NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Smoking: reducing tobacco use in the community.

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 23 July 2014

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for smoking: reducing tobacco use in the community. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development sources

The key development sources referenced in this briefing paper are:

- Smoking cessation in secondary care: acute, maternity and mental health services Public health guidance 48 (2013).
- School-based interventions to prevent the uptake of smoking among children. Public health guidance 23 (2010).
- Guidance on preventing the uptake of smoking by children and young people. Public health guidance 14 (2008).
- Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007).

2 Overview

2.1 Focus of quality standard

This quality standard will cover reducing tobacco use in the community including interventions to discourage people from taking up smoking, tobacco control strategies and smokefree policies. The quality standard will not cover referral to and delivery of stop smoking services which is already covered by NICE quality standard 43 - Smoking cessation: supporting people to stop smoking.

2.2 Smoking overview

Tobacco smoking remains the single greatest cause of preventable illness and premature death in England. Smoking causes a range of diseases including cancer, cardiovascular diseases and respiratory diseases. It contributes to many other debilitating conditions such as age-related macular degeneration, gastric ulcers, impotence and osteoporosis. Further, it can cause complications in pregnancy, including increased risk of miscarriage, premature birth and low birthweight. It is also associated with lower survival rates, delayed wound healing, increased infections, prolonged hospital stays and repeated admissions after surgery.

Smoking is the largest single cause of inequalities in health and accounts for about half of the difference in life expectancy between the lowest and highest income groups. According to Public Health England in the UK, the unemployed are twice as likely to be smokers compared to employed people. Smoking is highly prevalent among the homeless, those in prison, and other marginalised or otherwise highly disadvantaged groups. Smoking is more than twice as prevalent among people with mental disorders as among the general population and has changed little over the past 20 years, in contrast to the progressive decline in smoking prevalence in the general population. Smokers in disadvantaged groups have typically started to smoke at a younger age, smoke more cigarettes per day, and take in more nicotine from each cigarette.

Children who smoke become addicted to nicotine very quickly and most of them continue the habit into adulthood. Around two-thirds of people who have smoked took up the habit before the age of 18.

Exposure to second-hand smoke (also referred to as passive smoking) also causes significant harm. Among adults, passive smoking causes thousands of deaths from lung cancer, cardiovascular disease and COPD. Passive exposure of children increases the risk of sudden infant death syndrome, lower respiratory infections, asthma and wheezing illness, meningitis and middle ear disease.

2.3 Incidence and prevalence

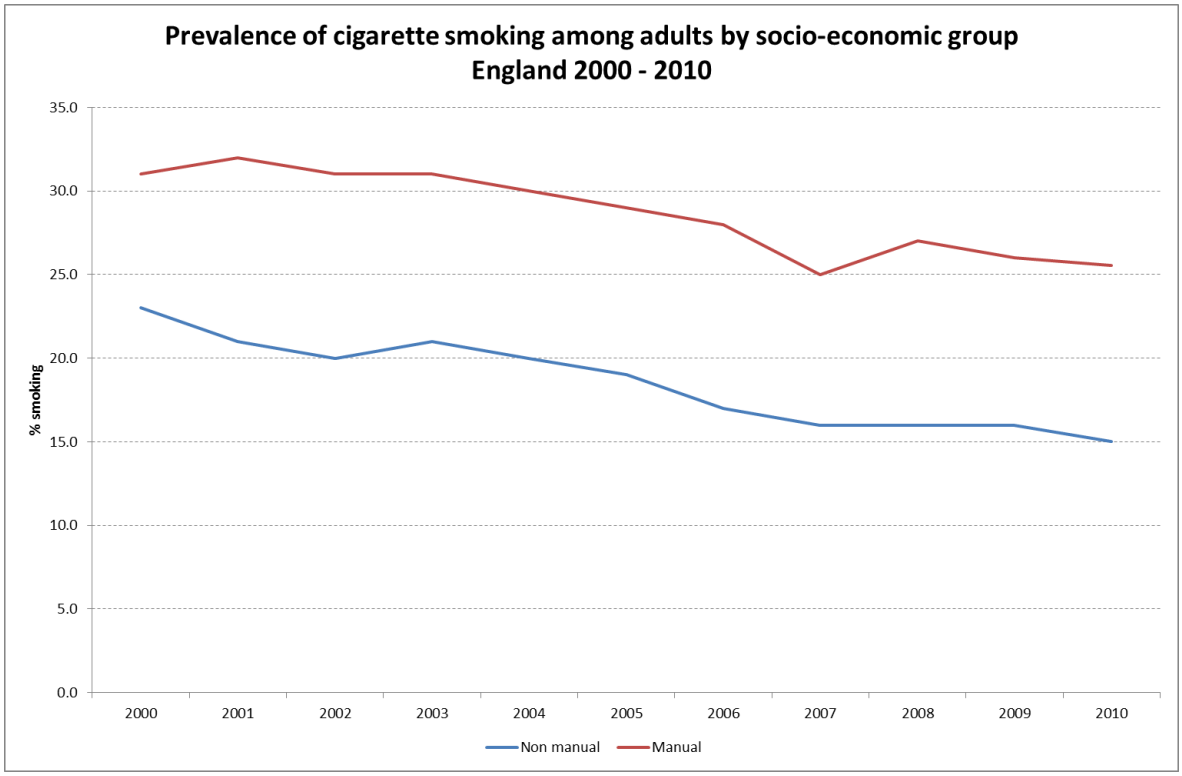
Statistics on Smoking, England (2013) illustrate that there has been a long-term decline in the prevalence of smoking among pupils 11 to 15 years old since the mid-1990s. Whilst in 1996 nearly half (49 %) of the pupils had tried smoking at least once, in 2012, less than a quarter (23%) had done so. About 4% of pupils smoked regularly (defined as smoking at least one cigarette a week). Table 1 illustrates ages at which current smokers started to smoke regularly by socio-economic group.

Table 1

Age adults started smoking regularly	All classifications (%)	Managerial and professional (%)	Intermediate (%)	Routine and manual (%)
Under 16	39.1	31.2	39.5	45.0
16-17	26.9	28.6	25.2	26.8
18-19	17.1	21.3	16.5	14.1
20-24	11.8	14.1	13.2	9.1
25 and over	5.1	4.8	5.6	5.1

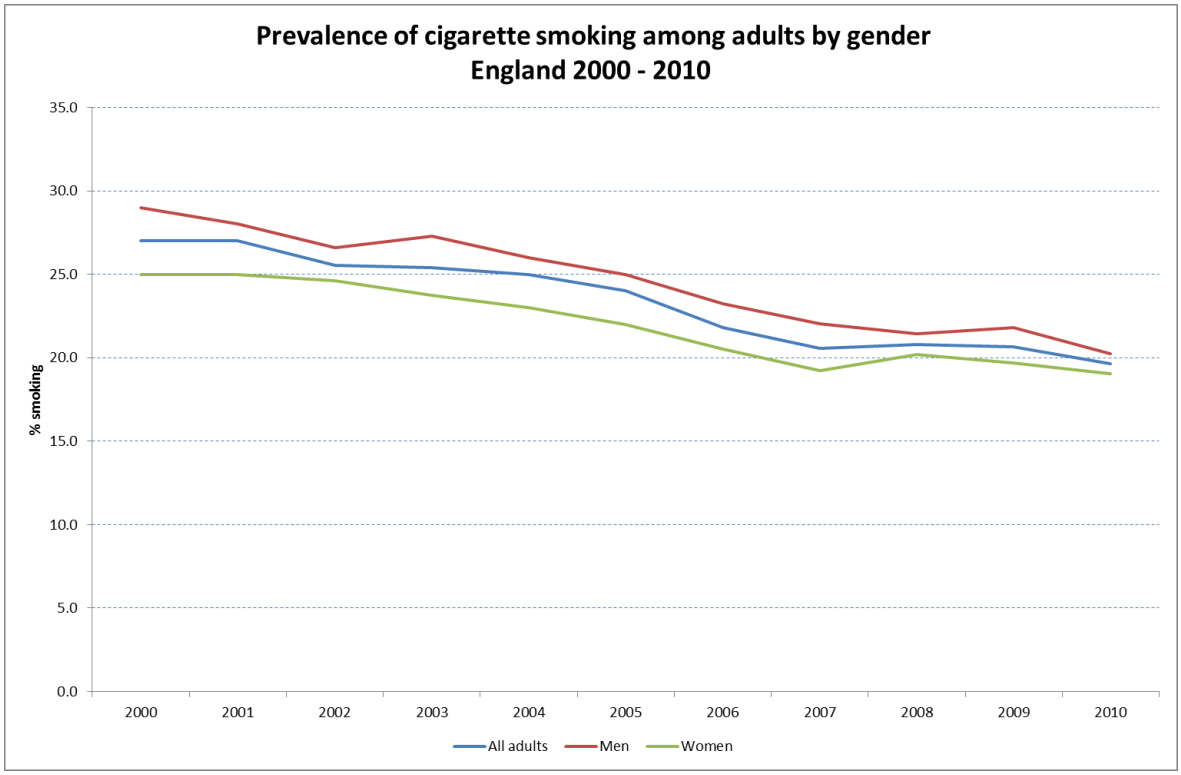
According to the Integrated Household Survey, prevalence of smoking among people aged 18 years and over in 2012 was 19.5%. However, prevalence of smoking among persons aged 18 years and over in the routine and manual group in the same year was 29.7%. Statistics on Smoking, England (2013) show that whilst prevalence of smoking has been going down over the last decade within both social groups, smoking among the non-manual social group has been decreasing at a faster pace than among the manual group (Figure 1).

