

Smoking: supporting people to stop

Quality standard

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This standard is based on TA123, PH26, PH48 and NG92.

This standard should be read in conjunction with QS21, QS25, QS41, QS10, QS15, QS22, QS82, QS92, QS96, QS52, QS68, QS79, QS81, QS88, QS108, QS102, QS100, QS99, QS95, QS80, QS110, QS9, QS146 and QS156.

Introduction

This quality standard covers smoking cessation, which includes support for people to stop smoking and for people accessing smoking cessation services. 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 rich and poor.

A wide range of diseases and conditions are caused by smoking, 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.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measureable 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 outcome frameworks published by the Department of Health:

- [NHS Outcomes Framework 2013–14](#)
- [Improving outcomes and supporting transparency: a public health outcomes framework for England 2013–16, Part 1 and Part 1A.](#)

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2013–14

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p>Overarching indicators</p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>i Adults ii Children and young people</p> <p>1b Life expectancy at 75</p> <p>i males ii females</p> <p>Improvement areas</p> <p>Reducing premature mortality from the major causes of death</p> <p>1.1 Under 75 mortality rate from cardiovascular disease*</p> <p>1.2 Under 75 mortality rate from respiratory disease*</p> <p>1.4 Under 75 mortality rate from cancer*</p> <p>i One- and ii Five-year survival from all cancers</p> <p>iii One- and iv Five-year survival from breast, lung and colorectal cancer</p> <p>Reducing premature death in people with serious mental illness</p> <p>1.5 Excess under 75 mortality rate in adults with serious mental illness*</p> <p>Reducing deaths in babies and young children</p> <p>1.6.i Infant mortality*</p> <p>ii Neonatal mortality and stillbirths</p> <p>Reducing premature death in people with learning disabilities</p> <p>1.7 Excess under 60 mortality rate in adults with a learning disability</p>

<p>2 Enhancing quality of life for people with long-term conditions</p>	<p>Overarching indicator</p> <p>2 Health-related quality of life for people with long-term conditions**</p> <p>Improvement areas</p> <p>Ensuring people feel supported to manage their condition</p> <p>2.1 Proportion of people feeling supported to manage their condition**</p> <p>Reducing time spent in hospital by people with long-term conditions</p> <p>2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)</p> <p>2.3 ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s</p> <p>Enhancing quality of life for carers</p> <p>2.4 Health-related quality of life for carers**</p>
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<p>3 Helping people to recover from episodes of ill health or following injury</p>	<p>Overarching indicators</p> <p>3a Emergency admissions for acute conditions that should not usually require hospital admission</p> <p>3b Emergency readmissions within 30 days of discharge from hospital* (Placeholder)</p> <p>Improvement areas</p> <p>Improving outcomes from planned treatments</p> <p>3.1 Total health gain as assessed by patients for elective procedures</p> <p>i Hip replacement</p> <p>ii Knee replacement</p> <p>iii Groin hernia</p> <p>iv Varicose veins</p> <p>Preventing lower respiratory tract infections (LRTI) in children from becoming serious</p> <p>3.2 Emergency admissions for children with LRTI</p> <p>Improving recovery from injuries and trauma</p> <p>3.3 Proportion of people who recover from major trauma</p> <p>Improving recovery from stroke</p> <p>3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months</p> <p>Improving recovery from fragility fractures</p> <p>3.5 Proportion of patients recovering to their previous levels of mobility / walking ability at i 30 and ii 120 days</p>
<p>Alignment across the health and social care system</p> <p>* Indicator shared with Public Health Outcomes Framework (PHOF)</p> <p>** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)</p>	

