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Quality standards

Consultation summary report: tobacco: treating dependence

Quality Standards Advisory Committee post-consultation meeting: 21 September 2022

1. Introduction

The draft quality standard for tobacco: treating dependence was made available on the NICE website for a 4-week public consultation period between 11 July and 12 August 2022. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 18 organisations, which included service providers, national organisations, professional bodies and others.

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

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

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

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

12. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form.

Stakeholders were also invited to respond to several statement-specific questions. These are detailed in section 4.

1. General comments

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

* Some support for the content of the quality standard.
* Some stakeholders were concerned that the key areas of quality improvement have not been identified.
* The variation in services by area makes it difficult to comment on the draft quality standard.
* Smoking cessation is not solely the work of a few healthcare professionals but all in healthcare. The quality standard should include training in very brief advice for all healthcare staff who come into contact with patients and carers, and all healthcare professionals should be aware of local services available to support treatment.
* There are no standards for maternity services. Maternity identification of smokers involves carbon monoxide (CO) testing in addition to enquiry.
* There should be a focus on the “ask, advise, act” smoking assessment.
* Support to quit is only recommended in statement 5 in an in-patient setting. This represents only a tiny fraction of all NHS key points of contact and so the statements should be extended to include all settings which are supported by stop-smoking services.
* There should be more focus on vaping or be clear where vaping is covered.
* The increased risk of developing type 2 diabetes and complications for those who smoke should be highlighted in the quality standard.
* Equality and diversity considerations should include making sure advice is linguistically and culturally appropriate for all groups for both tobacco and smokeless tobacco use and include groups with high prevalence of smoking.

### Consultation comments on data collection

* Some stakeholders said that systems and structures should be in place to collect data, others felt that data systems are not in place.
  + British Thoracic Society audit is every 2 to 3 years and does not capture the majority of data in the standard.
  + Large gaps in local government data and this only provides aggregate data, difficult to match to the new NHS data.
  + NHS Long Term Plan smoking cessation services will start collecting some of the data but is still in its infancy and needs to bed in.
* No standardised data collection or reporting across different health and social care providers, and community services and so may be difficult to analyse at commissioner level, undermining the intention of the quality standard.
* Recording of smoking habits by primary care is good, but less so for vaping and other forms of tobacco use. The method of smoking cessation advice is not always clear. Smoking is not routinely coded in hospital discharge summaries and may be a mix of computerised and paper records.
* The movement to use of apps can allow for more convenient data collection.

### Consultation comments on resource impact

* Some stakeholders agreed that standards are achievable with appropriate resources but note the different provisions offered by different services.
* Other stakeholders noted that funding for public health and tobacco control has been reduced over recent years and local authorities have consistently reported a lack of funding to be a limiting factor in their tobacco control activity. They suggest this standard would have a resource impact:
  + Smoking cessation services vary around the UK. Additional funding is needed for ‘tobacco dependency advisors’ working across primary care and other sectors, to offer a universal service. The quality statements would extend the scope of current local government provision and the scope of the NHS Long Term Plan.
  + Significant resources would need to be invested in training and recruiting healthcare professionals.
  + Additional resources needed for IT development, prescribing and testing for smoking cessation.
* The use of remote devices and apps reduce the need for face-to-face clinics, and a traffic light system to tailor more in-depth support for certain groups may help with cost-savings.
* There should be investment in long-lasting treatments.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

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

### Consultation comments

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

* Key points of social care should be included and defined.
* Use of smokeless tobacco is rarely documented.
* Primary care can use messaging services to ask about smoking and the response automatically coded.
* Family members and carers should be included.
* Provision of directories for counsellors and therapies could allow access to options that may better suit people’s cultures, preferences and beliefs.

### Consultation question 4

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

Stakeholders made the following comments in relation to consultation question 4:

* Urgent care centres and emergency departments.
* On submission of an urgent appointment request.
* Primary care contact, community care contact, home visit for housebound patients and contact with 111.
* Any professional in contact with a smoker, such as opticians and pharmacists.
* Attendance for a test.
* Different versions of a health check and vaccination appointments.
* Every contact when a patient is pregnant.
* The bullet in the list should be amended to ‘consultation about a condition related to or exacerbated by smoking’ to capture conditions in which smoking is not causative but may worsen symptoms or progression.
* A consultation relating to mental health and wellbeing.

### Issues for consideration

#### For discussion:

* Should the social care setting be included in the quality statement?
* Are amendments needed to the definition of key points of contact? if so, what should be added?

#### For decision:

* Should the statement include both health and social care settings?
* What amendment is needed to the definition of key points of contact?
  1. Draft statement 2

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

### Consultation comments

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

* Is there evidence that advice on its own delivers impact and the expected outcomes?

### Consultation question 5

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

Stakeholders made the following comments in relation to consultation question 5:

* No national data sources. This is not part of the new tobacco dependence treatment services data collection. Local robust systems will be required where population need is identified.
* Not often asked or documented. Not aware of relevant consistent read coding. It may be difficult to identify users in certain populations.
* There is limited national surveillance on use of smokeless tobacco.
* There is lack of education and awareness. There is no systematic collection of data on staff training on delivery advice or guidance to smokers although local trust may do this through local systems.

### Consultation question 6

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

Stakeholders made the following comments in relation to consultation question 6:

* Unless the question is asked it is unlikely that the answer will be accurately coded. Data collection would need to be from local records which would require time and have a cost implication.
* The collection of data linked to quit rates using smokeless tobacco will be different to many of the quit rate assessments which use carbon monoxide monitoring (surrogate for inhaled smoke).

### Issues for consideration

#### For discussion:

* Issues around services and data collection for use of smokeless tobacco.

#### For decision:

* Should the quality statement include actions focussed on people who use smokeless tobacco considering the issues raised by stakeholders, including lack of data collection?
  1. Draft statement 3

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

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

* The statement does not include Allen Carr’s Easyway as a stop-smoking intervention.
* It should be clear that e-cigarettes are a harm-reducing and not harmless option, when discussing options with people who want to quit. It would be helpful to make this explicit here, as in statement 4.
* It should be clear that specialist support is required for this discussion. The process measure is incorrect.
* There should be guidance on referral processes.
* Dependent on what local services are available.

### Consultation question 7

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

Stakeholders made the following comments in relation to consultation question 7:

* Yes, to address health inequalities. It allows local areas to establish whether there is a need in the local population.
* We wonder if those who use smokeless tobacco products should be counted separately as it causes a different set of issues. Numbers may be small.
* There is a danger that focus on this area takes away resource and focus on the bigger issue of smoked tobacco. The scope of the NHS Long Term Plan only extends to smoking tobacco and so capacity and funding has not been factored in for smokeless tobacco. There needs to be adequate commissioning to ensure that additional work for smokeless tobacco support can be provided.

### Issues for consideration

#### For discussion:

* Is stop-smoking support and advice provided by all healthcare professionals or specialists only?
* Suitable interventions to help people quit use of smokeless tobacco.

#### For decision:

* Should the quality standard include actions and interventions focussed on people who use smokeless tobacco?
  1. Draft statement 4

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

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

* Risk reduction should include second-hand smoke.
* Hypnosis can be a long lasting and effective method for empowering smokers to change their habits and improve motivation towards smoking cessation.
* It is important to ensure accuracy of the outcome measure used for a harm reduction approach, including clarity on the accuracy of cotinine tests.

### Consultation question 8

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

Stakeholders made the following comments in relation to consultation question 8:

* Probably not.
* Further research is required. The evidence base should be evaluated regularly.
* A harm reduction approach is always appropriate for anyone not currently placed to quit.

