Smoking: reducing tobacco use in the community

NICE quality standard

Draft for consultation

September 2014

Introduction

This quality standard is relevant to anyone involved in protecting health and promoting healthy behaviour among children, young people and adults. This includes people working in the NHS, local authorities, education and the wider public, private, voluntary and community sectors.

This quality standard covers reducing tobacco use in the community, including interventions to discourage people from taking up smoking, tobacco control strategies and smokefree policies. The quality standard does not cover referral to and delivery of stop smoking services, which is already covered by Smoking cessation: supporting people to stop smoking (NICE quality standard 43). The quality standard does not cover harm reduction approaches to smoking, which has been referred to NICE as a separate topic. For more information see the topic overview.

Why this quality standard is needed

Smoking is the main cause of preventable illness and premature death in England. It is the primary reason for the gap in healthy life expectancy between the rich and the poor.

Smoking contributes to a wide range of diseases, including cancers, respiratory diseases, coronary heart and other circulatory diseases, stomach and duodenal ulcers, erectile dysfunction, infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis.

Smoking can cause complications in pregnancy and labour, including ectopic pregnancy, bleeding during pregnancy, premature detachment of the placenta and premature rupture of the membranes. The health risks for babies of mothers who smoke are substantial.

Children who smoke become addicted to nicotine very quickly. They also tend to continue the habit into adulthood. Around two-thirds of people who have smoked took up the habit before the age of 18. Healthy lives, healthy people: a tobacco control plan for England highlights that it is crucial to reduce the number of young people taking up smoking in the first place. If smoking is seen by young people as a normal part of everyday life, they are much more likely to smoke themselves. This illustrates the need to alter the social norms around smoking. The latest research in social psychology and behavioural economics suggests that reducing the uptake of smoking is best achieved by influencing the adult world in which young people grow up.

Getting people to quit is crucial in preventing uptake. Therefore this quality standard should be considered alongside Smoking cessation: supporting people to stop smoking (NICE quality standard 43).

People with a longstanding mental health problem are twice as likely to smoke as those without a mental health problem. Not only is smoking more common in this group but the degree of addiction is greater. Mortality among people with serious mental illness is 3.6 times higher than among the general population, and smoking is one of the factors substantially contributing to this outcome.

This quality standard is expected to contribute to improvements in the following outcomes:

- life expectancy
- healthy life expectancy
- smoking prevalence
- smoking-related hospital admissions
- smoking-related mortality
- sickness absence.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- Improving outcomes and supporting transparency: a public health outcomes framework for England 2013–2016, Parts 1A, 1B and 2.
- NHS Outcomes Framework 2014–15

Table 1 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*** 1.9 Sickness absence
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.1 Low birthweight of term babies 2.3 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* 4.3 Mortality from causes considered preventable** 4.4 Under 75 mortality rate from all cardiovascular disease* 4.5 Under 75 mortality rate from cancer* 4.7 Under 75 mortality rate from respiratory disease* 4.12 Preventable sight loss age-related macular degeneration
Aligning across the health and care system * Indicator complementary ** Indicator shared	

Table 2 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* **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 Infant mortality*
Alignment across the health and social care system * Indicator shared with Public Health Outcomes Framework (PHOF)	

Coordinated services

The quality standard for smoking: reducing tobacco use in the community specifies that services should be commissioned from and coordinated across all relevant agencies. An integrated approach to prevention, smoking cessation, harm reduction and shaping social norms is fundamental to reducing tobacco use in the community.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Other quality standards that should also be considered when choosing, commissioning or providing high-quality services that contribute to reducing tobacco use in the community in all people who are in are listed in related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health, public health and social care practitioners involved in reducing tobacco use in the community should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.

Role of families and carers

Quality standards recognise the important role families and carers have in reducing tobacco use in the community. If appropriate, professionals should ensure that family members and carers are involved in the decision-making process about interventions and initiatives that stop people taking up smoking, reduce tobacco use and help people quit completely.

List of quality statements

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.

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.

Statement 3. Educational establishments have an organisation-wide smokefree policy that is coordinated with the local tobacco control strategy.

Statement 4. Employers encourage employees who smoke to access smoking cessation support during working hours without loss of pay.