Table 2 Public health outcomes framework for England, 2013–16

Domain	Objectives and indicators
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<p>2 Health improvement</p>	<p>Objective</p> <p>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p>Indicators</p> <p>2.1 Low birth weight of term babies</p> <p>2.3 Smoking status at time of delivery</p> <p>2.9 Smoking prevalence – 15 year olds (Placeholder)</p> <p>2.14 Smoking prevalence – adult (over 18s)</p>
<p>4 Healthcare public health and preventing premature mortality</p>	<p>Objective</p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</p> <p>Reducing deaths in babies and young children</p> <p>1.6.i Infant mortality*</p> <p>Indicators</p> <p>4.1 Infant mortality*</p> <p>4.3 Mortality from causes considered preventable**</p> <p>4.4 Mortality from all cardiovascular diseases (including heart disease and stroke)*</p> <p>4.5 Mortality from cancer*</p> <p>4.7 Mortality from respiratory diseases*</p> <p>4.9 Excess under 75 mortality in adults with serious mental illness* (Placeholder)</p> <p>4.11 Emergency readmissions within 30 days of discharge from hospital* (Placeholder)</p> <p>4.12 Preventable sight loss</p> <p>4.13 Health-related quality of life for older people (Placeholder)</p>
<p>Alignment across the health and social care system</p> <p>* Indicator shared with NHS Outcomes Framework</p> <p>** Indicator complementary with NHS Outcomes Framework</p>	

Coordinated services

The quality standard for 'smoking cessation: supporting people to stop smoking' specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole smoking cessation pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality smoking cessation services.

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. Commissioners and providers of health and social care should refer to the [library of NICE quality standards](#) when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality smoking cessation service 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 and social care practitioners involved in assessing, caring for and treating people who smoke should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.

List of quality statements

Statement 1 People are asked if they smoke by their healthcare practitioner, and those who smoke are offered advice on how to stop.

Statement 2 People who smoke are offered a referral to an evidence-based smoking cessation service.

Statement 3 People who smoke are offered behavioural support with pharmacotherapy by an evidence-based smoking cessation service.

Statement 4 People who seek support to stop smoking and who agree to take pharmacotherapy are offered a full course.

Statement 5 People who smoke who have set a quit date with an evidence-based smoking cessation service are assessed for carbon monoxide levels 4 weeks after the quit date.

Quality statement 1: Identifying people who smoke

Quality statement

People are asked if they smoke by their healthcare practitioner, and those who smoke are offered advice on how to stop.

Rationale

There is evidence that people who smoke are receptive to smoking cessation advice in all healthcare settings. It is therefore important that healthcare practitioners proactively ask people if they smoke, and offer advice on how to stop.

Quality measures

Structure

Evidence of local arrangements to ensure that people are asked if they smoke by their healthcare practitioner, and those who smoke are offered advice on how to stop.

Data source: Local data collection.

Process

a) Proportion of people who are asked if they smoke by their healthcare practitioner.

Numerator – the number of people in the denominator who are asked if they smoke by their healthcare practitioner.

Denominator – the number of people who have face-to-face contact with a healthcare practitioner.

Data source: a) Local data collection and the quality and outcomes framework (QOF) indicator SMOK001.

b) Proportion of people who smoke who receive advice on how to stop.

Numerator – the number of people in the denominator who receive advice on how to stop.

Denominator – the number of people who report that they smoke during face-to-face contact with a healthcare practitioner.

Data source: b) Local data collection and the QOF indicator SMOK004.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers ensure that systems are in place for people to be asked if they smoke by their healthcare practitioner, and for those who smoke to be offered advice on how to stop.

Healthcare practitioners ask their patients if they smoke, and offer those who smoke advice on how to stop.

Commissioners ensure that they commission services where healthcare practitioners ask their patients if they smoke, and that they offer those who smoke advice on how to stop.

What the quality statement means for patients, service users and carers

People are asked if they smoke by their healthcare practitioners, and those who smoke are offered advice on how to stop.

Source guidance

- [Stop smoking interventions and services](#) (2018) NICE guideline NG92, recommendation 1.4.1
- [Smoking: stopping in pregnancy and after childbirth](#) (2010) NICE guideline PH26, recommendations 1, 2 and 8
- [Smoking: acute, maternity and mental health services](#) (2013) NICE guideline PH48, recommendations 1, 2, 6, 7, 9 and 14

Definitions of terms used in this quality statement

Healthcare practitioners

These include, but are not limited to, doctors, nurses, midwives, pharmacists, dentists, opticians and allied health professionals.

Advice

This can vary by healthcare setting. In the context of primary care settings, this would involve evidence-based, opportunistic advice offered to people who smoke about the options and support available to help them stop smoking. In the context of secondary care settings, advice may involve the practitioner providing people who smoke with information and referring them to an evidence-based smoking cessation service.

The [National Centre for Smoking Cessation and Training](#) offers a training module on the delivery of evidence-based smoking cessation interventions, to ensure that this is done in a sensitive way within the brief time available with the patient.