### Consultation question 9

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

Stakeholders made the following comments in relation to consultation question 9:

* It seems feasible with suitable coding but the evaluation of change by the person is harder to identify. May be collected via stop-smoking services and possibly the new NHS Long Term Plan data collection, especially in the mental health setting. Data management systems would need adaptation and clear guidance on how this is expected to be reported.
* It is not currently collected in the NHS tobacco dependence data collection to ensure there is a focus on the full quit.
* Stakeholders offered examples of local services that record this information.

### Issues for consideration

#### For discussion:

* What services provide a harm-reduction approach to stopping smoking?
* Is a harm-reduction approach suitable for users of smokeless tobacco?
* Are there resources available to collect data on a harm reduction approach?
* Is there a significant impact on resource associated with this statement?
* Does a statement on harm-reduction approach detract from focussing on quitting?

#### For decision:

* Should this statement be limited to specialist providers of stop-smoking support?
* Should the quality statement include people who use smokeless tobacco?
  1. Draft statement 5

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

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

* The statement is ambitious. Funding levels seem to fluctuate. There needs to be clear guidance on how acute settings can adapt and achieve this.
* NHS services are funded to provide behavioural support whilst an inpatient and funded nicotine replacement therapy (NRT) following discharge. This statement requires behavioural support extended for the full 4-week period. NRT is sometimes not provided with behavioural support. There needs to be clear communication between the hospital and primary care to support the patient.
* Hypnosis should be considered as an option to quit smoking upon admission to hospital.
* Outcome measure should also prompt processes for the referral pathway and engagement with local stop-smoking service.
* Quit status should be measured beyond 4 weeks and support offered for at least 6 months post discharge. Quit outcomes should be reviewed at 4 weeks, 3 months and 6 months and potentially at 1 year post discharge.

### Consultation question 10

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

Stakeholders made the following comments in relation to consultation question 10:

* We believe this is feasible.
* This is the NHS ambition, but no data is available to guide how realistic this is or what percentage of referred inpatient smokers will be seen within this timeframe.
* Two metrics of importance are:
  + the proportion of smokers who accept an offer of behavioural support on admission
  + the proportion that are seen within 24 hours.
* Interventions for inpatients will be collected via the new NHS data collection and will include behavioural support alone.
* Additional training and IT development will be required to ascertain smoking status and then to offer support within 24 hours of admission.
* There should be an individualised and empathetic approach. A time-window may encourage healthcare professionals to approach it at a time that does not consider the wider patient experience and is less effective. The NHS Long Term Plan model identifies an ideal timescale of within 24 hours. Stakeholders provided examples of pathways based on 48 hours or 1 working day based on local circumstances. Costs of service delivery might be prohibitive to smaller providers. They suggest access to NRT following admission may be a more appropriate indicator.

### Consultation question 11

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

Stakeholders made the following comments in relation to consultation question 11:

* Yes, is it feasible. This would be labour intensive but smoking cessation service within trusts may be able to track this.
* The outcome measure does not reflect the quality standard which focusses on support delivered in hospital settings. Linking the outcome to those who have accessed community stop-smoking support on discharge focusses on a minority.
* It will need suitable follow-up to support and code abstinence.
* The NHS has adopted 4-week abstinence as a measure for many years and to change would make previous comparisons difficult.
* The data that will be collected may not reflect 4 weeks after discharge. Stop-smoking services may report 4 weeks after the patient has last smoked (pre-admission). Alternatives could be:
  + Measurement of the proportion of people who smoked on admission to hospital who received tobacco dependence support as inpatients and who self-reported as quit, 28 days following the start of their agreed quit window. This is part of the NHS Long Term Plan metrics.
  + Measurement of the proportion of people who smoked on admission to hospital who received stop-smoking support on discharge and were abstinent from smoking for 4-weeks from the date of their last cigarette. This would need multiple data sources and is not currently reported.
  + Using a 12-week time interval.
* All hospitals should follow the same data definitions for recording and reporting.
* There needs to be local commissioning arrangements in place to extend behavioural support for the full 4-week period.
* Data sharing between providers is complex. A single patient record would enhance the follow-up and recording of this.
* Some tertiary centres may have high numbers of out of area patients and may not be able to achieve the quality standard.

### Issues for consideration

#### For discussion:

* Is this statement realistic considering the recent implementation of the NHS data collection, complex data sharing between providers and the commissioning arrangements required?
* The timeframe for offer and receipt of behavioural support.
* The measures included to support the quality statement.

#### For decision:

* Should we amend the timeframe for receipt of behavioural support, and should the denominator include only those who accept the offer of behavioural support?
* What is the most appropriate outcome measure for this statement?
* Should this quality statement remain in the quality standard considering the issues raised by stakeholders? The NHS Long Term Plan includes an action offer NHS-funded tobacco treatment services to all people admitted to hospital who smoke.

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# Appendix 1: Quality standard consultation comments table – registered stakeholders