Figure 1



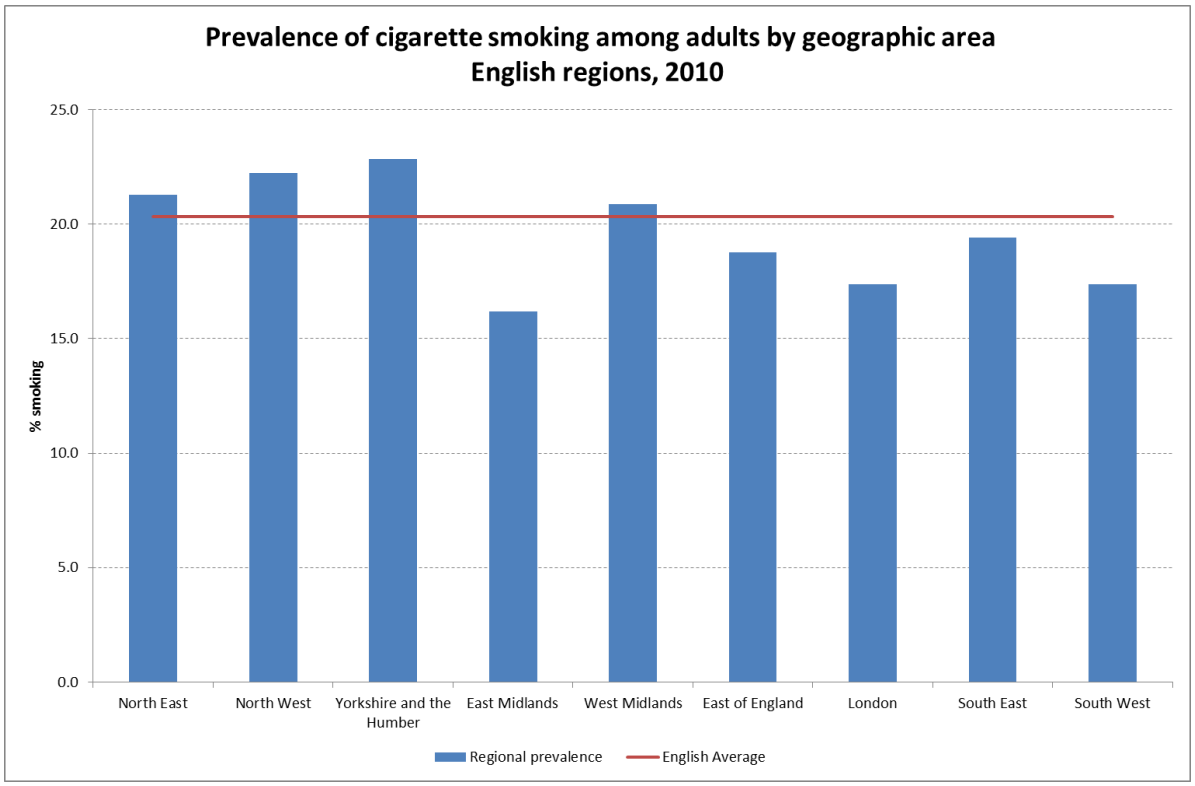
Smoking is still more prevalent among men than among women but the gap has been narrowing over the last decade (Figure 2).

Figure 2



Statistics on Smoking, England (2013) show that visible regional variations not only exist between England (20.3%), Wales (24.9%) and Scotland (24.5%) but also between regions within England. Differences in prevalence of smoking between English regions are illustrated below (Figure 3).

Figure 3



Figures presented in Local Tobacco Control Profiles for England indicate that in 2012/13 12.7 women smoked at time of delivery per 100 maternities in England. This is only a slight improvement on 2010/11 when this figure was 13.5 per 100 maternities.

Statistics on Smoking, England (2013) illustrate that in 2011, an estimated 79,100 adults aged 35 and over died in England as a result of smoking, accounting for 18% of all deaths in that age group. What is more, 28% of deaths from all cancers, 36% from respiratory diseases and 14% from circulatory diseases were caused by smoking.

In 2011/12, an estimated 462,900 hospital admissions among adults aged 35 and over in England were attributable to smoking, accounting for 5% of all admissions, 11% of all cancer admissions, 25% of all admissions for respiratory diseases and 15% of all admissions for cardiovascular diseases.

The case for local action on tobacco estimates that treating smoking-related illnesses costs the NHS £2.7 billion in 2010. The costs of tobacco use are much

greater than just costs to the NHS, and the overall economic burden of tobacco use to society is estimated at £13.8 billion a year.

2.4 Strategies

There are a variety of strategies for reducing tobacco use in the community. The latest recommendations outlined in the Healthy Lives, Healthy People: A Tobacco Control Plan for England suggest taking a multi-faceted and comprehensive approach to tobacco control strategies at both national and local level. The communities across England are encouraged to reshape social norms, so that tobacco becomes less desirable, less acceptable and less accessible. The document groups tobacco control strategies into the six strands:

- stopping the promotion of tobacco;
- making tobacco less affordable;
- effective regulation of tobacco products;
- helping tobacco users to quit;
- reducing exposure to secondhand smoke;
- effective communications for tobacco control.

2.5 National Outcome Frameworks

Tables 2 – 4 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 2 The Adult Social Care Outcomes Framework 2014–15

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life**(NHSOF 2) ***Outcome measures*** **People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.** 1B Proportion of people who use services who have control over their daily life
2 Delaying and reducing the need for care and support	***Overarching measure*** 2A Permanent admissions to residential and nursing care homes, per 100,000 population. ***Outcome measures*** **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.** **Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.** 2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services* (NHSOF 3.6i-ii)
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services.** 3A Overall satisfaction of people who use services with their care and support. 3E Improving people's experience of integrated care **(NHSOF 4.9) ***Outcome measures*** **Carers feel that they are respected as equal partners throughout the care process** 3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.** 3D The proportion of people who use services and carers who find it easy to find information about support
Aligning across the health and care system * Indicator complementary ** Indicator shared	

Table 3 NHS Outcomes Framework 2014–15

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicator*** 1B Life expectancy at 75 i Males ii Females ***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.1 Under 75 mortality rate from cardiovascular disease* 1.2 Under 75 mortality rate from respiratory disease* 1.3 Under 75 mortality rate from liver disease* 1.4 Under 75 mortality rate from cancer* i One- and ii Five-year survival from all cancers iii One- and iv Five-year survival from breast, lung and colorectal cancer **Reducing premature death in people with serious mental illness** 1.5 Excess under 75 mortality rate in adults with serious mental illness* **Reducing deaths in babies and young children** 1.6 i Infant mortality* ii Neonatal mortality and stillbirths iii Five year survival from all cancers in children **Reducing premature death in people with a learning disability** 1.7 Excess under 60 mortality rate in adults with a learning disability

2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition** **Improving functional ability in people with long-term conditions** 2.2 Employment of people with long-term conditions**** **Reducing time spent in hospital by people with long-term conditions** 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers** **Enhancing quality of life for people with mental illness** 2.5 Employment of people with mental illness****

3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital* ***Improvement areas*** **Improving outcomes from planned treatments** 3.1 Total health gain as assessed by patients for elective procedures i Hip replacement ii Knee replacement iii Groin hernia iv Varicose veins v Psychological therapies **Preventing lower respiratory tract infections (LRTI) in children from becoming serious** 3.2 Emergency admissions for children with LRTI **Improving recovery from injuries and trauma** 3.3 Survival from major trauma **Improving recovery from stroke** 3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months **Improving recovery from fragility fractures** 3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days **Helping older people to recover their independence after illness or injury** 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service** ii Proportion offered rehabilitation following discharge from acute or community hospital**

Alignment across the health and social care system

* Indicator shared with Public Health Outcomes Framework (PHOF)

** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)

*** Indicator shared with Adult Social Care Outcomes Framework

**** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework

Table 4 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.01 Children in poverty i all dependent children under 20 ii under 16s 1.08i Gap in employment rate between those with a long-term health condition and the overall employment rate 1.08iii Gap in employment rate between those in contact with secondary mental health services and the overall employment rate 1.09 Sickness absence i The percentage of employees who had a least one day off in the previous week ii The percentage of working days lost due to sickness absence
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.01 Low birthweight of term babies 2.03 Smoking status at time of delivery 2.14 Smoking prevalence 2.14 Smoking prevalence – routine and manual
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities ***Indicators*** 4.1 Infant mortality 4.03 Mortality from causes considered preventable 4.04 Under 75 mortality rate from all cardiovascular disease 4.04 Under 75 mortality rate from cardiovascular disease considered preventable 4.05 Under 75 mortality rate from cancer 4.05 Under 75 mortality rate from cancer considered preventable 4.07 Under 75 mortality rate from respiratory disease 4.07 Under 75 mortality rate from respiratory disease considered preventable 4.11 Emergency readmissions within 30 days of discharge from hospital 4.12i Preventable sight loss age related macular degeneration

3 Summary of suggestions

3.1 Responses

In total, 8 stakeholders responded to the 2-week engagement exercise 29/05/14 – 12/06/14. Two stakeholders advised that they had no comments to make at this stage of the development of the quality standard.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 5 for further consideration by the Committee.