This statement is linked to statement 2, because advice on how to stop may include a referral to an evidence-based smoking cessation service.

Equality and diversity considerations

Advice should be culturally appropriate and accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

Advice may include referral to an evidence-based smoking cessation service. Such services should target minority ethnic and socioeconomically disadvantaged communities in the local population; it is important to ensure that services are easily accessible by people from these groups and that they are encouraged to use them.

Lesbian, gay, bisexual and transgender (LGBT) groups have higher smoking prevalence rates than the general population, and as such, services should be accessible and commissioned to address this need.

Healthcare practitioners should be sensitive to the issue of smoking in young people. NICE guidance recommends that young people aged 12–17 who smoke should be offered information, advice and support on how to stop smoking and be encouraged to use local evidence-based smoking cessation services.

Practitioners should be aware that some pregnant women find it difficult to say that they smoke because the pressure not to smoke during pregnancy is so intense.

Quality statement 2: Referral to smoking cessation services

Quality statement

People who smoke are offered a referral to an evidence-based smoking cessation service.

Rationale

Smoking cessation services provide the most effective route to stopping smoking, but many people who smoke do not use these services when they try to stop. It is therefore important that practitioners are aware of and make use of the opportunities to refer people who smoke to an evidence-based smoking cessation service.

Statement 5 in the NICE quality standard on antenatal care sets out the high-quality requirements for ensuring that pregnant women who smoke are referred to an evidence-based smoking cessation service.

Quality measures

Structure

Evidence of local arrangements to ensure that people who smoke are offered a referral to an evidence-based smoking cessation service.

Data source: Local data collection.

Process

Proportion of people who smoke who are referred to an evidence-based smoking cessation service.

Numerator – the number of people in the denominator who are referred to an evidence-based smoking cessation service.

Denominator – the number of people identified as smokers in any healthcare setting.

Data source: Local data collection and the quality and outcomes framework (QOF) indicator SMOK004.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers ensure that systems are in place for people who smoke to be offered a referral to an evidence-based smoking cessation service.

Healthcare practitioners offer people who smoke a referral to an evidence-based smoking cessation service.

Commissioners ensure that they commission services that offer people who smoke a referral to an evidence-based smoking cessation service.

What the quality statement means for patients, service users and carers

People who smoke are offered a referral to an evidence-based smoking cessation service to help them stop smoking.

Source guidance

- [Stop smoking interventions and services](#) (2018) NICE guideline NG92, recommendation 1.6.1
- [Smoking: stopping in pregnancy and after childbirth](#) (2010) NICE guideline PH26, recommendations 1, 2, 3 and 8
- [Smoking: acute, maternity and mental health services](#) (2013) NICE guideline PH48, recommendations 1, 2, 3, 7, 9 and 14
- [Varenicline for smoking cessation](#) (2007) NICE technology appraisal guidance 123, recommendations 1.1 and 1.2

Definitions of terms used in this quality statement

Healthcare practitioners

These include, but are not limited to, doctors, nurses, midwives, pharmacists, dentists, opticians and allied health professionals.

Evidence-based smoking cessation services

These are local services providing accessible, evidence-based and cost-effective support to people who want to stop smoking.

The [National Centre for Smoking Cessation and Training](#) offers training modules for people delivering smoking cessation interventions.

This statement is linked to statement 1, because advice on how to stop may include a referral to an evidence-based smoking cessation service.

Statement 5 in the NICE quality standard on [antenatal care](#) states that 'Pregnant women who smoke are referred to an evidence-based stop smoking service at the booking appointment' and the appropriate referral criteria are defined. The supporting information also states that the midwife may provide the pregnant woman with information (in a variety of formats, for example, a leaflet) about the risks to the unborn child of smoking when pregnant and the hazards of exposure to secondhand smoke for both mother and baby.

Equality and diversity considerations

Evidence-based smoking cessation services should target minority ethnic and socioeconomically disadvantaged communities in the local population; it is important to ensure that services are easily accessible by people from these groups and that they are encouraged to use them.

Lesbian, gay, bisexual and transgender (LGBT) groups have higher smoking prevalence rates than the general population, and as such, services should be accessible and commissioned to address this need.