| ID | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
| 01 | Action on Smoking and Health (ASH) | General | ASH supports the areas outlined in this quality standard. ASH has responded to consultation questions where we have expertise. |
| 02 | Association of Respiratory Nurse Specialists | General | These questions were difficult to answer as the answer very much depends on where you work and the services available in your area.  Focus on simple “Ask advise act” smoking assessment.  Will vaping need to be included, e.g. unlicensed use – addition of CBD oil for example?  Term of “stop in one go” change to “stop completely after setting a quit date”.  Page 10 ,13, 15 contraindications on statement to use varenicline, but not available in UK. |
| 03 | NHSE (primary care) | General | The recognition of the importance of grasping the opportunity whilst an inpatient to quit and the importance of ensuring post discharge support is notable. Also, the recognition that there are many appropriate and capable individuals who can advise/support, and that smoking cessation is not solely the work of a few HCPs but all of us in healthcare. |
| 04 | NHSE (prevention team) | General | There are no standards directly applicable to maternity services, nor do current one reflect maternal smoking, for example, Quality Standard 1 does not recognise that in maternity identification of smokers also involves CO testing in addition to enquiry.  Equity and diversity considerations solely concentrate on smokeless tobacco and south Asian populations. The format of advice should be linguistically and culturally appropriate, with interpreting services and translated material available, for all groups including other groups with high prevalence (Roma community etc) for both tobacco and smokeless tobacco use. |
| 05 | Royal College of General Practitioners | General | The Royal College of General Practitioners is strongly supportive of interventions that improve health outcomes and continue to support the importance of treating tobacco dependency (TTD) as a major clinical and public health intervention. Along with healthy diet and activity, treating tobacco dependency is highly evidenced based with proven benefits to our population hence should be prioritised. |
| 06 | Royal College of Paediatrics and Child Health | General | We are happy with this draft quality standard. |
| 07 | Royal College of Physicians | General | The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our Tobacco Advisory Group (TAG) and would like to comment as follows. |
| 08 | Royal College of Physicians and Surgeons of Glasgow | General | The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the UK. While NICE has a remit for England (where 50% of our UK membership is based), many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments.  The College is in general very supportive of the Standard, Tobacco: treating dependence.  We note there is no reference to commercially available nicotine containing vaporisers which may contain tobacco. |
| 09 | The National Hypnotherapy Society | General | The draft covers a great deal of different communities and methods to encourage smoking cessation that are person-centred. I have offered some additional information for statements 4 and 5 that I believe will be of benefit. |
| 10 | University College London Hospital | General | This document gives a good overview of the key points. However more detail is needed regarding the data recording and collection across acute and community areas. More focus should be given in terms of education and training, advice regarding all sectors having their own local policies on tobacco dependency. There should be greater emphasis on medicalizing tobacco dependency and its treatment, moving aware from the idea of it being seen as social and lifestyle and tobacco dependency treatment needs to be seen as a priority across all areas.  The focus needs to be on ensure the data collection and allocation of resources is consistent to ensure that all services are pull in the same direction.  Education and training should be increased in relation to e-cigarettes and smokeless tobacco.  There needs to be more emphasis put smoking cessation being discussed as and seen as a medical and clinical issue. |
| 11 | Action on Smoking and Health (ASH) | Question 1 | Yes. |
| 12 | Association of Respiratory Nurse Specialists | Question 1 | Yes. |
| 13 | British Thoracic Oncology Group | Question 1 | Does this draft quality standard accurately reflect the key areas for quality improvement?  No – the quality statements cover the key issues of screening everyone for smoking/ use of smokeless at key points of contact with the health service but only recommends support to quit (statement 5) in an in-patient hospital setting.  The in-patient hospital setting only represents a tiny fraction of all NHS key points of contacts –the vast majority of contacts are in Primary Care, hospital out-patients, Urgent Care/ Emergency departments. This quality statement should be extended to include these settings which local government stop smoking services provide support. In addition, key points of social care should be included (and defined) –why is this just NHS focussed, people who do not need health services over many years (especially people in their 20’s and 30’s) my use social services.  The Royal College of Physicians (Smoking and Health 2021 <https://www.rcplondon.ac.uk/projects/outputs/smoking-and-health-2021-coming-age-tobacco-control> recommended interventions at all points of NHS contact and the health benefits of extending this intervention in Primary Care were modelled in the CRUK report ‘Making Conversations count’ <https://www.cancerresearchuk.org/sites/default/files/cancer-stats/making_conversations_count_-_full_report_-_october_2020/making_conversations_count_-_full_report_-_october_2020_0.pdf> |
| 14 | Department of Health and Social Care,  Office for Health Improvement and Disparities | Question 1 | These quality standards represent important areas for improvement. Smoking remains one of the leading causes of preventable premature death in the UK and Government remains committed to securing a smokefree society. Though not widespread, the use of smokeless tobacco products also causes significant harm in specific populations. The quality standards and associated interventions are needed in healthcare systems to provide opportunities to engage with effective cessation and eliminate tobacco consumption. |
| 15 | Diabetes UK | Question 1 | We feel that the quality standard broadly reflects the key areas for improvement to treat dependence in people who currently smoke. However, we are unclear about the context that is provided on the harms of smoking including the increased risk of developing type 2 diabetes and diabetes complications for those who smoke and think that this should be highlighted given the prevalence of the condition. The number of people with diabetes has doubled in the last 15 years with 4.9 million people – 1 in 14 - now living with the condition in the UK. There is also a further estimated 13.6 million people at an increased risk of developing type 2 diabetes |
| 16 | NHSE (primary care) | Question 1 | Yes, particularly around data capture and continuity of care. |
| 17 | NHSE (prevention team) | Question 1 | *Does this draft quality standard accurately reflect the key areas for quality improvement?*  No - the quality standards appear to be solely focussed on healthcare and do not acknowledge the significant role that local authority commissioned Stop Smoking Services play in delivery of smoking cessation services. In order to allow consistency of approach and comparability should these be universally applicable? We are also missing a huge range of key contacts in social care.  Additionally, within healthcare this only makes specific reference to inpatient settings. Inpatient setting only represent a small fraction of NHS contacts and this wider action is reflected elsewhere in the standards in relation to key contact in outpatients and primary care etc. |
| 18 | Royal College of General Practitioners | Question 1 | It does cover many of the key areas though there is nothing in the quality standard suggesting that systems should ensure that all clinical staff who come into contact with patients or carers (including parents) who may smoke should be at least trained in very brief advice (VBA) (from the National Centre for Smoking Cessation Training) on a regular basis. This aspiration should potentially also include non-clinical staff who have contact with patients and carers too – and that all clinical staff are aware of local services available to support treatment. (Our experience – discussing with audiences across boundaries in the NHS is that clinicians and non-clinical staff recognise the importance of TTD, but many have not been trained in basic efficient use of VBA and anecdotally become embroiled in protracted difficult discussions with patients that may encourage entrenched positions). |
| 19 | Royal College of Physicians | Question 1 | Does this draft quality standard accurately reflect the key areas for quality improvement?  Our experts believe the draft quality standard does not accurately reflect the key areas for quality improvement. The quality statements cover the key issues of screening everyone for smoking/ use of smokeless at key points of contact with the health service but only recommends support to quit (statement 5) in an in-patient hospital setting.  The in-patient hospital setting only represents a tiny fraction of all NHS key points of contacts –most contacts are in Primary Care, hospital out-patients, Urgent Care/Emergency departments. This quality statement should be extended to include these settings which local government stop smoking services provide support. In addition, key points of social care should be included (and defined) –why is this just NHS focussed, people who do not need health services over many years (especially people in their 20’s and 30’s) may use social services.  The Royal College of Physicians (Smoking and Health 2021 <https://www.rcplondon.ac.uk/projects/outputs/smoking-and-health-2021-coming-age-tobacco-control> recommended interventions at all points of NHS contact and the health benefits of extending this intervention in Primary Care were modelled in the CRUK report ‘Making Conversations count’ <https://www.cancerresearchuk.org/sites/default/files/cancer-stats/making_conversations_count_-_full_report_-_october_2020/making_conversations_count_-_full_report_-_october_2020_0.pdf> |