Statement 5. Acute, maternity and mental health secondary care services implement a smokefree site policy.

Statement 6. (Placeholder) Preventing access to, and supply of, illicit tobacco.

Questions for consultation

Questions about the quality standard

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

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

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

Questions about the individual quality statements

Question 4 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.

Quality statement 1: Mass-media campaigns

Quality statement

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

Rationale

Most mass-media campaigns are targeted at people who smoke, with stop smoking messages and information about secondhand smoke. A limited number of campaigns target children and young people, with messages aimed at preventing them from taking up smoking. There is evidence that mass-media campaigns can stop people from taking up smoking and can influence knowledge, attitudes and intentions of children and young people. These campaigns are particularly important for targeting young people who are not in education and therefore not subject to school-based interventions. For maximum effectiveness mass-media campaigns should be combined with other activities aimed at prevention and form part of a comprehensive tobacco control strategy.

Quality measures

Structure

Evidence of local commissioners and campaign planners working together to develop and implement mass-media campaigns to prevent children and young people under 18 from taking up smoking.

Process

a) Proportion of local or regional mass-media campaigns to prevent people taking up smoking that are based on research evidence.

Numerator – the number in the denominator based on research evidence.

Denominator – the number of local or regional mass-media campaigns to prevent people taking up smoking.

Data source: Local data collection.

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.

Numerator – the number in the denominator developed in partnership with children and young people.

Denominator – the number of local or regional mass-media campaigns to prevent people taking up smoking.

Data source: Local data collection.

c) Proportion of local or regional mass-media campaigns to prevent people taking up smoking that used a range of strategies.

Numerator – the number in the denominator that used a range of strategies.

Denominator – the number of local or regional mass-media campaigns to prevent people taking up smoking.

Data source: Local data collection.

Outcome

Smoking prevalence among children and young people under 18.

Data source: Statistics on smoking, England 2013 cover national prevalence of smoking among young people aged 16–19 and secondary school children (mostly aged 11–15). A new survey 'What about youth?' is being carried out and will provide results at local authority level. The first set of results will be available towards the end of 2015.

What the quality statement means for local authorities and Public Health England

Local authorities supported by Public Health England ensure that they develop and implement local or regional mass-media campaigns to prevent people taking up smoking that are based on research evidence, use a range of strategies and are developed with children and young people.

What the quality statement means for children and young people

Children and young people are targeted with campaign messages that prevent them from taking up smoking.

Source guidance

- Preventing the uptake of smoking by children and young people. NICE public health guidance 14 (2008), recommendations 1, 2 and 3.

Definitions of terms used in this quality statement:

Mass-media campaigns

Mass-media campaigns use a range of strategies to communicate a message. This can include local, regional or national television, radio and newspapers, leaflets and booklets and it can also include using opportunities arising from social media. 'Social media' refers to communication via the internet or mobile phone. It can involve real-time streaming of information, podcasts, discussions with experts and social networking sites. The campaigns should:

- use a range of strategies
- be based on research evidence
- be developed in partnership with children and young people. [Adapted from NICE public health guidance 14]

Equality and diversity considerations

Smoking is more common in socially deprived areas and children and young people from poorer socioeconomic backgrounds take up smoking at an earlier age. This should be considered when developing campaigns. Particular effort should be made to ensure that young people from disadvantaged backgrounds are also involved in the process to ensure the campaigns are suitable for their peers.

Quality statement 2: Underage sales

Quality statement

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

Rationale

It is illegal to sell tobacco products to anyone under 18. All local authorities and their partners should make full use of their legal powers to protect children and young people from the risks of smoking. Partnership work is needed to coordinate the approach, improve efficiency and enable sharing of resources to prevent the sale of tobacco to those under 18.

Quality measures

Structure

a) Evidence of local arrangements between local authorities and their partners to obtain, interpret and act on reliable information to identify tobacco sales outlets that sell tobacco products to people who are under 18.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that local authorities are working in partnership to address underage tobacco sales.

Data source: Local data collection.

Process

b) Proportion of tobacco test purchases that record an underage sale.

Numerator – The number in the denominator with a recorded underage sale.

Denominator – The number of tobacco test purchases carried out in a specified geographic area.

Data source: Local data collection.

c) Proportion of individuals who are prosecuted for persistently selling tobacco to people under 18.