Healthcare practitioners should be sensitive to the issue of smoking in young people. NICE guidance recommends that young people aged 12–17 who smoke should be offered information, advice and support on how to stop smoking and be encouraged to use evidence-based smoking cessation services.

Practitioners should be aware that some pregnant women find it difficult to say that they smoke because the pressure not to smoke during pregnancy is so intense.

Quality statement 3: Behavioural support with pharmacotherapy

Quality statement

People who smoke are offered behavioural support with pharmacotherapy by an evidence-based smoking cessation service.

Rationale

People who smoke are more likely to stop smoking if they are offered a combination of interventions, with combined behavioural support and pharmacotherapy the most likely to be successful.

Quality measures

Structure

Evidence of local arrangements to ensure that people who smoke are offered behavioural support with pharmacotherapy by an evidence-based smoking cessation service.

Data source: Local data collection.

Process

Proportion of people who receive behavioural support with pharmacotherapy from an evidence-based smoking cessation service.

Numerator – the number of people in the denominator who receive behavioural support with pharmacotherapy from an evidence-based smoking cessation service.

Denominator – the number of people referred to an evidence-based smoking cessation service.

Data source: Local data collection. [Statistics on NHS Stop Smoking Services: England, April 2011 to March 2012](#) from the Health and Social Care Information Centre reports on smoking cessation interventions.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers ensure that systems are in place for people who smoke to be offered behavioural support with pharmacotherapy by an evidence-based smoking cessation service.

Healthcare practitioners offer behavioural support with pharmacotherapy to people who have been referred to an evidence-based smoking cessation service.

Commissioners ensure that they commission evidence-based smoking cessation services that offer people who smoke behavioural support with pharmacotherapy.

What the quality statement means for patients, service users and carers

People who have been referred to an evidence-based smoking cessation service are offered behavioural support (which may be either individual or group counselling) together with drug treatment.

Source guidance

- [Stop smoking interventions and services](#) (2018) NICE guideline NG92, recommendation 1.6.3
- [Smoking: stopping in pregnancy and after childbirth](#) (2010) NICE guideline PH26, recommendations 4 and 5
- [Smoking: acute, maternity and mental health services](#) (2013) NICE guideline PH48, recommendations 1, 2, 7 and 9
- [Varenicline for smoking cessation](#) (2007) NICE technology appraisal guidance 123, recommendations 1.1 and 1.2

Definitions of terms used in this quality statement

Behavioural support

This can be individual or group behavioural support.

NICE's guideline on [stop smoking interventions and services](#) states that individual behavioural support involves scheduled face-to-face meetings between someone who smokes and a counsellor

trained in smoking cessation. Typically, it involves weekly sessions over a period of at least 4 weeks after the quit date and is normally combined with pharmacotherapy.

It also states that group behavioural support involves scheduled meetings in which people who smoke receive information, advice and encouragement and some form of behavioural intervention (for example, cognitive behavioural therapy). This therapy is offered weekly for at least the first 4 weeks of a quit attempt (that is, for 4 weeks following the quit date). It is normally combined with pharmacotherapy.

Pharmacotherapy

Pharmacotherapies for smoking cessation are nicotine replacement therapy (NRT), varenicline or bupropion.

NICE's guideline on [stopping smoking in pregnancy and after childbirth](#) states that there should be a discussion about the risks and benefits of NRT with pregnant women who smoke. Nicotine replacement therapy should be offered if smoking cessation without NRT fails, or practitioner judgement should be used if women express a clear preference for NRT. Neither varenicline nor bupropion should be offered to pregnant or breastfeeding women.

A summary of further considerations relating to pharmacotherapy is provided in quality statement 4.

Evidence-based smoking cessation services

These are local services providing accessible, evidence-based and cost-effective support to people who want to stop smoking.

Quality statement 4: Pharmacotherapy

Quality statement

People who seek support to stop smoking and who agree to take pharmacotherapy are offered a full course.

Rationale

Pharmacotherapy interventions act as an aid to help people to stop smoking, and it is important that people who seek support to stop smoking receive the full course of their chosen pharmacotherapy to increase the chances of success.

Quality measures

Structure

Evidence of local arrangements to ensure that people who seek support to stop smoking and who agree to take pharmacotherapy are offered a full course.

Data source: Local data collection.

Process

Proportion of people who seek support to stop smoking and who agree to take pharmacotherapy who receive a full course.