| 20 | Royal College of Physicians and Surgeons of Glasgow | Question 1 | Yes |
| 21 | The National Hypnotherapy Society | Question 1 | Mostly. Some comments for improvements have been made in comment numbers 14 and 15. |
| 22 | University College London Hospital | Question 1 | This reflects most of the key areas for quality improvement. There should be more focus on the use of e-cigarettes and clarity in this area, so all services are giving the same message.  There needs to be a focus improving data recording and collection and sharing.  A focus on smokeless tobacco is key, thought this highlights the need for more education and training in this area and data recording in this already.  Clarity on the type of language used within tobacco dependency to ensure that it is see as a medical/clinical issue and not lifestyle issue and given the correct importance. |
| 23 | Action on Smoking and Health (ASH) | Question 2 | Systems and structures should be in place to collect data for the quality standards outlined, with the exception of data on smokeless tobacco. |
| 24 | Association of Respiratory Nurse Specialists | Question 2 | Smoking cessation services vary significantly around the UK on availability and type of support available both in Primary & Secondary care. Statement 3 & 5 would therefore be more difficult to achieve unless more funding or training & protected time is given to staff to provide this service more consistently through the NHS. |
| 25 | British Thoracic Oncology Group | Question 2 | Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  Data systems are not in place to collect the majority of this data currently. This is a major flaw that runs through all of these quality standards and I suggest should be entirely revisited before issuing these quality statements, otherwise there is a risk of reputational damage to NICE.  The BTS audit is only every 2-3 years and does not capture the majority of the information suggested in these quality standards. Local government data reported via NHS Digital on LG stop smoking services have large gaps too and are not filled in by every local government and not every locality has LG SSS. The new NHS Long Term Plan smoking cessation services will start collecting data, but not on all the fields required to support these quality standards. Other national data collection e.g., the Annual Population survey does not collect this data.  There is a chapter on data collection in the RCP report ‘Hiding in Plain Sight’ 2018 <https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs> |
| 26 | Department of Health and Social Care,  Office for Health Improvement and Disparities | Question 2 | Most healthcare systems should have the necessary requirements to record and monitor these quality standards. |
| 27 | NHSE (primary care) | Question 2 | Agreeing and sharing codes seems achievable although I don’t know how much AHP care is coded (or shared, I have never seen this as a part of the discharge letter). As we develop electronic record sharing, consistency and accuracy should improve. |
| 28 | NHSE (prevention team) | Question 2 | *Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?*  There is no standardised data collection, storage or reporting across the different health and social care provider sectors. Getting consistent reporting and being able to analyse at a commissioner level is going to be very difficult; undermining the intention of the quality standards.  The New NHS patient level tobacco dependence treatment data collection will help to close some of these gaps but has not been designed to capture data at every key touch point. It is also still in its infancy and will take a number of years to bed in across all providers in line with the rollout of services.  The NHS Digital Stop Smoking Services quarterly return for local authority stop smoking services (SSS) is not a mandatory return and only provides aggregate data, so it will be difficult to match to the new NHS data collection. It would require a full review of the collection and agreement from the Data Alliance Partnership Board for agreement to change and then uptake by LA SSS. |
| 29 | Royal College of General Practitioners | Question 2 | We believe that the recording in primary care is overall good for documenting smoking habits in a coded way, though less so for vaping and other forms of tobacco use, and increasingly so the recording of the provision of smoking cessation advice as well. However, it is not always clear the method of smoking cessation advice used.  We do not see smoking routinely coded in hospital discharge summaries and are aware of mixed use of computerised patient records and paper recording. We would encourage single patient records across boundaries to encourage appropriate sharing of information and coding across boundaries. |
| 30 | Royal College of Physicians | Question 2 | Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  Data systems are not in place to collect most of this data. This is a major flaw that runs through all these quality standards, and our experts suggest that these should be entirely revisited before issuing these quality statements, otherwise there is a risk of reputational damage to NICE.  The BTS audit is only every 2-3 years and does not capture most of the information suggested in these quality standards. Local government data reported via NHS Digital on LG stop smoking services have large gaps too and are not filled in by every local government and not every locality has LG SSS. The new NHS Long Term Plan smoking cessation services will start collecting data, but not on all the fields required to support these quality standards. Other national data collection e.g., the Annual Population survey does not collect this data.  There is a chapter on data collection in the RCP report ‘Hiding in Plain Sight’ 2018 <https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs> |
| 31 | Royal College of Physicians and Surgeons of Glasgow | Question 2 | We are concerned that processes are not in place either in Primary or Secondary care. We are also aware that many monitoring systems in various specialities have slipped and have not been restored during and following the COVID-19 pandemic. Formal assessment of how widespread this is will need to be made. |
| 32 | The National Hypnotherapy Society | Question 2 | Arguably yes. The movement onto Apps (such as Livi used in Plymouth) can also allow for much more convenient data-collecting and outreach to people who may not need to visit a healthcare setting to communicate with their healthcare professional. Questionnaires could be sent out via apps such as this to gain self-report data as well for those who may not be in contact with a healthcare professional for some time. |
| 33 | University College London Hospital | Question 2 | The are some local systems in place to record smoking status and record basic VBA and send basic local referrals to the community services.  There are no current data provisions to record community quit outcomes and each NHS trust and community stop smoking services have different provisions and ways of recording data.  What is needed is for there to be robust national data system where all the different areas can feed in their data.  We are in the process of updating our EPR smoking cessation section to encompass more of this information. |
| 34 | Action on Smoking and Health (ASH) | Question 3 | Local areas’ success in achieving the statements may be significantly hampered by funding cuts. Funding for public health and tobacco control, provided through the Public Health Grant, has been reduced substantially over recent years, amounting to a cut of a third in real terms since 2015. [1] The All Party Parliamentary Group on Smoking and Health, supported by many leading health organisations across the UK have called on the Government to introduce a Smokefree 2030 Fund, which would place a ‘polluter pays’ levy on the tobacco manufacturers,[2] forcing them to pay for the harm they cause, and the measures needed to reduce smoking and support people to quit. Local authorities have consistently reported lack of funding to be a limiting factor in their tobacco control activity [3] and therefore may be limited in their ability to deliver on the statements set out in this quality standard.  The Health Foundation. [Why greater investment in the public health grant should be a priority](https://www.health.org.uk/news-and-comment/charts-and-infographics/why-greater-investment-in-the-public-health-grant-should-be-a-priority#:~:text=Failure%20to%20invest%20in%20vital,to%20improve%20the%20nation's%20health.). October 2021.  APPG on Smoking and Health. [Delivering a Smokefree 2030: The All Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021](https://ash.org.uk/about-ash/all-party-parliamentary-group-on-smoking-health/inquiries-reports/deliveringasf2030appgtcp2021/). June 2021.  ASH and Cancer Research UK. [Many Ways Forward. Stop smoking services and tobacco control work in English local authorities, 2019](https://ash.org.uk/wp-content/uploads/2020/01/Many-Ways-Forward.pdf). January 2020. |