Full details on the suggestions provided are given in appendix 1 for information.

Table 5 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Prevention • Preventing uptake • School based interventions	SWYPFT
Workplace interventions • Promotion of smoking cessation & smoking cessation services in the workplace • Targeted engagement of the smoking cessation services with workplaces	SWYPFT
Smokefree policies • Secondary care • Play areas in public parks • Prisons • Homes • Cars	SCM, SWYPFT, DMBC
Additional areas: • Harm reduction approach • NICE Champion role • NICE guidance and service specifications • Organisational cost benefit analysis • QS and CQC inspections • QS evidence base analysis • Referral pathways • Smoking and pregnancy • Smoking and long term conditions (LTC) • Smoking cessation in secondary care settings	SCM, DMBC, SWYPFT, RCP, ASH

ASH – Action on smoking and health
DMBC – Doncaster Metropolitan Borough Council
RCP – Royal College of Physicians
SCM – Specialist Committee Member
SWYPFT – South West Yorkshire Partnership Foundation Trust

4 Suggested improvement areas

4.1 Prevention

4.1.1 Summary of suggestions

Preventing uptake

Stakeholders highlighted the role of prevention approaches in addressing and denormalising smoking among children and young people as key area for improvement.

School based interventions

Stakeholders highlighted the role of school based interventions in addressing and denormalizing smoking among children and young people as key area for improvement.

4.1.2 Selected recommendations from development sources

Table 6 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Preventing uptake	**Mass media** NICE PH14 Recommendations 1, 2, 3 **Illegal sales** NICE PH14 Recommendation 5
School based interventions	NICE PH23 Recommendations 1, 2, 3, 4, 5

Preventing uptake

<u>NICE PH14 Recommendation 1 (campaign development)</u>

- Develop national, regional or local mass-media campaigns to prevent the uptake of smoking among young people under 18. The campaigns should:
    - be informed by research that identifies and understands the target audiences

  - consider groups which epidemiological data indicate have higher than average or rising rates of smoking

  - be developed in partnership with: national, regional and local government and non-governmental organisations, the NHS, children and young people, media professionals (using their best practice), healthcare professionals, public relations agencies and local anti-tobacco activists.

- The campaign(s) should not be developed in conjunction with the tobacco industry.

NICE PH14 Recommendation 2 (campaign messages)

- Convey messages based on strategic research and qualitative pre- and post-testing with the target audiences. These could include messages that:

  - elicit a strong, negative emotional reaction (for example, loss, disgust, fear) while providing sources of further information and support

  - portray tobacco as a deadly product, not just as a drug that is inappropriate for children and young people to use

  - use personal testimonials that children and young people can relate to

  - are presented by celebrities to whom children and young people can relate (taking care to avoid credibility and other problems)

  - empower children and young people to refuse offers of cigarettes

  - include graphic images portraying smoking's detrimental effect on health as well as appearance (for example, its effect on the appearance of skin and teeth).

- Repeat the messages in a number of ways and regularly update them to keep the audience's attention.

NICE PH14 Recommendation 3 (campaign strategies)

- Use a range of strategies as part of any campaign to reduce the attractiveness of tobacco and contribute to changing society's attitude towards tobacco use, so that smoking is not considered the norm by any group. Strategies could include:

  - generating news by writing articles, commissioning newsworthy research and issuing press releases

  - using posters, brochures and other materials to promote the campaign

  - using opportunities arising from new media.

- The campaign(s) should not be delivered in conjunction with (or supported by) the tobacco industry.

- National campaigns should exploit the full range of media used by children and young people, including television advertising.

- Regional and local campaigns should build on, and be integrated with, a national communications strategy to tackle tobacco use. Regional campaigns should use regional press and radio (local campaigns should use local press and radio) to reach specific audiences and to get unpaid coverage in the press. They should also use regional and local networks (as appropriate) to generate as much publicity as possible.

- Effective practice, including effective local and regional media messages, should be shared locally, regionally and nationally.

- Campaigns should run for 3–5 years.

<u>NICE PH14 Recommendation 5 (illegal sales)</u>

- Ensure retailers are aware of legislation prohibiting under-age tobacco sales by:

  - providing training and guidance on how to avoid illegal sales

  - encouraging them to:

    - request proof of age from anyone who appears younger than 18 who attempts to buy cigarettes and get it verified (examples of proof-of-age include a passport or driving licence or cards bearing the nationally-accredited 'PASS' hologram)

    - complete the 'Age restricted products refusal register' for each tobacco sale refused on the grounds of age

  - running campaigns to publicise the legislation; these could include details of possible fines that retailers can face, where tobacco is being sold illegally and successful local prosecutions, as well as health information.

- Make it as difficult as possible for young people under 18 to get cigarettes and other tobacco products. In particular, exercise a statutory duty under the Children and Young Persons (protection from tobacco) Act 1991 to prevent under-age sales by:

    - prosecuting retailers who persistently break the law

  - undertaking test purchases each year, using local data to detect breaches in the law and auditing them regularly to ensure consistent practice across all local authorities

- Work with other agencies to identify areas where under-age tobacco sales are a particular problem.

- Work with the Local Better Regulation Office to improve inspection and enforcement activities related to illegal tobacco sales.

- Assess whether an advocacy campaign is needed to support enforcement. Any such campaign should be run in accordance with best practice and provide a clear, published statement on how to deal with under-age tobacco sales.

- Actively discourage use of enforcement and related campaigns developed by the tobacco industry.

- Ensure efforts to reduce illegal tobacco sales by retailers are sustained.

School based interventions

NICE PH23 Recommendation 1(organisation-wide or 'whole-school' approaches)

- Develop a whole-school or organisation-wide smokefree policy in consultation with young people and staff. This should include smoking prevention activities (led by adults or young people) and staff training and development. The policy should take account of children and young people's cultural, special educational or physical needs. (For example, large-print versions of information may be needed.)

- Ensure the policy forms part of the wider healthy school or healthy further education strategy on wellbeing, sex and relationships education, drug education and behaviour.

- Apply the policy to everyone using the premises (grounds as well as buildings), for any purpose, at any time. Do not allow any areas in the grounds to be designated for smoking (with the exception of caretakers' homes, as specified by law).

- Widely publicise the policy and ensure it is easily accessible so that everyone using the premises is aware of its content. (This includes making a printed version available.)

- Ensure the policy supports smoking cessation in addition to prevention, by making information on local NHS Stop Smoking Services easily available to staff

and students. This should include details on the type of help available, when and where, and how to access the services.

NICE PH23 Recommendation 2 (adult-led interventions)

- Integrate information about the health effects of tobacco use, as well as the legal, economic and social aspects of smoking, into the curriculum. For example, classroom discussions about tobacco could be relevant when teaching a range of subjects including biology, chemistry, citizenship, geography, mathematics and media studies.

- Deliver interventions that aim to prevent the uptake of smoking as part of PSHE (drugs education) and activities related to Healthy Schools or Healthy Further Education status. Link them to the whole-school or organisation-wide smokefree policy and involve children and young people in their design. Interventions should:

    - be entertaining, factual and interactive

    - be tailored to age and ability

    - be ethnically, culturally and gender-sensitive and non-judgemental

    - aim to develop decision-making skills through active learning techniques

    - include strategies for enhancing self-esteem and resisting the pressure to smoke from the media, family members, peers and the tobacco industry

    - include accurate information about smoking, including its prevalence and its consequences: tobacco use by adults and peers should be discussed and challenged

    - be delivered by teachers and higher-level teaching assistants who are both credible and competent in the subject, or by external professionals trained to work with children and young people on tobacco issues.

- Support tobacco education in the classroom with additional 'booster' activities until school leaving age. These might include school health fairs and guest speakers.

- Encourage parents and carers to become involved, for example, by letting them know about class work or by asking them to help with homework assignments.

- Work with local partners involved in smoking prevention and cessation activities to deliver interventions. This could include local health improvement services,

regional tobacco policy leads, local tobacco control alliances and NHS Stop Smoking Services.

NICE PH23 Recommendation 3 (peer – led interventions)

- Consider offering evidence-based, peer-led interventions aimed at preventing the uptake of smoking such as the ASSIST (A Stop Smoking in School Trial[1]) programme. They should:
  - link to relevant PSHE activities
  - be delivered both in class and informally, outside the classroom
  - be led by young people nominated by the students themselves (the peer leaders could be the same age or older)
  - ensure the peer leaders are trained outside school by adults who have the appropriate expertise
  - ensure peer leaders receive support from these experts during the course of the programme
  - ensure young people can consider and, if necessary, challenge peer and family norms on smoking, discuss the risks associated with it and the benefits of not smoking.

