealed many examples of Local and / or Regional campaigns that were developed in a seemingly ad hoc manner without an evidence base to support their roll out. |
| 22 | Association of Convenience Stores | Statement 2 | Young people obtain tobacco from a range of sources. HSCIC figures show that purchasing tobacco for themselves is not the most likely way for a young person to obtain tobacco, it is more likely that tobacco will be given or sold to them by another third party, friend, sibling parent or stranger. There is a significant weakness in the overall Standard that there are no other Quality Statements about other interventions to close down routes to obtaining tobacco. There should at least be a reference to sales by proxy (which will be an offence as a result of legislation contained in the Children and Families Act 2014 and mechanisms for detecting and prosecuting those that do this). |
| 23 | Association of Convenience Stores | Statement 2 | Quality measures (a) – this reference to local arrangements to obtain, interpret and act on information that a store is selling tobacco to under 18s is simplistic and fails to reflect important standards such as establishing persistent negligent or criminally motivated practices, one offs, and mistakes. Quality measures (b) – this section reinforces a clear problem in the way some local authorities and public health professionals operate in that they fail to acknowledge the valid role that local businesses can play as a partner in actions to reduce access to tobacco for under 18s, both directly through sales restrictions but also through intelligence gathering and awareness raising. Retailers work hard to ensure that they retail tobacco products responsibly, through enforce age restrictions using policies such as Challenge 25 to ensure that under age people cannot buy tobacco. Age verification schemes are common place in the convenience market and an effective deterrent for underage sales. |
| 24 | Association of Convenience Stores | Statement 2 | ACS welcomes partnerships between local authorities and retailers to combat illegal tobacco sales. ACS supports enforcement activity against any retailer that persistently sells tobacco products to children and references to this in the guidance. However, all enforcement activity should be evidence led and proportionate - the guidance should make reference to evidence led - enforcement activity by local authorities. |
| 25 | Association of Convenience Stores | Statement 2 | We believe there should be reference to standards in effective communication about test purchasing activities as follows: Retailers should have letter sent 3 months prior to enforcement campaigns Retailers need to be notified about their pass/fail (in all cases) to reward/rectify compliance 2 test purchases should be in a time frame where something can be done to rectify the fail before banning orders are considered. |
| 26 | Pfizer Ltd | Statement 2 | At the time of writing there is not currently a legal restriction in the UK on the age of people to whom electronic cigarettes can be sold. However, the government has announced earlier this year that it is looking to implement a ban on the selling of e-cigarettes to children under 18. Currently, new powers in the Children and Families Act 2014 allow for the introduction of such a ban on selling e-cigarettes to under 18s [2]. Consequently, we ask NICE to be aware that at the time when this Quality Standard is published, a legal age limit for purchasing e-cigarettes may have been brought into force. If this is the case, prohibition on the selling of e-cigarettes to under 18s should be included in Quality Statement 2 alongside the selling of tobacco.[2] Children and Families Act 2014 http://www.legislation.gov.uk/ukpga/2014/6/part/5/crossheading/tobacco-nicotine-products-and-smoking/enacted |