| 35 | Association of Respiratory Nurse Specialists | Question 3 | As discussed above, there needs to be standardised services for health care professionals to refer to, or patients to self refer for smoking cessation services. This may include a more general approach for a “health advisor” role who could also go through alcohol management / weight or dietary management advice. Funding would need to be provided by the CCG or local city council. In a local PCN in Southampton, we have a community well being team who take smoking cessation referrals in a specific area. The targeted lung health programme in Southampton also have smoking cessation advisors for patients who participate in the programme. Another alternative is to engage pharmacy services nationally to provide smoking cessation clinics. The issue is the multitude of different services in different areas – some are also only telephone support, some are face to face. It can be a “post code lottery”.  This may be achievable in primary care if using digital tools (e.g., Accrux) |
| 36 | British Thoracic Oncology Group | Question 3 | Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them?  No – Without additional funding for new ‘tobacco dependency advisors’ working across primary care and other sectors is a universal offer for smoking cessation intervention possible. Many LG SSS do not provide a service for all population groups and struggle with funding to meet their current demand. The Quality statements would extend the scope of current LG SSS provision and the scope of the NHS LTP commitments to smoking cessation (currently in-patients, community mental health, staff who smoke and maternity.)  The data capture to underpin/ measure these quality standards is not achievable (see question 2 above)  Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.  Significant funding is required for a universal stop smoking intervention to be provided across all healthcare settings as suggested in these quality standards. Please see the Javad Khan review for estimates of what is needed. <https://www.gov.uk/government/publications/the-khan-review-making-smoking-obsolete#:~:text=Details,make%20England%20smokefree%20by%202030>.  Significant resource would be required to fill the data gap of what is recorded/ what needs to be recorded.  Significant resources would need to be invested in training healthcare staff of all professions and grades to fulfil QS 3 if this applies to all healthcare settings. In hospitals this function could be fulfilled by newly appointed ‘tobacco dependency advisors’ but these rules do not exist in other healthcare settings. |
| 37 | NHSE (primary care) | Question 3 | This is work that should already be happening. Clearer data capture and electronic sharing would reduce duplication and improve efficiency, this may also result in a more effective pathway for the patient. |
| 38 | NHSE (prevention team) | Question 3 | *Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them?*  No – not without additional funding for front line service delivery.  Funding was historically transferred from the NHS to local authorities for smoking cessation. Additional new funding would be required to cover costs of NHS delivered care. If there is a desire to maintain services in SSS then they will require additional funding plus the potential for additional NHS resources to facilitate transfers of care.   Where there has been disinvestment and there are no SSS then funding would be required in the NHS to deliver services.   There should also be comprehensive training materials and ideally an agreed central data collection system. |
| 39 | Royal College of General Practitioners | Question 3 | Our members talk of highly variable local services certainly across NHS England, with variable provision. Resources need to ensure:   * training in VBA for all health care professionals (HCP) * timely intervention for trained HCP able to provide professional support and advise * appropriate availability of products that facilitate successful quit attempts.   The cost savings we recognise will be hard to quantify as the phase between successful TTD and improving outcomes, though rapid in the start, will not provide an opportunity for disinvestment in the near future (but may prevent need for increasing service development). |
| 40 | Royal College of Physicians | Question 3 | Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them?  Our experts believe that without additional funding for new ‘tobacco dependency advisors’ working across primary care and other sectors, a universal offer for smoking cessation intervention would not be possible. Many LG SSS do not provide a service for all population groups and struggle with funding to meet their current demand. The Quality statements would extend the scope of current LG SSS provision and the scope of the NHS LTP commitments to smoking cessation (currently in-patients, community mental health, staff who smoke and maternity.)  The data capture to underpin/ measure these quality standards is not achievable (see question 2 above).  Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.  Significant funding is required for a universal stop smoking intervention to be provided across all healthcare settings as suggested in these quality standards. Please see the Javad Khan review for estimates of what is needed. <https://www.gov.uk/government/publications/the-khan-review-making-smoking-obsolete#:~:text=Details,make%20England%20smokefree%20by%202030>.  Significant resource would be required to fill the data gap of what is recorded/ what needs to be recorded.  Significant resources would need to be invested in training healthcare staff of all professions and grades to fulfil QS 3 if this applies to all healthcare settings. In hospitals this function could be fulfilled by newly appointed ‘tobacco dependency advisors’ but these rules do not exist in other healthcare settings. |
| 41 | Royal College of Physicians and Surgeons of Glasgow | Question 3 | Yes, we believe that the standards are achievable with appropriate resources. This may require the resource of a local auditor/data collector. The only identifiable cost saving is a reduction in use of health care resources as a result ceasing smoking. This is a long-term objective and difficult to quantify. |
| 42 | The National Hypnotherapy Society | Question 3 | Yes. Additionally, there should be investment into long-lasting treatments that not only manage the physical addiction but the underling psychological causes for the continuation of smoking and the unwillingness to quit. Whilst implementing more therapeutic measures may be more costly at the time, if this encourages higher rates of long-term success then the overall costs will be significantly less overall. |
| 43 | University College London Hospital | Question 3 | These statements are achievable by some services, but in the whole not as all the different services offer different provisions and they do not record their data in the same way.  What is needed is a pharmacotherapy/support offer that is consistent across all sectors and areas. A consistent offer of behavioural change support across all sectors.  One way to explore cost savings is to increase the use of ICO quit remote devices and apps, to increase the virtual offer and reducing the need for face-to-face clinics. Another cost saving would be to use a traffic light system in order to tailor more in-depth support for certain groups and reduced support for those that are more highly engaged and require less intensive support. |
| 44 | Action on Smoking and Health (ASH) | Statement 1 Question 4 | Yes. |
| 45 | Association of Respiratory Nurse Specialists | Statement 1 | Only if the smokeless tobacco smokers are identified at the point of contact and correct coding is used (applies to primary care, not sure about the systems in secondary and tertiary care). I rarely see this being documented or asked in Primary/Secondary care. Prompts on IT templates/admission paperwork is advised as suggested above. |
| 46 | Association of Respiratory Nurse Specialists | Statement 1 Question 4 | On submission of an urgent appointment request where the patient is identified as a smoker (via eConsult or triage in Primary care). Midwifery / health visitor reviews. Home visits for housebound patients. Non-urgent 111 calls if patient is a smoker.  In primary care patient can also be proactively asked about smoking via messaging service, e.g., Accrux (batch sending) and the response automatically coded using SNOWMED codes. |
| 47 | British Thoracic Oncology Group | Statement 1 | For draft quality statement 1: We have added a definition of ‘key points of contact’ as a guide to when people should be asked about their smoking as a minimum. Are there other key points of contact that should be included?  Yes –Urgent care centres and Emergency Departments should be added to the list as many patients will only access these services and these are excellent moments where people will be waiting a long time for treatment and in a ‘teachable moment’ (See COSTeD trial of e-cigs for smoking cessation in ED due to be published next year https://www.uea.ac.uk/groups-and-centres/addiction-research-group/costed-trial) |
| 48 | Department of Health and Social Care,  Office for Health Improvement and Disparities | Statement 1 Question 4 | The inclusion of ‘A consultation relating to mental health and wellbeing’ should be included here. This is due to the high rates of smoking with people with a mental health condition and improvements quitting has for mental health. |
| 49 | Diabetes UK | Statement 1 Question 4 | The ‘Key Points of Contact’ section could be more explicit about the important role pharmacists can play by including a suggestion for pharmacists to routinely ask people with long-term conditions like diabetes if they smoke and offer them support when picking up prescriptions or buying relevant over-the-counter medicines, as recommended in the Public Health England report ‘Pharmacy: A Way Forward for Public Health’.  Reference: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643520/Pharmacy_a_way_forward_for_public_health.pdf> |
| 50 | NHSE (primary care) | Statement 1 Question 4 | Within the description of health care professionals, it may be beneficial to add optometrists since the NHS eye check seems a good opportunity especially if smoking-related findings are seen.  “a consultation about a condition related to smoking” should this be “related to or exacerbated by” to capture conditions in which smoking is not causative but may worsen symptoms or progression? |