NICE PH23 Recommendation 4 (training and development)

- Provide training for all staff who will be involved in smoking prevention work.
- Work in partnership to design, deliver, monitor and evaluate smoking prevention training and interventions. Partners could include: national and local education agencies, training agencies, local authorities, the school nursing service, voluntary sector organisations, local health improvement services and universities.

NICE PH23 Recommendation 5 (coordinated approach)

- Ensure smoking prevention interventions in schools and other educational establishments are part of a local tobacco control strategy.
- Ensure schools and other educational establishments deliver evidence-based smoking prevention interventions. These should be linked to their smokefree policy and consistent with regional and national tobacco control strategies.

- Ensure the interventions are integrated into the curriculum, PSHE education and work associated with Healthy Further Education and Healthy Schools status. They should also follow the Healthy Schools enhancement model (stage 5).

4.1.3 Current UK practice

Preventing uptake

Media campaigns

Langley et al. (2013) characterized TV campaigns funded and run by the Department of Health in England between 2004 and 2010 and explored if they were in line with recommendations from the literature in terms of their content and intensity. The results showed that:

- only a small proportion of tobacco control advertisements utilized the most effective strategies—negative health effects messages and testimonials from real-life smokers
- the intensity of campaigns was lower than international recommendations
- the campaigns were often not sustained .

During the study period the vast majority of the campaigns (89%) were for adult cessation; in 2008–2010, this figure was 98%. A very small proportion was for smoking in pregnancy (0.3%). No prevention campaigns were identified within the study period.

Numerous regional campaigns have been developed and delivered over the last few years across the country. However, great majority is focussed on stop smoking messages rather than preventing uptake. Recent regional campaigns addressing smoking uptake include:

- Keep it Out - campaign from the North of England Tackling Illicit Tobacco for Better Health Programme, running in the North East, North West and Yorkshire & Humber. The campaign followed on from two phases of the Get Some Answers campaign which raised questions like “how can our children afford to smoke?” with a much more direct call to action to inform on illegal tobacco dealers (carried out by Fresh and Tobacco Free Futures).
- Tackling illegal tobacco - campaign launched on 30 June 2014 with roadshows running over the summer supported by billboard and radio advertising. The campaign was first launched in November 2011 with phase 2 following in February 2013. The campaign targets smokers and non-smokers, specifically

'concerned parents' as defined by the national Illicit tobacco strategy. It targets areas where there are moderate levels of illegal tobacco consumption but also enough doubts in attitude to build on and affect change (carried out by Smokefree South West).

- Smoke & Mirrors – is a project that takes an unusual approach to encourage young people not to smoke. It challenges young people to unveil existing negative practice within the tobacco industry, to research the hard facts behind the tobacco industry in order expose the truth themselves, including issues such as marketing, deforestation and the use of child labour. The project encourages young people to get involved, communicate their views and opinions via a wide range of media including facebook, twitter and YouTube. It also ran a film competition for young people to express their views via that medium (carried out by Tobacco Free Futures).

- Plain Packs Protect – campaign urging the Government to adopt standardised packs with larger health warnings (carried out by Smokefree South West)

Illegal sales

Tobacco Control Survey, England 2012/13: the report presents results from a survey of trading standards activities carried out by councils in England during the financial year April 2012 to March 2013. An online survey was emailed to all councils in England in April 2013 undertaking tobacco control activities (151 councils in total). The survey was completed by 147 councils, which provided a response rate of 97%. Although this response rate is high, the base for some findings does vary, as not every respondent answered every question. Relevant findings include the following:

- Under-age sales: premises

  - 95% of all councils had conducted tobacco control activities in relation to under-age sales.

  - 89% of all councils had dealt with complaints and enquiries about under-age sales of tobacco concerning retail premises, receiving 1,528 complaints and enquiries in total.

  - 89% of all councils had visited premises with trading standards officers (TSOs) in relation to under-age sales, achieving a total of 6,328 visits.

  - 115 out of the 131 councils who conducted visits with TSOs were able to provide detail on the types of premises visited. The greatest proportion of visits undertaken was to small retailers (42% of all visits).

- 92% of all councils had carried out visits to retail premises with volunteer young persons (aged under 18) to test compliance with the legislation on the sale of tobacco products to under 18s. Of these:
    - 134 out of 135 councils supplied the number of premises visited; the total number was 4,477.
    - 80% reported that cigarettes or tobacco products had been sold to the volunteer young persons in at least one premises; cigarettes were sold to under-age young persons at a total of 506 premises.
    - Where data was provided on the number of premises and number of sales, illegal sales of cigarettes occurred in 12% of test purchase operations made at premises.
    - 116 councils out of 135 were able to provide detail on both the types of premises visited and where sales occurred. The largest proportion of visits were undertaken to small retailers (37%), with the largest proportion of sales occurring at independent newsagents (16%).

- Under-age sales: actions taken in relation to the Children and Young Persons Act 1933 (as amended):
    - verbal or written warnings 71%
    - legal action (prosecution cases) 37%
- Education initiatives
    - 66% of all councils had conducted education initiatives
    - Of those who had conducted education initiatives:
        - 82% with small retailers, 79% with independent newsagents, and 78%with off licences
    - most often undertaken in relation to underage sales activity
    - most often delivered through advisory visits
- Collaborative working
    - 86% of all councils had undertaken some form of collaborative working
    - 87% of councils undertaking collaborative working stated that tobacco control was included in their health and wellbeing strategy

- 83% of all councils had undertaken collaborative work with specific key partners, for example Primary Care Trust, HMRC

School based interventions

Ofsted report on personal, social, health and economic (PSHE) education in school, found that in most schools pupils had learnt about the effects of tobacco and understood its' dangers to health. This report found that teaching required improvement in 42% of primary and 38% of secondary schools, in relation to PSHE. It also found that in 20% of schools, staff had received little or no training in PSHE education

Even though the 2007 smokefree legislation does not include outdoor areas, if a school has been awarded the National Healthy School Status or is working towards it, the Status requires outdoor areas to be smokefree. All local authorities were notified of the following minimum requirement through the National Healthy Schools Status audit: for the Standard in December 2006.

- The school is a smokefree site or plans are in place for it to be so by summer 2007 (exception: caretaker's house)
- Children/young people, staff, parent/carers and governors have helped in the development of the smokefree site.
- The school is proactive in providing information and support for smokers to quit.

Smokefree South West has supported local areas to deliver the DECIPHer- Assist peer-led school prevention programme. The programme has been rolled out in 80 schools across the South West and has involved almost 20,000 year 8 pupils. Based on the results of the original trial, it is estimated that up to 600 young people in the South West, between the ages of 12 and 13, have not started smoking as a result of the programme.

4.2 Workplace interventions

4.2.1 Summary of suggestions

Promotion of smoking cessation & smoking cessation services in the workplace

Stakeholders highlighted the importance of workplace interventions to promote smoking cessation services available in various settings, particularly for manual workers, pregnant women and hard to reach communities.

Targeted engagement of smoking cessation services with workplaces

Stakeholders highlighted the importance of stop smoking services engaging with workplaces expected to have higher prevalence of smoking among their employees i.e. workplaces that have high numbers of routine and manual workers.

4.2.2 Selected recommendations from development sources

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Promotion of smoking cessation & smoking cessation services in the workplace	NICE PH5 Recommendation 1
Targeted engagement of smoking cessation services with workplaces	NICE PH5 Recommendation 5

Promotion of smoking cessation & smoking cessation services in the workplace

<u>NICE PH5 Recommendation 1</u>

- Publicise the interventions identified in this guidance and make information on local stop smoking support services widely available at work. This information should include details on the type of help available, when and where, and how to access the services.

- Be responsive to individual needs and preferences. Where feasible, and where there is sufficient demand, provide on-site stop smoking support.

- Allow staff to attend smoking cessation services during working hours without loss of pay.

- Develop a smoking cessation policy in collaboration with staff and their representatives as one element of an overall smokefree workplace policy.

Targeted engagement of smoking cessation services with workplaces

NICE PH5 Recommendation 5

- Offer support to employers who want to help their employees to stop smoking. Where appropriate and feasible, provide support on the employer's premises.

- If initial demand exceeds the resources available, focus on the following:

  - small and medium-sized enterprises (SMEs)

  - enterprises where a high proportion of employees are on low pay

  - enterprises where a high proportion of employees are from a disadvantaged background

  - enterprises where a high proportion of employees are heavy smokers.

4.2.3 Current UK practice

Promotion of smoking cessation & smoking cessation services in the workplace

The Royal College of Physicians (2014) report presents findings from the Staff health improvement project, which assessed how NHS trusts have successfully implemented the NICE public health guidance for the workplace. The findings are based on an organisational audit conducted by the Health and Work Development Unit. The audit is based on six pieces of guidance for the workplace published by NICE. A simple scoring system was used to measure the extent of the implementation of NICE guidance and the audit uses self-reported data.