Numerator – The number in the denominator who are prosecuted for persistently selling tobacco to people under 18.

Denominator – The number of individuals identified as persistently selling tobacco to people under 18.

Data source: Local data collection.

d) Proportion of tobacco sales outlets prosecuted for persistently selling tobacco to people under 18.

Numerator – The number in the denominator prosecuted for persistently selling tobacco to people under 18.

Denominator – The number of tobacco sales outlets identified as persistently selling tobacco to people under 18.

Data source: Local data collection.

Outcome

Incidence of underage tobacco sales.

Data source: Local data collection.

What the quality statement means for local trading standards and local retailers

Local trading standards work in partnership with the police, Her Majesty Revenue and Customs (HMRC), voluntary and community groups and local retailers to increase awareness of the tobacco regulations and to reduce sales of tobacco products to people under 18.

Local retailers may be subject to tobacco test purchasing and more rigorous law enforcement if identified as persistently selling tobacco to people under 18. They may also expect training and support from local trading standards in compliance with the regulations.

What the quality statement means for children and young people

Children and young people find it harder to buy tobacco products, which makes it more difficult for them to start smoking and to carry on if they have started. This means that they are better protected from smoking-related harm.

Source guidance

- Preventing the uptake of smoking by children and young people. NICE public health guidance 14 (2008), recommendation 5.

Definitions of terms used in this quality statement:

Identifying retailers

Trading standards bodies within local authorities, the police, HMRC, voluntary and community groups work in partnership to obtain, interpret and act on reliable intelligence to identify premises that sell cigarettes to people who are under the age of 18.

Trading standards also work with local retailers to increase awareness of, and compliance with, the tobacco regulations. [NICE public health guidance 14 and expert opinion]

Prosecuting retailers

Trading standards can impose penalties such as fines or sanctions. The maximum fine is £2500. When a person is convicted of a making an illegal sale to anyone under the age of 18 years and, on at least 2 other occasions within a 2-year period, has committed other similar offences (these do not need to have resulted in a conviction), a sanction may be applied for. A local authority may apply to a Magistrates Court for a Restricted Premises Order or a Restricted Sale Order or both.

Restricted Premises Order – The retail premises is prohibited from selling tobacco products for a period of up to 12 months.

Restricted Sale Order – A named person is prohibited from selling tobacco or managing premises in relation to the sale of tobacco products for a period of up to

12 months – the business may still sell tobacco but the individual may not. [Responsible tobacco retailing, 2014]

Equality and diversity considerations

Smoking is more common in socially deprived areas and children and young people from poorer socioeconomic backgrounds take up smoking at an earlier age. Targeting retailers with awareness-raising campaigns and test purchasing can potentially have more impact in disadvantaged areas.

Quality statement 3: Organisation-wide approach to smoking

Quality statement

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

Rationale

Educational establishments have an important role in helping children and young people to understand the harm associated with tobacco products. Learning and teaching about tobacco use and its effects should be an integral part of health promotion. Many young people see smoking as the norm because they mistakenly believe it is more prevalent than it really is. No single intervention or programme can stop children and young people from taking up smoking. Prevention needs a comprehensive approach that includes individual, social, community and societal issues. Preventing children and young people going on to smoke as adults may involve both activities to stop them taking up smoking and activities to help them give up.

Quality measures

Structure

Evidence of local arrangements to ensure that educational establishments have an organisation-wide smokefree strategy that is coordinated with the local tobacco control strategy.

Data source: Local data collection.

Process

a) Proportion of educational establishments that have an organisation-wide smokefree strategy.

Numerator – the number in the denominator with an organisation-wide smokefree strategy.

Denominator – the number of educational establishments within a specified geographic area.

Data source: Statistics on smoking, England 2013 covers national prevalence of smoking among young people aged 16–19 and secondary school children (mostly aged 11–15). A new survey 'What about youth?' is being carried out and will provide results at local authority level. The first set of results will be available towards the end of 2015.

b) Proportion of organisation-wide smokefree strategies that are coordinated with local tobacco control strategies.

Numerator – the number in the denominator coordinated with local tobacco control strategies.

Denominator – the number of educational establishments with organisation-wide smokefree strategies.