| 51 | NHSE (prevention team) | Statement 1 Question 4 | *For draft quality statement 1: We have added a definition of ‘key points of contact’ as a guide to when people should be asked about their smoking as a minimum. Are there other key points of contact that should be included?*  Key points of contact need more specific guidance to allow consistency and comparability.  Additional key points of contact:  Dentist appointment, primary care contact, community care contact, different versions of the Health check, contact with 111, Accident and Emergency, Ante natal appointments, Inpatient maternity episodes associated with birth, Post-natal health checks, Child/adult Imm & Vacc appointments.  Social care is missing in totality. |
| 52 | Royal College of General Practitioners | Statement 1 Question 4 | Key points of contact appear sensible. Others may include the attendance for a test (Xray / phlebotomy / ECG etc.). It may also be feasible at some immunisation clinics. There are interventions linked to community pharmacy, attendance at optometrists and physiotherapists that can also be good points of contact to provide similar messages to other health care professionals. It may be worth emphasising the importance in mental health consultations also. |
| 53 | Royal College of Physicians | Statement 1 | For draft quality statement 1: We have added a definition of ‘key points of contact’ as a guide to when people should be asked about their smoking as a minimum. Are there other key points of contact that should be included?  Yes –Urgent care centres and Emergency Departments should be added to the list as many patients will only access these services and these are excellent moments where people will be waiting a long time for treatment and in a ‘teachable moment’ ( See COSTeD trial of e-cigs for smoking cessation in ED due to be published next year <https://www.uea.ac.uk/groups-and-centres/addiction-research-group/costed-trial>) |
| 54 | Royal College of Physicians and Surgeons of Glasgow | Statement 1 Question 4 | We feel you should specifically include general practitioner, primary care or community health care professional and specifically pharmacists. |
| 55 | The National Hypnotherapy Society | Statement 1 Question 4 | Yes. The public could also be provided directories for counsellors and therapies of various disciplines to allow them access to options that may better suit their cultures, preferences and beliefs. |
| 56 | University College London Hospital | Statement 1 | No as there is a lack of clarity and education in regard to smokeless tobacco and the support services applicable for these addictions. |
| 57 | University College London Hospital | Statement 1 Question 4 | We need to ensure that all patient encounters with HCPs and community services consist of smoking cessation advice. (GPs, acute trusts, NHS community services, local authority stop smoking services etc).  To ensure that all services are delivering the same consist messages and ensure that significant others and family members are included in the offer. |
| 58 | Action on Smoking and Health (ASH) | Statement 2 Question 5 | There has been limited national surveillance of the magnitude, patterns, determinants and consequences of smokeless tobacco consumption in the UK. Some local surveying work has been undertaken. A wide variation in prevalence estimates (2%- 57%) has been observed, particularly in Bangladeshi communities. [4] The variation in prevalence estimates may be due to a lack of uniformity in defining smokeless tobacco products by investigators.  McNeill A, Pritchard C, Longman J, Leonardi-Bee J, Myles P, Aveyard P, et al. [Smokeless tobacco in the UK – products, populations and policy](http://www.ukctcs.org/ukctcs/documents/smokelessprojectreport.pdf). 2011. |
| 59 | Association of Respiratory Nurse Specialists | Statement 2 | I believe more education & awareness is required on smokeless tobacco as I believe data collected would be very limited/minimal. |
| 60 | Association of Respiratory Nurse Specialists | Statement 2 Question 5 | Not in my experience in Primary or Secondary care. It is often not asked or documented, likely due to lack of education/awareness in the area. Locally, this could be added to admission paperwork templates for hospital patients; or added as part of a prompt on I.T. systems as part of a patient’s assessment of smoking in Primary care (on EMIS Web / SystmOne /Vision)  It should be collected and accordingly coded in SNOWMED but I believe it is often not directly asked/thought about and not explicitly asked, hence often missed. |
| 61 | British Thoracic Oncology Group | Statement 2 | For draft statement 2: Is data collected around the use of smokeless tobacco, including provision of advice and support on quitting?  I don’t know of any data source for this.  For draft statement 2: Is it feasible to measure quit rates in people who use smokeless tobacco using local data collection?  No- the only hope is if it is collected by local stop smoking services |
| 62 | Department of Health and Social Care,  Office for Health Improvement and Disparities | Statement 2 Question 5 | Data is not routinely recorded or published at national level for smokeless tobacco. In England, smokeless tobacco use is believed to be predominately in Indian, Pakistani and Bangladeshi communities and in older age groups. Local and robust systems for smokeless tobacco interventions will be required where population need is identifiable. |
| 63 | Department of Health and Social Care,  Office for Health Improvement and Disparities | Statement 2 Question 6 | If there are local systems in place to establish smoking quality standards, it should be feasible to include smokeless tobacco quality standards, where the demand is identified. |
| 64 | NHSE (primary care) | Statement 2 Question 5 | I don’t know how widely this is asked. Mostly the question is “Do you smoke?” Perhaps we should consider changing how we ask that question in healthcare environments. |
| 65 | NHSE (primary care) | Statement 2 Question 6 | It should be feasible however (as above), unless we ask the question it is unlikely that we’ll accurately code the answer. I regularly review GP records and sometimes dentist and optometry, I have not seen this captured. |
| 66 | NHSE (prevention team) | Statement 2 Question 5 | *For draft statement 2: Is data collected around the use of smokeless tobacco, including provision of advice and support on quitting?*  There is no routine collection of smokeless tobacco products in the NHS. This is not part of the new tobacco dependence treatment services data collection.  Advice is that local services where population demographics dictate it should collect this data locally.  Currently there is no systematic collection of data on staff training on delivering advice / guidance to smokers. Local trusts may do this through local systems.  Is this differentiation required for SSS as well as healthcare? |
| 67 | NHSE (prevention team) | Statement 2 Question 6 | *For draft statement 2: Is it feasible to measure quit rates in people who use smokeless tobacco using local data collection?*  There is no routine collection of smokeless tobacco so trust where this is prevalent in their population would have to update local records, provide appropriate training (treatment and the differentiating between smoked and smokeless – to all staff as well as advisers as they need to be identified). This will require time and likely have a cost implication for the provider.  It is unknown whether SSS collect this data. |
| 68 | NHSE (prevention team) | Statement 2 | Quality standards 2 and 3 both make reference to providing advice with 3 going further. Is quality standard 2 appropriate to stand alone – is there evidence that advice on its own delivers impact?  Specifically, in relation to Quality Standard 2 – it is unclear what the expected outcome is expected. The indicators include quit rates and smoking prevalence. Is there robust evidence that advice leads to a quit? Or is brief advice an adjunct to referral to specialist support – in which case indicators to reflect engagement with specialist support may be more appropriate indicators i.e., more akin to quality standard 3. |
| 69 | Royal College of General Practitioners | Statement 2 Question 5 | We are not aware of reliable routine data being collected on smokeless tobacco at the current time. We are not aware of relevant consistent Read coding. This may be a learning need for clinicians across the NHS. |
| 70 | Royal College of General Practitioners | Statement 2 Question 6 | The collection of data linked to quit rates when using smokeless tobacco will be different to many of the quit rate assessments (linked to CO monitoring) as the CO level is taken as a surrogate for cessation of inhalation of smoke. |
| 71 | Royal College of Physicians | Statement 2 | For draft statement 2: Is data collected around the use of smokeless tobacco, including provision of advice and support on quitting?  Our experts don’t know of any data source for this.  For draft statement 2: Is it feasible to measure quit rates in people who use smokeless tobacco using local data collection?  Our experts believe this is only feasible if collected by local stop smoking services. |
| 72 | Royal College of Physicians and Surgeons of Glasgow | Statement 2 Question 5 | We know of no data around this particular issue. Our expert reviewer did not recognise a big issue with smokeless tobacco in their local population mix. This form of tobacco can be used by various minority communities where English may not be the first language and are often difficult to contact and identify. |
| 73 | Royal College of Physicians and Surgeons of Glasgow | Statement 2 Question 6 | Smokeless tobacco gives rise to slightly different risks. It may not be possible to identify users in certain populations which may make a cessation programme impossible. |