The 2014 document reports on round two data collected in 2013 and compares results with round one data collected in 2010. The total headcount of staff in all 178 trusts participating in round two was reported as 862,365. This represents 73% of all NHS staff in England. Relevant findings include the following:

- 75% of the trusts had an organisation-wide plan or policy on smoking

- 87% of the trusts that had the plan or policy, involved staff in planning and designing an organisational approach
- 92% of the trusts provide access to smoking cessation support (either on site or through arrangements with another local service)
- 62% of the trusts allow staff to attend stop smoking services during working hours without loss of pay
- 53% of trusts with a smoking plan report that they measure uptake according to inequality characteristics

Targeted engagement of smoking cessation services with workplaces

No published studies on current practice were highlighted for this suggested area for quality improvement.

4.3 Smokefree policies

4.3.1 Summary of suggestions

Smokefree secondary care

Stakeholders highlighted the role of the secondary care providers in promoting smokefree environments. Stakeholders stressed the need for all secondary care providers to implement smokefree site policy that would include smokefree grounds and also suggested that smokefree site policy should be a quality measure within the CCG secondary care contract. Stakeholders highlighted existing smoking shelters for staff and patients as example of current poor practice that needs to be addressed.

Smokefree play areas in public parks

Stakeholders suggested extending the smokefree code of practice to children's play areas in public parks. Stakeholders highlighted the importance of influencing the adult world in which children grow up in in reducing smoking and suggested that implementation of smokefree playgrounds would reduce child exposure to smoking and de-normalises tobacco use within the community.

Smokefree prisons

Stakeholders suggested extending the smokefree legislation to adult prisons. Stakeholders highlighted that whilst young offender institutes were included in the smokefree legislation, adult prisons were granted an exception, which allowed smoking to continue outside of communal areas in designated cells. Stakeholders highlighted the high rates of smoking in adult prison population as well as the risk of exposure to secondhand smoke for non-smokers (including staff).

Smokefree homes

Stakeholders suggested that smokefree homes should become part of the dialogue around harm-reduction approach to smoking. They highlighted its' usefulness for heavy smokers who struggle to quick completely. Stakeholders also highlighted the impact of child exposure to smoking including morbidity, mortality and smoking uptake.

Smokefree cars

Stakeholders suggested addressing smoking in cars as an area for improvement which would reduce the impact of second hand smoke on babies and children and reduce smoking uptake in the longer term.

4.3.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Smokefree secondary care	NICE PH48 Recommendations 11, 12 and 16
Smokefree play areas in public parks	Not covered in NICE guidance and no recommendations are presented.
Smokefree prisons	Not covered in NICE guidance and no recommendations are presented.
Smokefree homes	NICE PH48 Recommendation 5 NICE PH26 Recommendation 7
Smokefree cars	NICE PH48 Recommendation 5 NICE PH26 Recommendation 7

Smokefree secondary care

NICE PH48 Recommendation 11(Develop smokefree policies)

- Develop a policy for smokefree grounds in collaboration with staff and people who use secondary care services, or their representatives. The policy should:
  - set out a clear timeframe to establish or reinstate smokefree grounds
  - identify the roles and responsibilities of staff
  - prohibit staff-supervised and staff-facilitated smoking breaks in secondary care
  - identify adequate resources to support the policy
  - prohibit the sale of tobacco products in secondary care settings
  - be periodically reviewed and updated, in line with all other organisational policies.
- Ensure smokefree implementation plans include the following:
  - stop smoking and temporary abstinence support for staff and people who use secondary care services (in line with the recommendations in this guidance)

  - training for staff (see recommendation 14)
  - removal of shelters or other designated outdoor smoking areas
  - staff, contractor and volunteer contracts that do not allow smoking during work hours or when recognisable as an employee (for example, when in uniform, or wearing identification, or handling hospital business)
  - how to work with service users and carers to protect staff from tobacco smoke when they are visiting the homes of people using secondary care services.

- Ensure policies, procedures and resources are in place to:
  - facilitate compliance with, and resolve immediately, any breaches of smokefree policies, including a process for staff to report incidents
  - support staff to encourage compliance with the smokefree policy
  - work with service users, carers, staff and visitors to overcome any problems that may result from smoking restrictions (supported by 'personal care plans' as covered in recommendation 1).
- Ensure all staff are aware of the smokefree policy and comply with it.

NICE PH48 Recommendation 12 (Communicate the smokefree policy)

- Develop, deliver and maintain a communications strategy about local smokefree policy requirements. This should include information for people who use secondary care services and their parents or carers, staff and visitors, and the wider local population. The strategy should include:
  - clear, consistent messages about the need to keep buildings and grounds smokefree
  - positive messages about the health benefits of a smokefree environment
  - acknowledgement of the duty of the health and social care profession to provide a safe and healthy environment for staff and people who use or visit secondary care services
  - information about stop smoking support and how to access services, including support for temporary abstinence, for staff and people who use secondary care services
  - information emphasising that staff should not smoke at any time during working hours or when recognisable as an employee, contractor or

volunteer (for example, when in uniform, wearing identification, or handling hospital business).

NICE PH48 Recommendation 16 (Commission smokefree secondary care services)

- Ensure all secondary care buildings and grounds are smokefree.
- Ensure the NHS standard contract and local authority contract includes smokefree strategies.
- Ensure services are commissioned to provide a range of stop smoking pharmacotherapies.
- Ensure health and social care practitioners in secondary care identify people who smoke and offer them advice, support and treatment, or offer them a referral to a stop smoking service.
- Ensure all hospitals have an on-site stop smoking service.
- Ensure there is a requirement within service specifications and service level agreements that all staff are trained to deliver advice on stopping smoking and to make a referral to intensive support. It should also require that relevant staff undertake regular continuing professional development in how to provide intensive stop smoking support.
- Monitor and audit the implementation and impact of the recommendations in this guidance. This may include recording of individual smoking status (including at the time of giving birth), the number of referrals, uptake of interventions, prescribing of stop smoking pharmacotherapies, 4-week quit rates, training of staff. Ensure the needs of higher risk groups identified in the joint strategic needs assessment are being met (see recommendation 15).
- Ensure there are resources to enable secondary care providers to maintain smokefree policies.
- Ensure care pathways include: identification of people who smoke, provision of advice on likely smoking-related complications, advice to stop smoking and proactive referral to stop smoking services.
- Ensure stop smoking pharmacotherapies are included in secondary care formularies.
- Include sale of licensed nicotine-containing products in secondary care settings (for example, in hospital shops) within formulary and guidelines policy.

Smokefree homes & smokefree cars

NICE 48 Recommendation 5 (Provide information and advice for carers, family, other household members and hospital visitors)

- During contact with partners, parents, other household members and carers of people using acute, maternity and mental health services:
    - provide clear information and advice about the risks of smoking and secondhand smoke
    - advise them not to smoke near the patient, pregnant woman, mother or child; this includes not smoking in the house or private vehicle
    - offer people who want to stop or reduce smoking a referral to a hospital or local stop smoking service, as appropriate.
- During contact with partners of pregnant and breastfeeding women, follow recommendation 7 in NICE guidance on quitting smoking in pregnancy and following childbirth (NICE public health guidance 26).
- Provide information and take the opportunity to explain to visitors that smoking is not allowed on the premises. Direct those who wish to use licensed nicotine-containing products for temporary abstinence to a point of sale in the hospital (see recommendation 8).
- Provide information and take the opportunity to provide advice to visitors about the benefits of stopping smoking and how to contact local stop smoking services (for people who are working in the setting, see recommendation 13).

NICE 26 Recommendation 7 (Partners and others in the household who smoke)

- Ensure all midwives who deliver intensive stop-smoking interventions (one-to-one or group support – levels 2 and 3) are trained to the same standard as NHS stop-smoking advisers. The minimum standard for these interventions is set by the NHS Centre for Smoking Cessation and Training. They should also be provided with additional, specialised training and offered ongoing support and training updates.
- Ensure all midwives who are not specialist stop-smoking advisers are trained to assess and record people's smoking status and their readiness to quit. They should also know about the health risks of smoking and the benefits of quitting – and understand why it can be difficult to stop. In addition, they should know about the treatments that can help people to quit and how to refer them to local services

for treatment. (Acquisition of this knowledge and skill set is part of level 1 training in brief stop-smoking interventions. Please note, midwives are not advised to carry out brief interventions with pregnant women. However, they are advised to use these skills to initiate a referral to NHS Stop Smoking Services.)