Data source: Statistics on smoking, England 2013 covers national prevalence of smoking among young people aged 16–19 and secondary school children (mostly aged 11–15). A new survey 'What about youth?' is being carried out and will provide results at local authority level. The first set of results will be available towards the end of 2015.

What the quality statement means for educational establishments

Educational establishments work towards an organisation-wide smokefree strategy involving staff, pupils and a wide range of partners including local authorities, clinical commissioning groups and local tobacco control alliances.

What the quality statement means for children and young people

Children and young people are involved in developing smokefree policies and can influence the content and shape of smoking prevention activities accessible within the environment they study in.

Source guidance

- School-based interventions to prevent smoking. NICE public health guidance 23 (2010), recommendations 1 and 5.

Definitions of terms used in this quality statement

Educational establishments

The following educational establishments are covered by this quality standard:

- maintained and independent primary, secondary and special schools
- city technology colleges and academies
- pupil referral units, secure training and local authority secure units
- further education colleges
- 'extended schools' where childcare or informal education is provided outside school hours. [NICE public health guidance 23]

Organisation-wide smokefree strategy

An organisation-wide smokefree strategy includes developing a policy that:

- is developed in consultation with young people, staff and parents
- includes smoking prevention activities (adult-led and peer-led interventions)
- includes staff training and development
- takes account of young people's cultural, special educational and physical needs
- forms part of the wider healthy school or healthy further education strategy
- is applied to everyone using the premises (grounds as well as buildings)
- does not allow any areas in the grounds to be designated for smoking
- is widely publicised and accessible
- supports smoking cessation in addition to prevention. [Adapted from NICE public health guidance 23, recommendation 1]

Local tobacco control strategy

Local long term plan to reduce tobacco use in the community encompassing regulation policies, education programmes, cessation support services, reducing exposure to secondhand smoke and effective communications for tobacco control. [Adapted from the definition of comprehensive tobacco control strategy by the US

Surgeon General and World Health Organization and A Tobacco Control Plan for England]

Equality and diversity considerations

Smoking rates are higher among those excluded from school and they will not be able to benefit from these policies. Other activities carried out locally should address the needs of this group.

Quality statement 4: Workplace policy

Quality statement

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

Rationale

Many employers already have a policy outlining support to help employees to quit smoking. However, in practice, staff find it difficult to get time off to access smoking cessation services when needed. Evidence shows that the average person who smokes takes an average of 30 minutes in cigarette breaks within business hours each day. A typical stop smoking clinic appointment lasts 30 minutes, once a week for the first four weeks after the quit attempt then less frequently for a further eight weeks. Employees who smoke typically have higher rates of sickness absence, which can result in lost productivity. By enabling employees who smoke to attend smoking cessation services, employers support the implementation of smokefree workplace policy and are likely to realise benefits such as increased productivity, decreased sickness rates and improved adherence to smokefree policies.

Quality measures

Structure

a) Evidence of local arrangements to ensure that employers encourage employees to access smoking cessation services.

Data source: Local data collection.

b) Evidence of HR policies that allow accessing smoking cessation services during working hours without loss of pay.

Data source: Local data collection.

c) Evidence of local arrangements to ensure that smoking cessation services engage with local businesses.

Data source: Local data collection.

Process

a) Proportion of employees who were smokers who were offered support by smoking cessation services.

Numerator – The number in the denominator who were offered support by smoking cessation services.

Denominator – The number of employees who were smokers.

Data source: Local data collection.

b) Proportion of employees who were offered support by smoking cessation services in their usual working hours.

Numerator – The number in the denominator who were offered support by smoking cessation services in their usual working hours.

Denominator – The number of employees who were offered support by smoking cessation services.

Data source: Local data collection.

c) Proportion of employees who were able to access smoking cessation services in their usual working hours without loss of pay.

Numerator – The number in the denominator who did not lose pay.

Denominator – The number of employees who were able to access smoking cessation services in their usual working hours in the past year.

Data source: Local data collection.

Outcome

a) Smoking prevalence among the general population

Data source: Statistics on smoking, England 2013.

b) Smoking prevalence among people from routine and manual socio-economic group.

Data source: Statistics on smoking, England 2013.