Numerator – the number of people in the denominator who receive a full course of pharmacotherapy.

Denominator – the number of people who seek support to stop smoking and who agree to take pharmacotherapy.

Data source: Local data collection. [Statistics on NHS Stop Smoking Services: England, April 2011 to March 2012](#) from the Health and Social Care Information Centre reports on smoking cessation interventions.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers ensure that systems are in place so that people who seek support to stop smoking and who agree to take pharmacotherapy are offered a full course.

Healthcare practitioners offer a full course of pharmacotherapy to people who seek support to stop smoking and who agree to take pharmacotherapy.

Commissioners ensure that they commission services that offer a full course of pharmacotherapy to people who seek support to stop smoking and who agree to take pharmacotherapy.

What the quality statement means for patients, service users and carers

People who seek support to stop smoking and who agree to take pharmacotherapy are offered a full course of drug treatment.

Source guidance

- [Stop smoking interventions and services](#) (2018) NICE guideline NG92, recommendation 1.3.1
- [Smoking: stopping in pregnancy and after childbirth](#) (2010) NICE guideline PH26, recommendation 5
- [Smoking: acute, maternity and mental health services](#) (2013) NICE guideline PH48, recommendations 1, 2, 3, 6, 7, 8 and 9
- [Varenicline for smoking cessation](#) (2007) NICE technology appraisal guidance 123, recommendations 1.1 and 1.2

Definitions of terms used in this quality statement

Pharmacotherapy

Pharmacotherapies for smoking cessation are nicotine replacement therapy (NRT), varenicline or bupropion.

It is important that people who smoke who receive pharmacotherapy receive a full course, which will vary depending on the individual smoker. A full course for NRT is at least 8 weeks, for varenicline it is at least 12 weeks and for bupropion it is at least 8 weeks.

NICE's technology appraisal guidance on [varenicline for smoking cessation](#) states that varenicline should normally be prescribed only as part of a programme of behavioural support.

NICE's guideline on [stopping smoking in pregnancy and after childbirth](#) states that there should be a discussion about the risks and benefits of NRT with pregnant women who smoke. Nicotine replacement therapy should be offered if smoking cessation without NRT fails, or practitioner judgement should be used if women express a clear preference for NRT. Neither varenicline nor bupropion should be offered to pregnant or breastfeeding women.

Equality and diversity considerations

There should be a discussion about risks and benefits of using NRT with young people aged 12–17 and pregnant or breastfeeding women.

Quality statement 5: Outcome measurement

Quality statement

People who smoke who have set a quit date with an evidence-based smoking cessation service are assessed for carbon monoxide levels 4 weeks after the quit date.

Rationale

Recording smoking status using carbon monoxide testing after 4 weeks provides an incentive for people who are attempting to stop, and is an objective way to measure individual and service level outcomes.

Quality measures

Structure

Evidence of local arrangements to ensure that people who smoke who have set a quit date with an evidence-based smoking cessation service are assessed for carbon monoxide levels 4 weeks after the quit date.

Data source: Local data collection.

Process

Proportion of people who smoke who have set a quit date with an evidence-based smoking cessation service are assessed for carbon monoxide levels 4 weeks after the quit date.

Numerator – the number of people in the denominator who are assessed for carbon monoxide levels 4 weeks after the quit date.

Denominator – the number of people who smoke who have set a quit date with an evidence-based smoking cessation service.

Data source: Local data collection. The Health and Social Care Information Centre's [Indicator Portal](#) collects data on the number of people who smoke who successfully quit at the 4-week follow-up per 100,000 population.

Outcome

Four-week quit rates.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers ensure that systems are in place so that people who smoke who have set a quit date with an evidence-based smoking cessation service are assessed for carbon monoxide levels 4 weeks after the quit date.

Healthcare practitioners ensure that people who smoke who have set a quit date with an evidence-based smoking cessation service are assessed for carbon monoxide levels 4 weeks after the quit date.

Commissioners ensure that they commission services for people who smoke who have set a quit date with an evidence-based smoking cessation service are assessed for carbon monoxide levels 4 weeks after the quit date.

What the quality statement means for patients, service users and carers

People who smoke who have set a quit date with an evidence-based smoking cessation service are assessed for carbon monoxide levels 4 weeks after the quit date.