- Ensure midwives and NHS stop-smoking specialist advisers who work with pregnant women:
    - know how to ask them questions in such a way that encourages them to be open about their smoking
    - always recommend quitting rather than cutting down
    - have received accredited training in the use of CO monitors.
- Ensure brief stop-smoking interventions (level 1) and intensive one-to-one and group support to stop smoking (levels 2 and 3) are incorporated into pre- and post-registration midwifery training and midwives' continuing professional development, as appropriate.
- Ensure all healthcare and other professionals who work with the target group are trained in the same skills – and to the same standard – as those required of midwives who are not specialist smoking cessation advisers. This includes: GPs, practice nurses, health visitors, obstetricians, paediatricians, sonographers, midwives (including young people's lead midwives), family nurses and those working in fertility clinics, dental facilities and community pharmacies. It also includes those working in youth and teenage pregnancy services, children's centres, social services and voluntary and community organisations.
- Ensure all the healthcare and other professionals listed in the previous bullet:
    - know what support local NHS Stop Smoking Services offer and how to refer the women being targeted
    - understand the impact that smoking can have on a woman and her unborn child
    - understand the dangers of exposing a pregnant woman and her unborn child – and other children – to secondhand smoke.
- Ensure all training in relation to smoking and pregnancy addresses the:
    - barriers that some professionals may feel they face when trying to tackle smoking with a pregnant woman (for example, they may feel that broaching the subject might damage their relationship)

- important role that partners and 'significant others' can play in helping a woman who smokes and is pregnant (or who has recently given birth) to quit. This includes the need to get them to consider quitting if they themselves smoke.

4.3.3 Current UK practice

A study carried out in 2007 by Elena Ratchen et.al (University of Nottingham) aimed to determine the extent of smoke-free policy implementation in all English NHS acute and mental health trusts, and to explore challenges and impacts related to policy implementation.

Smoke-free policies were reported to be implemented in all mental health and 98% of acute settings studied. They applied to whole premises including grounds in 84% of acute, and 64% of mental health settings. However, exemptions were granted by 50% of acute and 78% of mental health settings, typically for bereaved relatives or psychiatric patients, in sheltered outdoor areas and smoking rooms.

Nearly two thirds of acute and over a third of mental health trusts reported that policy infringements occurred on a daily basis. Indeed, patients and visitors were observed smoking at 94% of acute sites visited and staff smoking at 35% of them. Reported challenges included policy enforcement and related risks of abuse, and litter on premises and adjacent public grounds.

5 Additional areas

5.1 Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise however they were felt to be outside the remit of quality standards or are addressed by other NICE quality standard topics.

There will be an opportunity for the QSAC to discuss these areas at the end of the session.

Harm reduction approach

Stakeholders highlighted the value of harm – reduction approaches in helping highly dependent smokers. This area of quality improvement is not within the remit of this topic and is likely to be addressed by a separate quality standard.

NICE Champion role

Stakeholders suggested that every NHS or LA funded health care organisation should have an identified NICE Champion at board/executive level. This area of quality improvement aims to address wider engagement and implementation with the work done by NICE and therefore is not within the remit of quality standards.

NICE guidance and service specifications

Stakeholders suggested that CCGs should be expected to formally consider NICE guidance when drawing up specifications for services and document their reasons if they decide against incorporating the requirements in contracts. This area is already covered by the Health and Social Care act 2012 and therefore is not within the remit of quality standard.

Organisational cost benefit analysis

Stakeholders suggested that every NHS or LA funded health care organisation should be required to calculate the costs of smoking amongst staff and patients to their organisation against the costs of supporting a smokefree workforce and providing smokefree care. This area of quality improvement suggests carrying out organisational cost benefit analysis and therefore is not within the remit of quality standards.

Quality Standards and CQC inspections

Stakeholders suggested that Care Quality Commission (CQC) should use quality standards in their inspections. This area of quality improvement aims to address wider engagement and implementation of quality standards and therefore is not within the remit of quality standards.

Quality Standards evidence base analysis

Stakeholders suggested that in order to produce this quality standard, following elements should be taken into account: return on investment, strength of the evidence and magnitude of the impact. This area for quality improvement suggests to re-evaluate the evidence used to produce NICE guidelines therefore it is not within the remit of quality standards.

Referral pathways

Stakeholders highlighted the importance of robust referral pathway to stop smoking services within the secondary care settings (including follow up in the community), schools and workplaces. This area of quality improvement is addressed in QS43 - Smoking cessation: supporting people to stop smoking. Quality statement 2: Referral to smoking cessation services reads: People who smoke are offered a referral to an evidence-based smoking cessation service.

Brief interventions

Stakeholder suggested that all professionals (health and other) working in primary care and community settings should be trained to ask the appropriate questions regarding smoking status, deliver brief interventions and refer to smoking cessation services if appropriate. This area of quality improvement would be better addressed in quality standard QS43 - Smoking cessation: supporting people to stop smoking which currently only covers identification and brief interventions delivered by healthcare practitioners.

Smoking and pregnancy

Stakeholders highlighted the importance of screening and referral to stop smoking service among pregnant women. Stakeholder suggested Universal collection of all pregnant women's smoking at time of delivery status at the 36+ weeks appointment, including verification by CO screening, as a quality measure within maternity contracts held with CCGs. Stakeholders also highlighted first time mothers as a particular group of concern. These areas of quality improvement are already addressed by QS22 - Quality standard for antenatal care Quality statement 5: Risk assessment – smoking cessation reads: Pregnant women who smoke are referred to an evidence-based stop smoking service at the booking appointment.

Smoking and long term conditions

Stakeholders highlighted the importance of implementation of opt-out CO screening and automatic referral to stop smoking service for all smoking patients with a long-term condition (CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses) within primary and secondary care contracts. This area is already covered within the QS43 - Smoking cessation: supporting people to stop smoking and existing QOF guidance published by NHS Employers. Quality statement 1: Identifying people who smoke reads: People are asked if they smoke by their healthcare practitioner, and those who smoke are offered advice on how to stop. Quality statement 2: Referral to smoking cessation services reads: People who smoke are offered a referral to an evidence-based smoking cessation service.

Access to smoking cessation in secondary care settings

Stakeholders stressed the importance of availability of smoking cessation support and treatment on site within the secondary care setting.

Appendix 1: Suggestions from stakeholder engagement exercise

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
001	SCM1	Key area for quality improvement 1	Inclusion of opt-out carbon monoxide (CO) screening at the booking appointment and automatic referral to stop smoking service for all women with a reading of 4ppm or more in the core maternity commissioning clinical commissioning group (CCG) tariff.	NICE guidance (Public Health Guidance 26 and 48) recommends that all pregnant women should be assessed for exposure to tobacco smoke via discussion and carbon monoxide screening and those who smoke should be referred to services for help to stop. However, experience at a local level has illustrated that: not all NHS Maternity Trusts have a mandatory, opt-out referral pathway for all pregnant smokers; differences exist in the pathway parameters; and implementation of the pathway is inconsistent between staff. Consequently, pregnant women may continue to smoke, be exposed to secondhand smoke or carbon monoxide fumes and a vital opportunity to provide support to quit smoking is being missed. Inclusion of smoking cessation in the core maternity tariff will systemise and embed organisational change to ensure all pregnant smokers are offered effective support in order to reduce the rates of smoking.	NICE guidance[1,2] recommends the following components to support a smoking cessation in pregnancy and following childbirth programme: • Identification of pregnant women who smoke • Assessment of the woman's exposure to tobacco smoke through discussion and use of CO screening • Provision of information on the risks of smoking and health benefits of stopping • Advice to stop smoking, not just to cut down

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					• Referral of pregnant smokers for help to stop smoking and explanation that it is normal practice to do this • Providing smoking cessation support (behavioural and pharmacotherapy) 1. National Institute for Health and Clinical Excellence (2010). *Quitting smoking in pregnancy and following childbirth*. Public Health Guidance 26. London: NICE. 2. National Institute for Health and Clinical

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Excellence (2013) *Smoking Cessation in secondary care: acute, maternity and mental health services*. Public Health Guidance 48. London:NICE http://www.nice.org.uk/PH48
002	SCM1	Key area for quality improvement 2	Universal collection of all pregnant women's Smoking At Time Of Delivery (SATOD) status at the 36+ weeks appointment, including verification by CO screening, as a quality measure within maternity contracts held with CCGs to establish a consistent and accurate measure.	Data relating to smoking at time of delivery status of pregnant women is collected by maternity units on behalf of CCGs and submitted quarterly to the Health and Social Care Information Centre (HSCIC) to measure progress against the national ambition to reduce maternal smoking prevalence to 11% or less by the end of 2015. However, exactly how and when this is undertaken, and how well it is done varies among trusts, which has led to significant differences in the levels of accuracy and completeness of the data. An audit was undertaken in Lancashire to compare the smoking status of pregnant women who had successfully quit smoking, validated by CO screening, with their respective smoking status that was recorded at the	Screening at 36+ week's gestation has been found to be a valid and reliable measure of smoking during pregnancy, far more reliable than asking at the time of delivery[3]. Data comparison between booking and 36+ week's gestation also enables assessment of how many pregnant smokers go on to quit. 3. Action on Smoking and Health (2013) *Smoking Cessation in*

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				time of delivery on the hospital Patient Administration Systems (PAS). This highlighted that two-fifths (41%) of those who were known non-smokers were inaccurately recorded as smokers in the hospital SATOD data. The current inaccuracies in the SATOD data collection across Lancashire may be attributed to a number of issues: 1. Midwives are not routinely asking pregnant women their smoking status at the time of delivery but use the information from the booking appointment to complete the birthing notes. This means that women who have quit smoking during their pregnancy would still be recorded as a smoker at time of delivery. 2. Similarly, a number of maternity PAS systems automatically populate the patient smoking status in the birthing records with the information from the pregnancy notes, which means that women who have quit would still be recorded as a smoker at the time of delivery. 3. When the smoking status of pregnant women is 'unknown', they are often coded as smoking at time	*Pregnancy - A call to action*. http://www.ash.org.uk/pregnancy2013