What the quality statement means for employers and employees

All employers encourage members of staff who smoke to access smoking cessation services. They facilitate participation in stop smoking clinics by allowing employees to attend within working hours without loss of pay. They may choose to organise on-site smoking cessation services if that is feasible.

Employees who smoke can access smoking cessation services within their working time, without loss of pay.

What the quality statement means for managers of smoking cessation services

Smoking cessation services proactively engage with local businesses offering their support and promoting their services. In particular, they target businesses with high numbers of staff working in routine and manual jobs. This may mean that smoking cessation services are provided on site and there is increased demand on the service.

Source guidance

- Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007), recommendations 1 and 5.

Definitions of terms used in this quality statement:

Employees are encouraged to access smoking cessation services

Encouraging access includes but is not limited to:

- publicising and making information on stop smoking services widely available at work
- being responsive to needs, preferences and demand – this includes on-site stop smoking support
- allowing staff to attend smoking cessation services during working hours without loss of pay

- developing a smoking cessation policy in collaboration with staff. [Adapted from NICE public health guidance 5, recommendation 1]

Equality and diversity considerations

Smoking is significantly more prevalent among less affluent socioeconomic groups. People from more deprived communities predominantly work in routine and manual jobs. Targeting employers who employ large numbers of people within this group has a potential to make a substantial difference.

Quality statement 5: Secondary care services: smokefree site policy

Quality statement

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

Rationale

Secondary care services have a duty of care to protect the health of, and promote healthy behaviour of, people who use or work in their services. They set an example to the wider community and ensure that ‘no smoking’ is the norm. Most secondary care services already have a smokefree policy in place, which includes smokefree grounds. However, in practice, there are many exemptions that allow people to smoke, and daily infringements of the policies by patients, visitors and staff. Many trusts facilitate smoking within their grounds by providing outdoor smoking areas.

Ensuring compliance with smokefree policies and facilitating abstinence should be prioritised by the services. Compliance should be monitored and any breaches resolved immediately.

Quality measures

Structure

a) Evidence of arrangements within the secondary care services to develop a smokefree site policy and ensure its delivery through implementation plans.

Data source: Local data collection.

b) Evidence of arrangements within the secondary care services to develop procedures and resources to facilitate compliance with smokefree policies and resolve breaches.

Data source: Local data collection.

Process

a) Proportion of secondary care services with a smokefree policy that includes smokefree grounds.

Numerator – The number in the denominator with a smokefree policy that includes smokefree grounds.

Denominator – The number of secondary care services in the specified geographic area.

Data source: Local data collection.

b) Proportion of secondary care services with employment contracts that do not allow smoking during working hours or when recognisable as an employee.

Numerator – The number in the denominator with employment contracts that do not allow smoking during working hours or when recognisable as an employee.

Denominator – The number of secondary care services in the specified geographic area.

Data source: Local data collection.

c) Proportion of secondary care services with no designated outdoor smoking areas or shelters.

Numerator – The number in the denominator with no designated outdoor smoking areas or shelters.

Denominator – The number of secondary care services in the specified geographic area.

Data source: Local data collection.

d) Proportion of secondary care services that provide stop smoking and temporary abstinence support for staff and people who use their services.

Numerator – The number in the denominator that provide stop smoking and temporary abstinence support for staff and people who use their services.

Denominator – The number of secondary care services in the specified geographic area.

Data source: Local data collection.

e) Proportion of secondary care services that provide on-site access to first-line smoking cessation pharmacotherapy.

Numerator – The number in the denominator that provide on-site access to first-line smoking cessation pharmacotherapy.

Denominator – The number of secondary care services in the specified geographic area.

Data source: Local data collection.

f) Proportion of secondary care services that provide stop smoking training for frontline staff.

Numerator – The number in the denominator that provide frontline staff with training to help people stop smoking.

Denominator – The number of secondary care services in the specified geographic area.

Data source: Local data collection.

What the quality statement means for directors and senior managers of secondary care services or their representatives, the commissioners and the employees

Directors and senior managers of secondary care services take on a leadership role in developing, communicating, implementing and enforcing smokefree policies. They ensure that compliance is monitored and issues around breaches of the policy are resolved.

Commissioners ensure that the NHS standard contract and local authority contract include smokefree strategies and that all secondary care buildings and grounds are

smokefree. This includes providing support in all hospitals to help people stop smoking.