| 74 | The National Hypnotherapy Society | Statement 2 Question 5 | Yes. |
| 75 | The National Hypnotherapy Society | Statement 2 Question 6 | Yes, using the same methods used for those using smoked tobacco products. |
| 76 | University College London Hospital | Statement 2 | Patients who are seen by the in-house smoke cessation service at the hospital will receive advice regarding smokeless tobacco and quitting. Though there is a lack of understanding with other HCPs and the provisions available in the community. So, more work is needed in terms of developing robust training programmes within the hospital and robust pathways of referral for smokeless tobacco users. |
| 77 | University College London Hospital | Statement 2 Question 5 | Within the trust we collect basic information regarding the usage of smokeless tobacco. But there is not data collected on the advice given regarding smokeless tobacco and quit outcomes are not clearly recorded.  More education is required in to understanding smokeless tobacco and it’s treatment and many local community services do not support patients with smokeless tobacco addiction so clarity is needed in treatment for smokeless tobacco and what provisions are available for clients. |
| 78 | Action on Smoking and Health (ASH) | Statement 3 Question 7 | Yes – to address inequalities in health caused by tobacco products. |
| 79 | Allen Carr’s Easyway | Statement 3 | There is a serious omission from the draft and that is that is does not include Allen Carr’s Easyway. An update to the main guideline will be published on 4th August recommending that service providers, healthcare professionals and commissioners should offer smokers access to behavioural interventions, medicinally licensed products, nicotine -containing e-cigarettes and Allen Carr’s Easyway. This should be shown under the range of stop smoking interventions on page 15. |
| 80 | Association of Respiratory Nurse Specialists | Statement 3 | Yes, harm reduction advisable with smoking / smokeless tobacco if patient is not ready to stop. |
| 81 | British Thoracic Oncology Group | Statement 3 | For draft statement 3: Is it appropriate to include people who use smokeless tobacco in the population for this quality statement?  This feels like a niche area and was not part of the evidence update for NG209. Do we have updated prevalence figure? There is a danger that a focus on this area, takes away resource and focus from the much bigger issue of smoked tobacco- I would drop this |
| 82 | Department of Health and Social Care,  Office for Health Improvement and Disparities | Statement 3 Question 7 | Yes, it allows the opportunity for local areas to establish whether there is a need in the local population and implement accordingly. |
| 83 | Diabetes UK | Statement 3 | For this statement we feel it is important to be clear that e-cigarettes are a harm-reducing, and not harmless, option when discussing options with people who wish to quit. Whilst Statement 4 goes on to state this it would also be helpful to also make this explicit here.  Information regarding the safety of long term e-cigarette use is not yet available and further research is needed in this area, as well as how best to use e-cigarettes as a harm-reduction option and how they compare to other methods of quitting. This is of concern to current smokers but also to young people who don’t smoke but may be encouraged to use e-cigarettes due their increased accessibility and their relative “harmlessness” compared to smoking tobacco. Product marketing for e-cigarettes is not clear on benefits and harms so there is a possible lack of awareness amongst the public around this that should be noted.  Reference: <https://pubmed.ncbi.nlm.nih.gov/31973060> |
| 84 | NHSE (primary care) | Statement 3 Question 7 | Yes, it seems appropriate although the numbers will be very small and reliant on the healthcare professional directly asking about smokeless products. |
| 85 | NHSE (prevention team) | Statement 3 Question 7 | *For draft statement 3: Is it appropriate to include people who use smokeless tobacco in the population for this quality statement?*  Potentially, although the current scope of current Long Term Plan investment for NHS activity to support smokers only extends to smoke tobacco and capacity/funding requirements have not been factored in for smokeless tobacco, so will need consideration.  Is there evidence about the prevalence of smokeless tobacco – does it impact nationally across most providers?  It has the potential to detract focus from smoked tobacco. |
| 86 | NHSE (prevention team) | Statement 3 | Specially in relation to quality standard 3 - feels that this section should be clear that specialist support is required for this discussion – in which case the process indicator ‘Proportion of people who want to stop smoking when asked at a key point of contact who had a discussion with a healthcare professional about the range of stop-smoking interventions available’ is incorrect. |
| 87 | Royal College of General Practitioners | Statement 3 Question 7 | There should be adequate commissioning to ensure that workload for any additional work involved in smokeless tobacco support can be provided. If this is not the case – it would be harder to support. |
| 88 | Royal College of Physicians | Statement 3 | For draft statement 3: Is it appropriate to include people who use smokeless tobacco in the population for this quality statement?  This feels like a niche area and was not part of the evidence update for NG209. Do we have updated prevalence figure? There is a danger that a focus on this area, takes away resource and focus from the much bigger issue of smoked tobacco- I would drop this |
| 89 | Royal College of Physicians and Surgeons of Glasgow | Statement 3 Question 7 | We wonder if those who use smokeless tobacco products should be counted separately as it causes a different set of issues. |
| 90 | The National Hypnotherapy Society | Statement 3 Question 7 | Yes. |
| 91 | University College London Hospital | Statement 3 | People are able to discuss stop smoking interventions and advice with an HCP within our organisation. |
| 92 | Action on Smoking and Health (ASH) | Statement  4 Question 8 | Further research is likely needed. |
| 93 | Association of Respiratory Nurse Specialists | Statement 4 | Again this is area dependent on what services are available. It’s not effectively recorded at present, however, it could be coded in the system and would allow for easy data collection via searches. In Southampton hospital, currently they do not have a smoking cessation advisor at the hospital. The patient is given advice / NRT and then usually signposted to local pharmacy after discharge from hospital. They are not often provided with behavioural support. The funding of these services seem to fluctuate. |
| 94 | Association of Respiratory Nurse Specialists | Statement 4 | Quality Standard 4: Risk reduction should include secondhand smoke for other household members including children – patients to choose smoking outdoors, not indoors. |
| 95 | British Thoracic Oncology Group | Statement 4 | For draft statement 4: Is the action in quality statement 4 appropriate for people who use smokeless tobacco?  Probably not  For draft statement 4: The process measure for quality statement 4 measures the receipt of a harm-reduction approach to stopping smoking. Is this recorded by services currently, and if not, is it feasible to collect data on this?  Might be collectable via LG SSS and possibly via the new NHS LTP data collection especially in the Mental Health setting |
| 96 | Department of Health and Social Care,  Office for Health Improvement and Disparities | Statement 4 Question 8 | Unless there is evidence to demonstrate that harm reduction approaches have no effect in this population, then the action should be considered appropriate. |
| 97 | Department of Health and Social Care,  Office for Health Improvement and Disparities | Statement 4 Question 9 | It should be feasible to collect this data. |
| 98 | Kent Community Health NHS Foundation Trust | Statement 4 | As a local authority smoking cessation service, we only offer an abrupt quit programme and do not record or support clients wishing to cut down. Locally we are fortunate to have a lifestyle service which are trained advisers in behaviour change and motivational interviewing techniques which can support harm reduction clients to reduce their tobacco usage and increase motivation to make an abrupt quit and refer to stop smoking services in which the service can provide 7 weeks support and access to pharmacotherapy. There is insufficient budget at a local level to provide pharmacotherapy to clients who are looking to cut down. Being able to record this on data management systems would require costed adaptions and clear guidance on how this is expected to be reported. |
| 99 | NHSE (primary care) | Statement 4 Question 8 | Yes, a harm reduction approach is always appropriate for anyone not currently placed to quit and would mean that the smokeless tobaccos use is coded and more likely to be followed up. |
| 100 | NHSE (primary care) | Statement 4 Question 9 | Not seen in GP records nor dentistry/eye health. Seems feasible with suitable coding. |
| 101 | NHSE (prevention team) | Statement 4 Question 8 | *For draft statement 4: Is the action in quality statement 4 appropriate for people who use smokeless tobacco?*  Should harm reduction be considered a quality standard for smoked or smoke-free tobacco? It is often a necessary step and could form part of treatment pathway, but should NICE be acknowledging it specifically as a quality standard? |