Source guidance

- [Stop smoking interventions and services \(2018\) NICE guideline NG92](#), recommendation 1.2.1
- [Smoking: stopping in pregnancy and after childbirth \(2010\) NICE guideline PH26](#), recommendation 4

Definitions of terms used in this quality statement

NICE's guideline on [stop smoking interventions and services](#) states that success should be defined by a carbon monoxide monitor reading of less than 10 ppm at 4 weeks after the quit date. This does not imply that treatment should stop at 4 weeks.

Evidence-based smoking cessation services

These are local services providing accessible, evidence-based and cost-effective support to people who want to stop smoking.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve 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.

See NICE's [how to use quality standards](#) 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 by commissioners, providers, health and social care practitioners, patients, service users and carers alongside the documents listed in [development sources](#).

Information for commissioners

NICE has produced [support for commissioning](#) that considers the commissioning implications and potential resource impact of this quality standard. This is available on the NICE website.

Information for the public

NICE has produced [information for the public](#) about this quality standard. Patients, service users and carers can use it to find out about the quality of care they should expect to receive; as a basis for asking questions about their care, and to help make choices between providers of social care services.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered. [Equality assessments](#) are available.

Good communication between health and social care practitioners and people accessing services who smoke is essential. Treatment, care and support, and the information given about it, should be both age-appropriate and 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 who smoke and access services 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 avoid unlawful discrimination and to have regard to promoting equality of opportunity. 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](#) on the NICE website.

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.

- [Stop smoking interventions and services](#) (2018) NICE guideline NG92
- [Smoking: acute, maternity and mental health services](#) (2013) NICE guideline PH48
- [Smoking: stopping in pregnancy and after childbirth](#) (2010) NICE guideline PH26
- [Varenicline for smoking cessation](#) (2007) NICE technology appraisal guidance 123

Policy context

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

- Department of Health (2012) [Local stop smoking services – key updates to the 2011/12 service delivery and monitoring guidance for 2012–13](#)
- Department of Health (2011) [Healthy lives, healthy people: a tobacco control plan for England](#)
- Department of Health (2011) [Stop smoking services – service delivery and monitoring guidance 2011–12](#)
- Department of Health (2010) [A smokefree future: a comprehensive tobacco control strategy for England](#)
- Department of Health (2009) [Tackling health inequalities: targeting routine and manual smokers in support of the Public Service Agreement smoking prevalence and health inequality targets](#)
- Department of Health (2008) [Excellence in tobacco control: 10 high impact changes to achieve tobacco control](#)

Definitions and data sources for the quality measures

- Health and Social Care Information Centre [Indicator Portal](#)
- Health and Social Care Information Centre [Statistics on NHS Stop Smoking Services: England, April 2011 to March 2012](#)
- [Quality and outcomes framework \(QOF\)](#)

Related NICE quality standards

- [Antenatal care](#) (2012, updated 2016) NICE quality standard 22 (see [statement 5](#) on smoking cessation in pregnancy)
- [Patient experience in adult NHS services](#) (2012) NICE quality standard 15
- [Chronic obstructive pulmonary disease \(COPD\)](#) (2011, updated 2016) NICE quality standard 10

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 1. For further information about the standing members of this committee see the [NICE website](#). The following specialist members joined the committee to develop this quality standard:

Professor Linda Bauld

Professor of Socio-management, University of Stirling

Mr Barrie Dwyer

Lay member, GMFA: The Gay Men's Health Charity

Mr Ron Gould

Community and mental health pharmacist, Liverpool CCG

Ms Carmel O'Gorman

Midwife, Heart of England NHS Foundation Trust

Professor Robert West

Professor of Health Psychology, University College, London

Mr Martyn Willmore

Performance Improvement Delivery Manager, Fresh: Smoke Free North East

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Update information

Minor changes since publication

March 2018: Source guidance sections and definitions have been updated to reflect the NICE guidance on [stop smoking interventions and services](#).

December 2016: Data sources updated for statements 1 and 2.

August 2015: Source guidance and links updated.

About this quality standard

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

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](#).

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Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [British Thoracic Society](#)
- [NCSCCT](#)
- [Primary Care Respiratory Society UK](#)
- [Royal College of General Practitioners](#)
- [Royal College of Physicians](#)
- [Faculty of General Dental Practice](#)