| | | | |
|---|---|---|---|
| 27 | Trading Standards Institute | Statement 2 | Sharing intelligence between organisations is vital BUT is often hindered by organisational protocol. Development of practical solutions to this are desirable but should be undertaken at national level rather than relying upon individual Local Authorities to develop their own arrangements locally . |
| 28 | Trading Standards Institute | Statement 2 | This data is also reported for England via the annual survey of tobacco control activities undertaken by trading standards services. The survey and report is funded by the Department of Health and is delivered by TSI .It provides trend data regarding levels of activity undertaken by respondents. It generates high response rates, 98% for the year 2013-14. |
| 29 | Trading Standards Institute | Statement 2 | There is no offence for the persistent sale of tobacco to people under 18 years – where repeated illegal sales are made, the appropriate sanction available is a restricted sale and / or restricted premises order. Data relating to the number of these sanctions that have been sought and awarded is collected in the annual survey as detailed above. |
| 30 | Trading Standards Institute | Statement 2 | TSI wishes to draw the attention of the committee to the significant reduction in TS activity in this area of tobacco control work in 2013-14. This has reduced both in terms of the number of TS services undertaking under age sales enforcement work and also in the amount of work undertaken by those that still do. One key reason has been the reduction in the trading standards work force by an average of 40% over the lifetime of this parliament . |
| 31 | Trading Standards Institute | Statement 2 | Whilst desirable, it is not correct to say that retailers may "expect" training and support from local trading standards. There is simply insufficient capacity to deliver this level of support in all local authority areas. However , resources do exists to assist retailers - for example Business Companion which provides free impartial guidance for retailers http://www.businesscompanion.info/ |
| 32 | Trading Standards Institute | Statement 2 | Shops are one source of tobacco for young people; a declining source for 11-15 years olds. Data for the older age range 16-17 years may reveal a different picture however. Does reference to tobacco include shisha? It is not clear whether the standard relates only to cigarettes |
| 33 | Trading Standards Institute | Statement 2 | Reliable intelligence is an issue in terms of conducting test purchase operations, particularly so since the publication of the BRDO code of practice on age restricted products and services. The need for authorisation under the Regulatory Investigations Powers Act 2000 (from a court) presents a further (additional) step in the enforcement process. |
| 34 | UK Centre for Tobacco and Alcohol Studies | Statement 2 | Licensing of retailers, with withdrawal of licenses for those who sell to underage children, and action to reduce the number of licenses available for retailers near schools, could also be effective, but requires a national legal framework and to be backed up by prosecutions. |
| 35 | British Thoracic Society | Statement 2 - question 1 | Yes |
| 36 | Health Equalities Group | Statement 2 - question 1 | The draft quality standard is important, relevant and feasible to implement and monitor. It broadly reflects the key areas for quality improvement. However, there is an argument that preventative measures including awareness raising among retailers and the public will also contribute to stopping underage sales of tobacco. The standard emphasises enforcement and prosecution except on page15 (Draft for consultation document), where a reference to 'Targeting retailers with awareness-raising campaigns' is made.The equality and diversity considerations are particularly important and should be emphasised at every opportunity. |

| | | | |
|---|---|---|---|
| 37 | British Thoracic Society | Statement 2 - question 2 | Yes |
| 38 | Health Equalities Group | Statement 2 - question 2 | The proposed systems and structures for the monitoring of the proposed quality measure are feasible. Although the Health Equalities Group is not directly involved in the delivery of this standard, our perception is that much good practice in relation to enforcement and monitoring already exists. |
| 39 | Public Health England | Statement 2 - question 2 | From the information given we see no reason why it would not be possible to collect the data for this quality measure. |
| 40 | Royal College of Paediatrics and Child Health | Statement 2 - question 2 | Should there be an appraisal of the number of test purchases that occur in each local authority in order for the "numerator: denominator" assessment to be valid |
| 41 | British Thoracic Society | Statement 2 - question 3 | Funding. To provide sufficient financial and people resources to allow local authorities and partners to identify, investigate and prosecute those retailers selling tobacco to underage people. |
| 42 | Health Equalities Group | Statement 2 - question 3 | The support of the quality statement would be improved by the sharing of good practice among Trading Standards, police, voluntary and community groups and local retailers. Improved knowledge and awareness among the public including young people may support this quality standard outcome by reducing proxy purchasing and providing other sources of intelligence. |
| 43 | Public Health England | Statement 2 - question 3 | Specific recognition of Shisha bars as being retailers of tobacco and inclusion of information specific to these establishments would be beneficial. |
| 44 | Association of School and College Leaders | Statement 3 | ASCL supports the idea that all schools and colleges should be smoke-free. This is already the case in the overwhelming majority of institutions led by ASCL members. |
| 45 | Health Equalities Group | Statement 3 | The availability, advertising and use of e-cigarettes have increased dramatically in England in recent years. Whilst the majority of young people using e-cigarettes are current or ex-smokers, there is concern that non-smokers may also use the devises and that they may act as a gateway to smoking tobacco cigarettes.<br><br>There is also emerging evidence that shisha pens and waterpipes, which may include tobacco are also increasing in popularity among young people. The use of cannabis among by young people whilst declining still remains relatively high and there is evidence that cannabis is used simultaneously with tobacco as well as it acting as a gateway to tobacco cigarettes in the longer term.The Draft consultation document makes references to 'the need to alter the social norms around smoking' (page 2) and 'an integrated approach to prevention, smoking cessation, harm reduction and shaping social norms is fundamental to reducing tobacco use in the community' (page 6). Therefore, it is recommended that the guidance document should at least make reference to the existence of other smoking related behaviours among young people. This seems to be particularly relevant for Standard 3: Educational establishments have an organisation-wide smokefree policy that is coordinated with the local tobacco control strategy. Potentially, the implementation of this standard would be weakened if e-cigarette use and other smoking behaviour was not acknowledged and addressed as part of a comprehensive and integrated smokefree policy in education establishments. |