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				of delivery.	
003	SCM1	Key area for quality improvement 3	Implementation of smokefree site status, and associated indicators, as quality measures in all secondary care contracts (acute, maternity and mental health) held with Clinical Commissioning Groups.	One in 20 of hospital admissions are smoking related[4] and nationally it costs the NHS over £2.7 billion to treat smoking-related illnesses each year[5]. Smoking is also responsible for huge losses in workforce productivity through smoking breaks and increased rates of sickness and absenteeism[6]. Within Lancashire, it is estimated that £23 million is lost from NHS secondary care budgets through employee smoking related breaks and sickness, which could otherwise be used to finance patient treatment and care in a climate of budgetary cuts and austerity. NICE guidance[2] recommends that all hospitals should adopt a comprehensive smokefree programme in line with their duty to protect patient health and promote healthy behaviour. However, prioritisation and implementation of this guidance by NHS Trusts locally in Lancashire to date has been inconsistent. For example, requests to remove smoking shelters have been denied and variations exist in the availability of smoking cessation first line treatments in hospital formulary. The inclusion of smokefree site quality measures within CCG secondary care	The Public Health Outcomes Framework[7] has outlined continued NHS commitment to reducing smoking prevalence rates in adults, children and pregnant women and secondary care settings have a significant role in promoting a smokefree lifestyle to staff, patients and visitors. NICE Public Health Guidance on Smoking Cessation in Secondary Care: Acute, Maternity and Mental Health Services[2] recommends that all hospitals should adopt a comprehensive smokefree programme. 7. Department of Health (2012). *Improving outcomes and supporting transparency.*

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				contracts would assist consistent and comprehensive implementation of the NICE Public Health Guidelines 48 and ensure patients, staff and visitors who smoke are given the opportunity to access support to quit. Examples of quality indicators include: • Implementation of a smokefree site policy, including the grounds. • Removal of existing smoking shelters. • Provision of all smoking cessation first line treatments in hospital formulary (Nicotine Replacement Therapy (NRT), Varenicline (Champix) and Bupropion (Zyban) • Sale of NRT on site for staff and visitors to buy support abstinence from smoking. 4. The Information Centre for Health and Social Care (2012). http://www.ic.nhs.uk/news-and-events/news/about-1260-hospital-admissions-a-day-due-to-smoking-new-figures-show 5. Callum C, Boyle S, Sandford A (2010). Estimating the cost of smoking to the NHS in England and the impact of declining prevalence. Health Economics Policy & Law 2010	*Part 1: A public health outcomes framework for England, 2013-2016.* London: Department of Health.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				doi:10.1017/S1744133110000241. 6. NICE (2005) http://www.nice.org.uk/nicemedia/pdf/PHI5SimplifiedBusinessCase.htm	
004	SCM1	Key area for quality improvement 4	Implementation of opt-out CO screening and automatic referral to stop smoking service for all smoking patients with a long-term condition (CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses) within GP contracts (NHS England, supported by QOF) and secondary care contracts (CCGs)	Smoking remains the single largest preventable cause of ill health and premature death in England from respiratory diseases, circulatory disease and cancer and reducing smoking rates in patients diagnosed with a long term condition remains a priority. National guidance recommends that all smokers should be routinely referred to a Stop Smoking Service[8,9] to receive behavioural support and pharmacotherapy as they are four times more likely to quit through this route than going it alone[9]. Whilst incentive payment is currently awarded to GPs to offer support and treatment for stop smoking to patients with a long term condition (QOF SMOK002 and SMOK005)[10], locally in Lancashire rates of referral to stop smoking services remain low. In turn, people with long-term chronic diseases continue to smoke with prevalence rates only reducing marginally over the last three years. Inclusion of an opt-out smoking cessation	NICE guidance recommends identifying and supporting those most at risk of dying prematurely to stop smoking[11-13] 11 National Institute for Health and Clinical Excellence (2008). NICE public health guidance 10: Smoking cessation services London 2008. 12 National Institute for Health and Clinical Excellence (2008). NICE public health guidance 15: Identifying and supporting people

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				pathway in both GP and secondary care contracts will create an organisational infrastructure to ensure all smokers diagnosed with a long term condition are automatically referred for effective support in order to reduce the rates of smoking. 8 Department of Health (2011) *Healthy Lives, Healthy People: A Tobacco Control Plan for England*. London:DH. 9 Department of Health (2011) *Local Stop Smoking Services: Service Delivery and Monitoring Guidance 2011/12.*London: DH 10 Tucker N (2013) *The Keep it Simple Guide to QOF 2013/14.* NB Medical education.	most at risk of dying prematurely London 2008. 13 National Institute for Health and Clinical Excellence (2010). NICE clinical guideline 101: Chronic obstructive pulmonary disease. Management of chronic obstructive pulmonary disease in adults in primary and secondary care (partial update).NICE: London 2010.
005	SCM	Key area for quality improvement 5	Extension of smokefree code of practice to children's play areas in public parks	Epidemiological data illustrates that young people continue to take up smoking, thereby replacing those who quit or die from this habit. Nationally, 11% of 15 year olds are current smokers[14] and an estimated 330,000 children under the age of 16 years try cigarettes for the first time each year[15].	Internationally, smoking in public play areas and parks is already banned in Spain, Hong Kong, Latvia, Singapore and in cities in Australia, New Zealand, Canada and California. Smoking was

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				Research in social psychology and behavioural economics highlights that influencing the adult world in which children grow up is pivotal to reducing their rates of smoking uptake[8]. Children become aware of cigarettes at an early age. Three out of four children are aware of cigarettes before they reach the age of five, irrespective of whether or not the parents' smoke[16]. However, if young people see smoking as a normal part of everyday life, they are more likely to become smokers themselves[17]. The implementation of smokefree playgrounds would reduce child exposure to smoking and de-normalises tobacco use within the community. The UK Government's National Tobacco Control Plan[8] recommends that: "*Local communities and organisations may also wish to go further than the requirements of smokefree laws in creating environments free from secondhand smoke, for example in children's playgrounds. Initiatives such as these can help to shape positive social norms and discourage the use of tobacco."* In the long term this will assist in	also barred in all 1,700 New York City parks in 2011 and from 12 regional parks in Vancouver in 2012. Within the UK, a number of Councils have made all of their open air play areas in parks smokefree including Cardiff, Coventry, Crawley, Glasgow Liverpool, Medway, Nottingham, North Somerset and Wirral. Public support for smokefree play areas within England is high. A YouGov survey undertaken in 2011 found that three-quarters of the general population, both nationally and within the North West (73%) backed a smoking ban in children's play areas, including the majority of smokers.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				decreasing uptake of smoking within the youth population. It will also reduce levels of unsightly cigarette litter such as cigarette butts, matches, empty packets and wrappers in play areas. Cigarette butts in particular are not biodegradable and the toxic chemicals they contain pose a risk to young children if ingested and also threaten the quality of aquatic ecosystems and wildlife. 14 The Information Centre for Health and Social Care (2012) *Smoking, drinking and drug use among young people in England in 2011*. 15 Department of Health (2009) Impact Assessment of prohibiting the display of tobacco at point of sale, for the Health Bill. DH, January 2009, p17 16 Office for National Statistics (1997) Teenage smoking attitudes in 1996. Office for National Statistics. 17 Buller D et al (2003). Understanding factors that influence smoking uptake. *Tobacco Control* **12** (4):iv16-25.	
006	SCM1	Additional developmental areas of	Extension of smokefree legislation to adult prisons	In view of the dangers of SHS to health the Health Act 2006 prohibited smoking in	NICE guidance recommends identifying

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		emergent practice		virtually all indoor and substantially enclosed work and public places by 1st July 2007[18]. Whilst young offender institutes were included in the smokefree legislation, adult prisons were granted an exception, which allowed smoking to continue outside of communal areas in designated cells. The prison population is over represented by people experiencing the most disadvantaged socio-economic backgrounds[19]. Smoking prevalence rates are four times higher among people incarcerated in prison compared to the national average (20%)[20], with an estimated 80% of offenders' smoking[21]. Such high levels of smoking impact on the health of this population and research has quantified that prisoners have poor physical health. A large-scale UK study has reported higher rates of chronic diseases amongst male prisoners compared to the wider community, with nearly half (46%) living with a longstanding illness or disability such as heart disease, asthma and diabetes[22]. Implementing a completely smokefree policy and discouraging smoking within the prison environment has a number of	and supporting those most at risk of dying prematurely to stop smoking[12] Internationally, prisons in the USA, Canada, New Zealand and Sweden now operate a comprehensive smokefree policy. Despite concerns regarding the detrimental impact of implementing a smokefree site policy on rates of inmate tension and violence on staff, reassuringly evidence suggests that the frequency and levels of aggression and abuse actually experienced are lower than expected[21,26]. Only two significant cases of disorder have been reported in prisons in Quebec and Queensland, neither of which could be conclusively or completely linked to the implementation of