Staff, contractors and volunteers should abstain from smoking during working hours or when recognisable as an employee. They are supported by the implementation plan and policies to quit, or abstain, through access to cessation services or pharmacotherapy, to enforce compliance with smokefree policies and protected from secondhand tobacco smoke.

What the quality statement means for patients and visitors

Patients and visitors are made aware of smokefree policies and are supported to abstain from smoking while in the secondary care settings (including the hospital grounds). They are asked not to smoke when using any hospital transport. Patients and visitors are also offered support within the secondary care service as well as within the community if they want to try to give up smoking.

Source guidance

- Smoking cessation in secondary care: acute, maternity and mental health services NICE public health guidance 48 (2013), recommendations 11, 12 and 16.

Definitions of terms used in this quality statement:

Secondary care services

All publicly funded secondary and tertiary care facilities, including buildings, grounds and vehicles. This includes drug and alcohol services in secondary care, emergency care, inpatient, residential and long-term care for severe mental illness in hospitals, psychiatric and specialist units and secure hospitals and planned specialist medical care or surgery. It also includes maternity care provided in hospitals, maternity units, outpatient clinics and in the community. It can be planned or emergency care. Planned secondary care generally follows a referral from a primary care provider, such as a GP. [NICE public health guidance 48]

Smokefree site policy

Smokefree site policy means that air is free of tobacco smoke in buildings, grounds and vehicles. The smokefree site policy should include:

- stop smoking and temporary abstinence support for staff and people who use secondary care services
- on-site access to first-line smoking cessation pharmacotherapy
- training for staff
- 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
- how to work with people using services and carers to protect staff from tobacco smoke when they are visiting the homes of people using secondary care services. [Adapted from NICE public health guidance 48]

Equality and diversity considerations

People who are unable to leave the premises because of disability, vulnerability or detention under the Mental Health Act will have to abstain from smoking, unlike other people who can potentially leave the grounds in order to smoke. Additional support should be provided for these people.

Quality statement 6 (placeholder): Illicit tobacco

Quality statement

Preventing access to, and supply of, illicit tobacco.

What is a placeholder statement?

A placeholder statement is an area of care that has been prioritised by the Quality Standards Advisory Committee but for which no source guidance is currently available. A placeholder statement indicates the need for evidence-based guidance to be developed in this area.

What is illicit tobacco?

- Cigarettes
    - 'Illicit white' cigarettes have no legal market in the UK. UK duty has not been paid and the appropriate health warnings and images may not be present. Some of these products may be legally sold in countries outside the UK.
    - Counterfeit cigarettes are illegally manufactured and sold by a party other than the original trademark or copyright holder. This can also include the counterfeiting of illicit whites.
    - Genuine cigarettes are those produced legitimately for a local market. This includes UK and non-UK brands. They have the correct health warnings and images and are intended for legal open sale. As well as cigarettes made for the UK this may include cigarettes intended for sale in another country that have been smuggled into the UK or duty free cigarettes being illegally sold, rather than kept for personal use.
- Hand-rolling tobacco
    - Non-UK hand-rolling tobacco brands are not intended for sale in the UK.
    - Counterfeit hand-rolling tobacco is, like cigarettes, illegally manufactured and sold by a party other than the original trademark or copyright owner. It can also include the counterfeiting of non-UK products.Genuine or UK hand-

rolling tobacco brands include products intended for both the UK and non-UK markets. [Tackling illicit tobacco for better health]

Rationale

Illicit tobacco products make tobacco more accessible to children and young people, and those from lower socioeconomic groups who already experience significant health inequalities. Illicit tobacco products are often half or a third of the price of duty-paid products and can be accessed from a wide range of unregulated suppliers. In addition, because many of these products are made from unregulated materials, the health consequences for people who smoke them can be acute. Preventing children and young people and adults in lower socioeconomic groups from accessing illicit tobacco is likely to have a significant effect on the rates of smoking and smoking uptake.

Question for consultation

Do you know of any relevant evidence-based guidance that could be used to develop this placeholder 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.