| | | | |
|---|---|---|---|
| 46 | UK Centre for Tobacco and Alcohol Studies | Statement 3 | Having a strategy should not be an outcome. The outcome should be implementation. Like hospitals, most schools have smoke free policies, but as a visit to any NHS facility teaches us, having a smoke-free policy and being smoke-free are two very different things. This standard encourages the former, not the latter. |
| 47 | British Thoracic Society | Statement 3 - question 1 | Yes |
| 48 | Health Equalities Group | Statement 3 - question 1 | The draft quality standard statement partially reflects the key areas for quality improvement. However, emphasis should be the delivery of an organisation-wide smokefree policy in line with the bullet points on page 18 (Draft for consultation document) rather than the current emphasis of simply 'having a policy'. The equality and diversity considerations are particularly important and should be emphasised at every opportunity. |
| 49 | British Thoracic Society | Statement 3 - question 2 | Yes |
| 50 | Health Equalities Group | Statement 3 - question 2 | Unlike quality standard 1 and 2 above, this standard does not include an outcome. Is this an oversight? A proposed outcome could be: Reduced smoking prevalence among children and young people under 18. The proposed systems and structures for the monitoring of the proposed quality measure are feasible. However, it is debatable whether the measures are a true indicator of the impact of this standard on children and young people's smoking behaviour. The monitoring should focus on action (implementation) rather than words (policy). |
| 51 | Public Health England | Statement 3 - question 2 | From the information given we see no reason why it would not be possible to collect the data for this quality measure. |
| 52 | British Thoracic Society | Statement 3 - question 3 | Ofsted and other educational regulators should ensure that a review of adherence to this policy is part of their inspection process and consequences if the policy is not adhered to |
| 53 | Health Equalities Group | Statement 3 - question 3 | The support of the quality statement would be improved by the identification and sharing of good practices in relation to the 'Organisation-wide smokefree strategy nine bullet points' on page 18. Arguably, the impact of this quality standard would be enhanced if there were minimum delivery standards for some of these bullet points. For example, education establishments may state they deliver smoking prevention activities. However, in practice this could range from an annual 20-minute lecture delivered to the whole school to a series of planned activities incorporated throughout the curriculum and delivered throughout the school year. |
| 54 | Public Health England | Statement 3 - question 3 | An opportunity exists here to identify how young people might become involved in developing regional mass-media campaigns. Also previous advocacy work that explores the production, sale and distribution of tobacco as a product, highlighting issues such as child slavery, market control and resource exploitation, and demonstrates engagement; however we are not aware of an evidence base that indicates this leads to a reduction in uptake. In addition recording of centres for education who engage in developing a curriculum that recognises tobacco as a global as well as a local issue would be useful. |

| | | | |
|---|---|---|---|
| 55 | Pfizer Ltd | Statement 4 | Pfizer welcomes the inclusion of a statement focussing on access for people who smoke to an evidence-based stop smoking service. NICE have previously defined this as such: 'Evidence-based stop smoking services are local services providing accessible, evidence-based and cost-effective support to people who want to stop smoking.' [1]We would also like to see NICE recommend employers work in partnership with the local SmokeFree stop smoking services. This will help develop pathways and processes to ensure good quality support is available to all employees, and that they in turn have access to a range of treatments and management options. Strengthening these links will thus increase the chances of successful quits, which is a fundamental part of the integrated approach to reducing tobacco use. This will also support measurement of the use and efficacy of the statement as services record and publish data on an annual basis. As the numerator for this statement captures 'smoking cessation services', we suggest that NICE reiterate this definition within this Quality Standard. We suggest this reasoning is captured in the rationale for the Quality Standard.[1] NICE Quality Standard - Quality Standard Smoking cessation: supporting people to stop smoking |
| 56 | Royal College of Paediatrics and Child Health | Statement 4 | More detail is required regarding "offered support by smoking cessation services" – how is this defined, for example does merely having leaflets available about these service fulfil this criteria? |
| 57 | UK Centre for Tobacco and Alcohol Studies | Statement 4 | Similarly, workplace policies to encourage referral achieve little if anything. Requiring employees to remain abstinent from smoking in the workplace, supported by cessation services, does. We need initiatives that encourage employers to go smoke-free. |
| 58 | British Thoracic Society | Statement 4 - question 1 | Yes |
| 59 | Health Equalities Group | Statement 4 - question 1 | Yes. The draft quality standard accurately reflects the key areas for quality improvement. The importance of targeting businesses employing people from routine and manual socio-economic group should be emphasised at every opportunity. |
| 60 | British Thoracic Society | Statement 4 - question 2 | Yes |
| 61 | Health Equalities Group | Statement 4 - question 2 | The proposed monitoring approach of the quality measure are feasible providing that systems and structures were available. However, the cost of collecting the numerator and denominator data on a business-by-business basis for the three process measures on page 21 would be significant. |
| 62 | Public Health England | Statement 4 - question 2 | It would seem unlikely that the collection of data about HR policies and access to stop smoking services for workplaces in a local authority area would be manageable, other than in a few large organisations. |
| 63 | British Thoracic Society | Statement 4 - question 3 | To ensure staff are aware of the availability of smoking cessation support during working hours should be regularly advertised internally. If the smoking status of the employee is known, these employees are reminded/invited regularly of the free access during working hours of the smoking cessation service |