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				benefits: • Reduced Exposure to Second Hand Smoke (SHS). This is particularly important given the length of time some prisoners spend in custody and the high levels of exposure observed in prisons[23,24] and will also avert legal challenges by non-smoking prisoners and staff. • Reduced Smoking. Offenders from smokefree prisons are more likely to be interested in utilising stop smoking support once released into the community[25]. • Improved health among prisoners and staff. Reducing rates of smoking and exposure to secondhand smoke will decrease the risk of developing long-term conditions and also lower the financial burden of smoking-related treatment and care. It would also reduce the cost of staffing escorts for prisoners to attend local hospitals. • Decreased rates of employee sickness absenteeism and early retirements due to ill health[6]. 18 HM Government (2006) *The Health Act 2006 (c.28)* http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060	smokefree policy[27]. Although there is currently no legislative requirement for prisons to become entirely smokefree in England and Wales, two institutions – the Isle of Man prison and Les Nicolles prison in Guernsey, have successfully extended their smokefree policies to all buildings and grounds in order to bring the prison environment into line with other places of work and protect staff, inmates and visitors from exposure to SHS. 26 Lincoln T, Chavaz R, Langmore-Avila E (2005). US experience of smokefree prisons. *BMJ* **17**:331 27 McNabola A, Gill L (2009). The Control of Environmental Tobacco Smoke: A

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				028_en.pdf 19 Lancashire *Prison Health Needs Assessment* (2011). 20 Office for National Statistics (2014) Integrated household survey, self-reported smoking prevalence, persons, aged 18+, 2011-12. 21 Kauffman RM, Ferketich AK, Wewers ME (2008). Tobacco Policy in American Prisons 2007. *Tobacco Control* **17**:357-360. 22 Bridgwood A, Malbon G (1995). *Survey of the physical health of prisoners 1994: a survey of sentenced male prisoners in England and Wales.* London: The Stationary Office. 23 Proescholdbell SK SK et al (2008). Indoor air quality in prisons before and after implementation of a smoking ban law. *Tobacco Control* **17**:123-127. 24 Hammond SK, Emmons KM (2005). Inmate exposure to secondhand smoke in correctional facilities and the impact of smoking restrictions. *Journal of exposure analysis and environmental*	Policy Review. *International Journal of Environmental Research and Public Health* **6**:741-758.

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				epidemiology **15**(3):205-11. 25 Pezzino G et al (1992). Impact of smoke-free policy on prisoners in Wisconsin, United States. *Tobacco Control* **1**:180-184.	
007	SCM2	Key area for quality improvement 1	CQC should use the quality standards in their inspections.	CQC has a key role in supporting the adoption and implementation of NICE guidance.	Examples can be provided where CQC recommendations have undermined organisations efforts to implement NICE guidance.
008	SCM2	Key area for quality improvement 2	CCGs should be expected to formally consider NICE guidance when drawing up specifications for services and document their reasons if they decide against incorporating the requirements in contracts.	Implementing NICE guidance in relation to reducing smoking prevalence is a proven cost effective measure.	
009	SCM2	Key area for quality improvement 3	Every NHS or LA funded health care organisation should have an identified NICE Champion at board/executive level and be required to calculate the costs to their organisation of smoking amongst staff and patients against the costs of supporting a smokefree workforce and providing smokefree care.	Implementing NICE guidance in relation to reducing smoking prevalence is a proven cost effective measure.	NHS and LAs need to ensure that smoking behaviours are being properly addressed by all organisations being publicly funded to provide health care.

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010	SCM2	Key area for quality improvement 4	Every acute provider should have a smokefree policy as defined within NICE guidance in each setting and patients should have access to a full range of NRT immediately on admission. No clinical member of staff should be required to facilitate smoking in any way ie purchasing, lighting, escorting etc.	The acute sector has a particularly important role in implanting NICE guidance to promote smokefree environments.	It is widely known that made acute providers are failing to implement NICE guidance and adopting arrangements which go against recommendations for example installing smoking shelters and allowing patients and staff to smoke in grounds.
011	South West Yorkshire Partnership Foundation Trust	Children and Young people	School based interventions to prevent uptake of smoking among children and prevention of smoking by children and young people is recommended within the NICE guidance. Smoking in children and young people needs to be addressed and denormalized to reduce the uptake of children and young people smoking and to have an uncomplicated referral pathway. All health care professionals and non health professionals working alongside children and young people need to understand and refer appropriately.	• Reduces smoking related disease • Improves quality of life • Increase awareness of the ill effects of smoking • Encourages a healthier personal wellbeing	
012	South West	Secondary Care	Smoking cessation in secondary	• Reduces smoking related disease	

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	Yorkshire Partnership Foundation Trust		care: acute, maternity and mental health is recommended with NICE guidance. Robust referral pathway to stop smoking services so that clients and patients can be referred in an appropriate and timely manner.	• Improves quality of life • Increase awareness of the ill effects of smoking • Encourages a healthier personal wellbeing	
013	South West Yorkshire Partnership Foundation Trust	Workplace	Workplace interventions to promote smoking cessation and smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities is recommended with NICE guidance. Certain types of workplaces will have a higher number of smokers eg industrial, manufacturing, factory work. It's important for stop smoking services to engage with workplaces that have high levels of routine and manual groups to help reduce ill health and denormalize smoking. Have a robust workplace referral pathway for smokers wanting to	• Reduces smoking related disease • Improves quality of life • Increase awareness of the ill effects of smoking • Encourages a healthier personal wellbeing	

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			quit and to gain appropriate support.		
014	South West Yorkshire Partnership Foundation Trust	Smoke free and smoke free homes	Tobacco: A harm-reduction approach to smoking is a recommendation supported by NICE guidance. The recommendation generally looks at reduction of smoking over a period of time which would incorporate discussion about smoke free and smoke free spaces. This is particularly useful for prolific / addicted smokers who are struggling to quit all together.	• Reduces smoking related disease • Improves quality of life • Increase awareness of the ill effects of smoking • Encourages a healthier personal wellbeing	
015	South West Yorkshire Partnership Foundation Trust	Brief intervention referral pathway	Brief interventions and referral for smoking cessation in primary care and other settings is again supported by NICE guidance. All professionals (health and other) working in community settings should be trained to ask the appropriate questions regarding smoking status. If the client/patient is motivated and willing to go to a supported programme then an information and advice should be given and a referral should be made.	• Consistent approach for all • Reduces smoking related disease • Improves quality of life • Increase awareness of the ill effects of smoking • Encourages a healthier personal wellbeing	
016	British	British Thoracic Society supports the development of a quality standard for smoking: reducing tobacco use within the community			

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	Thoracic Society (BTS)	setting			
017	Action on Smoking and Health	Overall structure (3.1)	Smoking is the biggest single cause of preventable illness and premature death. The quality standard has the potential to help local authorities prioritise their tobacco control activities.	It is not clear from the current wording whether there is an intention to weight the different components of the quality standard, e.g. whether prevention strategies are deemed to be equally as important as enforcing smokefree policies. If there was no intention to convey any weighting it would have been helpful to have a note to this effect. This is important because for some measures such as school-based interventions the strength of the evidence base is not as strong as that for measures such as smoking cessation. Consequently, we recommend that when constructing the quality standard the following should be taken into account: 1. What is the return on investment? 2. What is the strength of the evidence base? 3. What is the magnitude of the impact Unfortunately due to other work pressures we have not had time to give this as much consideration as we would have liked. However, given ASH's particular knowledge and expertise, we would welcome the opportunity to provide further input into the development of the standard and look forward to further communication	

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				from NICE in this regard.	
018	Royal College of Nursing	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 for the smoking: reducing tobacco use in the community quality standard.			
019	Royal College of Physicians	Key area for quality improvement 1	The key requirement is that NICE guidance on smoking is implemented. Our experts wish to highlight that as up to 2.5million smokers are admitted to hospitals in the UK each year, implementing NICE guidance on smoking cessation services in secondary care would have a significant impact on smoking prevalence in general. These smokers, if treated properly while in hospital, also need follow up care in the community. Therefore, the secondary care guidance should probably be included as a primary development sources under 3.2, rather than in the second division list that follows.		
020	Doncaster Metropolitan Borough Council	Smoking in Pregnancy for first time mothers	This is important because of the risk associated with smoking in pregnancy for both mother and unborn baby as per NICE guidance Mothers tend to replicate	If we can embed none smoking behaviours in first time mothers then the associated risks for mother and baby will be reduced.	

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			behaviours in subsequent pregnancies		
021	Doncaster Metropolitan Borough Council	Smoking in cars when babies and children are present	Babies and children exposed to cigarette smoke in cars are at an increased risk of cot death, bacterial meningitis, glue ear, respiratory disease amongst others.	If we can address smoking in cars as well as homes the associated risks for babies and children will be reduced. Also, longer term rates for take up of smoking will be reduced.	