Status of this quality standard

This is the draft quality standard released for consultation from 25 September to 23 October 2014. It is not NICE's final quality standard on smoking: reducing tobacco use in the community. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 23 October 2014. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from February 2015.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of

100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between health professionals, public health and local authority staff, trading standards officers, the police, licensing authorities, HM Revenue & Customs, head teachers, teachers, school governors and others who work in (or with) schools and people in the community is essential. Information and support should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People in the community should have access to an interpreter or advocate if needed.

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

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

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

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Department of Health (2013) Reducing smoking.
- Department of Health (2012) Stop smoking service: monitoring and guidance.
- Department of Health (2011) The tobacco control plan for England.
- Department of Health (2011) Guidance for providing and monitoring stop smoking services, 2011 to 2012.

Definitions and data sources for the quality measures

- Responsible tobacco retailing, 2014
- Statistics on smoking, England 2013 cover prevalence of smoking among young people 16–19 and secondary school children (mostly aged 11–15). The Health and Social Care Information Centre
- Smoking cessation in secondary care: acute, maternity and mental health services NICE public health guidance 48 (2013).
- School-based interventions to prevent the uptake of smoking among children. NICE public health guidance 23 (2010).

- Guidance on preventing the uptake of smoking by children and young people. NICE public health guidance 14 (2008).
- Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007).

Related NICE quality standards

This quality standard will be developed in the context of all topics in the NICE library of quality standards because reducing tobacco use in the community is relevant to a wide range of conditions and diseases and general health and wellbeing.

Published

- Smoking cessation – supporting people to stop smoking. NICE quality standard 43 (2013).
- Antenatal care. NICE quality standard 22 (2012).
- Lung cancer for adults. NICE quality standard 17 (2012).
- Chronic obstructive pulmonary disease (COPD). NICE quality standard 10 (2011).

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 3. Membership of this committee is as follows:

Dr Alastair Bradley
General Medical Practitioner, Tramways Medical Centre/Academic Unit of Primary Medical Care, University of Sheffield

Jan Dawson
Public Health Nutrition Lead and Registered Dietician, Manchester City Council

Dr Matthew Fay

GP, Westcliffe Medical Practice, Shipley, West Yorkshire

Dr Malcolm Fisk

Co-Director, Ageing Society Grand Challenge Initiative, Coventry University

Ms Margaret Goose

Lay member

Mrs Geeta Kumar

Clinical Director, Women's Services (East) Betsi Cadwaladr University Health Board

Mrs Rhian Last

Clinical Lead, Education For Health

Dr Hugh McIntyre (Chair)

Consultant Physician, East Sussex Healthcare Trust

Mrs Mandy Nagra

Cancer Drug Fund and Individual Funding Request Manager, Specialised Commissioning, NHS England

Ms Ann Nevinson

Lay member

Dr Jane O'Grady

Director of Public Health, Buckinghamshire County Council

Mrs Jane Orr-Campbell

Director, Orr-Campbell Consultancy, Bedfordshire

Professor Gillian Parker

Professor of Social Policy Research and Director, Social Policy Research Unit, University of York

Mr David Pugh

Independent Consultant, Gloucestershire County Council

Dr Eve Scott

Head of Safety and Risk, The Christie NHS Foundation Trust, Manchester

Dr Jim Stephenson

Consultant Medical Microbiologist, Epsom and St Helier NHS Trust

Mr Darryl Thompson

Psychosocial Interventions Development Lead, South West Yorkshire Partnership NHS Foundation Trust

Mrs Julia Thompson

Strategic Commissioning Manager, Sheffield City Council

The following specialist members joined the committee to develop this quality standard:

Mr Ian Gray

Principal Policy Officer (Public Health and Health Protection), Chartered Institute of Environmental Health, London

Dr Gill Grimshaw

Lay member

Ms Jo McCullagh

Public Health Specialist – Tobacco Control and Stop Smoking Services, Lancashire County Council, Preston

Ms Hilary Wareing

Director, Tobacco Control Collaborating Centre, Warwick

NICE project team

Mark Minchin

Associate Director

Shirley Crawshaw

Consultant Clinical Adviser

Rachel Neary-Jones
Programme Manager

Craig Grime
Technical advisor

Anna Wasielewska
Lead Technical Analyst

Esther Clifford
Project Manager

Rita Parkinson
Coordinator

About this quality standard

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

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway for smoking.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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