| | | | |
|---|---|---|---|
| 64 | Health Equalities Group | Statement 4 - question 3 | The business case for employees who smoke to access smoking cessation support during working hours without loss of pay needs to be made strongly. A multi-faceted approach including mass media campaigns; business leaders as champions and activity by local and regional chambers of commerce should be used to get the message across that smoking cessation is positively related to productivity.The identification and communication of good practices will strengthen the quality standard. This is particularly important in relation to engaging with small and medium size businesses and especially those employing people from routine and manual socio-economic group. |
| 65 | Public Health England | Statement 4 - question 3 | Neglecting to include people who are not in work from this section requires that a separate quality standard is developed for this population. |
| 66 | UK Centre for Tobacco and Alcohol Studies | Statement 5 | Again, the measured outcome is a policy, not a practice. Being smoke-free should be a condition of NHS commissioning, with financial penalties for failure to implement. Again, this is something that needs leadership at national as well as local level. |
| 67 | Health Equalities Group | Statement 5 - question 1 | Yes. The draft quality standard accurately reflects the key areas for quality improvement. |
| 68 | Health Equalities Group | Statement 5 - question 2 | The proposed monitoring approach of the quality measures are feasible providing that systems and structures were available. However, it is debatable whether the proposed measures will help ensure that hospital sites are completely smokefree. Arguably, many hospitals already have policies that address most or all of the process measures 'a' to 'f' on pages 25 – 26. Monitoring should focus on action rather than words. This would involve establishing process measures in relation to the communication, implementation and enforcement smokefree policies in an effective and equitable way. |
| 69 | Public Health England | Statement 5 - question 2 | From the information given we see no reason why it would not be possible to collect the data for this quality measure. |
| 70 | British Thoracic Society | Statement 5 - question 3 | As the number of smokers admitted to UK hospitals is large, over 1.1million per annum, and the majority of hospitals do not follow NICE PH48 Smokfree ground regulations, it is important that commissioners and regulators such as NHSE, CQC, CCG, Monitor, TDA, assist Trusts enforce this quality standard, holding Chief Executives and Trust Boards to account with penalties for non-adherence. Failure to do this is likely to lead to continued non implementation of PH48 recommendation. |
| 71 | Health Equalities Group | Statement 5 - question 3 | Support and guidance needs to be made available to secondary care services on a local and regional basis. Our experience in Cheshire and Merseyside demonstrates that whilst hospitals may be working in partnership with, and receiving support from, local public health teams and local stop smoking services, the support is variable. Few hospitals are seeking guidance from other hospitals. Mass media campaigns should be used to ensure that patients and visitors are made aware of smokefree policies and that support is available to abstain from smoking while in the secondary care settings (including the hospital grounds) and in the community. |
| 72 | Public Health England | Statement 5 - question 3 | The quality standard is clear and NICE guidance PH48 provides sufficient support to enable implementation and reduce barriers. |
| 73 | Association of Convenience Stores | Statement 6 | ACS welcomes that illicit tobacco has been selected as a placeholder statement, and has been prioritised by the Quality Standards Committee to address the need for the evidence-based guidance to be developed in this area. |

| | | | |
|---|---|---|---|
| 74 | Association of Convenience Stores | Statement 6 | ACS believes that the illicit trade needs to be specifically referenced within the guidance as it poses the greatest threat to an increase in tobacco consumption rates by children and young people. ACS is committed to working with local authorities to reduce the prevalence of the illicit trade. We believe the more investment in intelligence led enforcement at local level is needed to tackle the illicit trade. |
| 75 | Association of Convenience Stores | Statement 6 | There are important sources of information on the prevalence of illegal trade in particular areas, firstly from local HM Revenue and Customs officers that must be included as a partner, but also from 'pack swap' data that is commissioned by tobacco companies and is by far the best way to accurately measure trends in tobacco retailing. |
| 76 | British Thoracic Society | Statement 6 | No comment |
| 77 | Health Equalities Group | Statement 6 | No - we do not know of any relevant evidence-based guidance that could be used to develop this placeholder statement.New evidence-based guidance relating to taking action against the illicit tobacco trade would, presumably, have the potential to improve practice. Trading Standards, the police and other relevant partners will be able to provide advice about how to reduce the supply and demand for illicit tobacco. The illicit trade undermines the effectiveness of the proposed Smoking: reducing tobacco use in the community quality standards and efforts to reduce smoking generally. |
| 78 | Public Health England | Statement 6 | The work programme delivered by the centres of tobacco control in the North East, North West and South West of England, has been evaluated by the UK Centre for Tobacco and Alcohol Studies. The Tackling Illicit Tobacco for Better Health website, http://www.illegal-tobacco.co.uk/ provides details of this work. The report by the UKCTAS can be found here, https://www.newcastle.gov.uk/sites/drupalncc.newcastle.gov.uk/files/wwwfileroot/business/trading_standards/illicit_tobacco_evaluation1.pdf<br>We would agree that new evidence based guidance would be beneficial in improving practice aimed at reducing trade in illicit tobacco.<br>An important point to note is that any activity must be delivered at a supra-local level. The aim of any action in this area is to eliminate the trade in illicit tobacco, rather than move it from place to place, as can happen when levels of enforcement differ from locality to locality. |
| 79 | Trading Standards Institute | Statement 6 | TSI can provide data for the level of activity undertaken by Local Authority trading standards in respect of tackling illicit tobacco supply. Data is collected via the annual survey and includes types of illicit product that are seized, and the quantity. This data is shared routinely with HMRC. Partnership working is vital in this area but can be difficult to achieve and/or maintain. The quality statement could be developed in much the same format as that in QS2. |
| 80 | Trading Standards Institute | Statement 6 | TSI does not support the inclusion of the statement " In addition, because many of these products are made from unregulated materials the health consequences for people who smoke them can be acute". This can only be proved by the testing of each illicit product (costly) which is not undertaken routinely for seized products .Furthermore, it implies that the health consequences for people who smoke genuine tobacco products are less harmful which is not true. |

| | | | |
|---|---|---|---|
| 81 | UK Centre for Tobacco and Alcohol Studies | Statement 6 | Illicit supply is a local and national problem.. The response needs to coordinate national and local strategies to prevent imports of illicit supply as well as national and local distribution practices. Sentencing policy needs to change to make prison terms for tobacco smuggling equivalent to those for drug smuggling (they are currently substantially lower). Again, a national policy. There is evidence from the North of England Illicit tobacco programme which would help to address this standard and should be utilised. |

### *Stakeholders who submitted comments at consultation*

- Association of Convenience Stores
- Association of School and College Leaders
- British Thoracic Society
- Health Equalities Group
- NHS England
- Pfizer Ltd
- Public Health England
- Royal College of nursing
- Royal College of Paediatrics and Child Health
- Royal College of Physicians
- Trading Standards Institute
- UK Centre for Tobacco and Alcohol Studies

# Appendix 2: Quality standard consultation comments table (internal)

| ID | Internal NICE team | Statement No | Comments<br>Please insert each new comment in a new row. |
|---|---|---|---|
| 82 | QS Team | 1 | Local authorities provide local and regional mass media campaigns to prevent children and young people under 18 from taking up smoking – preferred wording. However, statement is still too broad. There needs to be a clear area for quality improvement specified here that will make recommended actions clear for the commissioners. |
| 83 | QS Team | 1 | Campaign planners needs to be defined or not used in the statement |
| 84 | QS Team | 2 | 2 parts to the statement that could be brought together better. Suggested wording: Local authorities identify and sanction retailers that persistently sell tobacco products to people under 18. |
| 85 | QS Team | 3 | Statements seems focused on having a policy rather than on a specific action. Would it not be better to focus on 1 specific practical area like implementing prevention activities in school? |
| 86 | QS Team | 4 | This should read: Employers allow employees who smoke to access smoking cessation support during working hours without loss of pay |
| 87 | QS Team | 4 | Do we want the focus of this statement to be for the employers to allow employees to access services or is it about them proactively seeking support for their staff? |
| 88 | QS Team | 5 | Suggested wording: Acute, maternity and mental health secondary care services have smokefree grounds/are smokefree sites |