| 102 | NHSE (prevention team) | Statement 4 Question 9 | *For draft statement 4: The process measure for quality statement 4 measures the receipt of a harm-reduction approach to stopping smoking. Is this recorded by services currently, and if not, is it feasible to collect data on this?*  It is not currently collected and is not part of the new NHS tobacco dependence data collection; this was a conscious decision to ensure there is a focus on the full quit. Local services may capture this, and anecdotal feedback from some Mental health Services is that they will, but it would require local adaptation of records and training with likely cost and resourcing implications.  It is unknown if this is collected as part of SSS. |
| 103 | Royal College of General Practitioners | Statement 4 Question 8 | The evidence base behind this standard should be evaluated regularly and appropriate changes to advice. There are some concerns about smokeless tobacco but the levels of risk reduction from different actions are not always clear and when this is the case it is harder to measure. |
| 104 | Royal College of General Practitioners | Statement 4 Question 9 | The recording of harm reduction approach could be easily documented if felt to be important – but the evaluation of change by the person harder to identify. |
| 105 | Royal College of Physicians | Statement 4 | For draft statement 4: Is the action in quality statement 4 appropriate for people who use smokeless tobacco?  No  For draft statement 4: The process measure for quality statement 4 measures the receipt of a harm-reduction approach to stopping smoking. Is this recorded by services currently, and if not, is it feasible to collect data on this?  Our experts believe this might be collectable via LG SSS and possibly via the new NHS LTP data collection especially in the Mental Health setting. |
| 106 | Royal College of Physicians and Surgeons of Glasgow | Statement 4 Question 8 | Our reviewer was not clear on this as it does not appear a problem in their locality. |
| 107 | Royal College of Physicians and Surgeons of Glasgow | Statement 4 Question 9 | In many centres it is recorded and if it is not it could be recorded. |
| 108 | The National Hypnotherapy Society | Statement 4 Question 8 | Yes. |
| 109 | The National Hypnotherapy Society | Statement 4 Question 9 | Not known. |
| 110 | The National Hypnotherapy Society | Statement 4 | Increasing motivation and achieving a reduction in harm for people who are not ready to or do not want to quit can be extremely challenging, as motivation to change is arguably crucial in quitting long-term. Hypnosis can be a long lasting and effective method for empowering smokers to change their habits and improve motivation towards smoking cessation. It also has no pharmacological side-effects so can be delivered to people of most ages and pregnant women, unlike some medications. Hypnotherapy also does not require long-term commitments to treatment sessions. Recent findings have also suggested that hypnotherapy can be just as effective if delivered online (Hasan et al., 2019), allowing for more convenient access to hypnotherapy to those who may be unwilling or unable to undergo in-person sessions.  The transtheoretical model of health behaviour change (Prochaska & Velicer, 1997) highlights six stages of behaviour change: precontemplation, preparation, action, maintenance, and termination. Munson, Barabasz & Barabasz (2018) examined the efficacy of hypnotherapy in the facilitation of movement through the stages of change for smoking cessation. They hypothesised that hypnosis would facilitate significantly greater movement through the stages of change. 30 participants who were smokers were split into two groups: a hypnosis group and a control group. Using the University of Rhode Island Change Assessment scale (URICA), the study addressed the participants’ feelings of motivation and ambivalence.  The results showed that the hypnotherapy group showed significant improvements on the contemplation and action subscales, as well as a significant reduction in the number of cigarettes smoked per day.  References:  Hasan, S. S., Pearson, J. S., Morris, J., Whorwell, P. J. (2019). Skype hypnotherapy for irritable bowel syndrome: effectiveness and comparison with face-to-face treatment. International Journal of Clinical and Experimental Hypnosis, 67(1), 69-80. <https://doi.org/10.1080/00207144.2019.1553766>  Munson, S. O., Barabasz, A. F., Barabasz, M. (2018). Ability of hypnosis to facilitate movement through stages of change for smoking cessation. International Journal of Clinical and Experimental Hypnosis, 66(1), 56-82. <https://doi.org/10.1080/00207144.2018.1396115>  Prochaska, J. O., Velicer, W. F. (1997). The transtheoretical model of health behaviour change. American Journal of Health Promotion, 12(1), 38-48. <https://doi.org/10.4278/0890-1171-12.1.38> |
| 111 | University College London Hospital | Statement 4 | It needs to be built in to our EPR that harm reduction and cutting down with the goal of quitting is recorded. Currently the hospital records those that want to quit as a yes/no. |
| 112 | Association of Respiratory Nurse Specialists | Statement 5 | The time interval might be too short. Would suggest 12 weeks. Also, clear communication between hospital and primary care must take place in order to support patient in smoking cessation and to allow primary care monitoring of the intervention effectiveness (unless fully delivered by hospital) |
| 113 | British Thoracic Oncology Group | Statement 5 | For draft statement 5: Process measure a) measures receipt of behavioural support within 24 hours of admission to hospital. How achievable is this for the majority of services?  Interventions for in-patients will be collected via the new NHS data collection- will include behavioural support alone.  For draft statement 5: We have suggested measurement of the proportion of people who smoked on admission to hospital who received stop-smoking support for at least 4 weeks after discharge and abstinence at 4 weeks to support outcomes for this quality statement. Do you agree with the use of these outcome measures and are the data sources appropriate to support these?  Yes |
| 114 | Department of Health and Social Care,  Office for Health Improvement and Disparities | Statement 5 Question 10 | Delivering behavioural support within 24 hours of admission to hospital is the NHS ambition, but we have not yet seen data on how realistic this is, or what % of referred inpatient smokers will be seen within this timeframe. We will have a clearer picture on this once NHS digital data on tobacco dependence treatment starts to flow. NICE should also clarify that the metric is the % of all smokers who **accept** a referral to inpatient support. There are two metrics of importance here, but they are separate – what proportion/number of smokers accept offer of behavioural support on admission, and what proportion/number of them are seen within 24 hours. |
| 115 | Department of Health and Social Care,  Office for Health Improvement and Disparities | Statement 5 Question 11 | This outcome measure doesn`t reflect the quality standard, which is focussed on the support delivered in hospital settings. Rather, by linking the outcome to only those who have accessed community SSS on discharge, this is only focussing on a minority of patients. Also, the data that will be collected for this cohort may not reflect 4 weeks after discharge, but instead may reflect 4 weeks after the patient last smoked (likely to be pre-admission), as this is when the SSS treat as the quit date. So we are not aware of any data collection which would support this measure as it is currently defined. Two alternatives would be to: 1. Measurement of the proportion of people who smoked on admission to hospital who received tobacco dependence support as inpatients and who self-reported as quit, 28 days following the start of their agreed quit window (i.e., the date of discharge from hospital for most inpatients). This is not linked to SSS support, and measures the longer term impact of the inpatient support. Or 2. Measurement of the proportion of people who smoked on admission to hospital who received stop-smoking support on discharge and were abstinent from smoking for 4-weeks from the date of their last cigarette. Option 2 would be more challenging to collect as it would involve combining multiple data sources in a way that has not yet been developed. Option 1 is to be captured as part of NHS LTP metrics. |
| 116 | Diabetes UK | Statement 5 Question 10 | We welcome the inclusion of this quality standard concerning inpatients who smoke and agree it is important that interventions are offered in this context. This measure may be practically achievable for services but we would emphasise the importance of an individualised and empathetic approach. Whilst there may be many other pressing concerns that a patient will have when admitted to hospital and think that specifying a time-window may encourage healthcare professionals to approach it at a time that doesn’t consider the wider patient experience and is less effective.  Instead, we would suggest that the 24 hour time window could be a recommended period with a caveat for healthcare professionals to consider if it is worth delaying this based on their assessment of a wider range of factors like the emotional wellbeing of the person who has been admitted. |
| 117 | Kent Community Health NHS Foundation Trust | Statement 5 | Given the funding provided at a local level I feel that there needs to be clear guidance on how acute settings can adapt and achieve this. If Acute trusts are using a Tobacco Dependence Adviser, locally trusts have enough funding to recruit to a part time member of staff to cover all admitted in patients – given this, I feel that being able to visit all patients admitted with a ‘yes’ smoking status within 24 hours is ambitious. It would be beneficial to provide supportive alternatives to Acute trusts in which would encourage training all ward/hospital staff in VBA (Very Brief Advice) techniques so that it becomes sustainable and embedded into hospital practices – by having all staff being able to have valuable conversations with patients about their smoking will provide resilience and ensure these questions and patients get the right support in a timely fashion. |
| 118 | NHSE (primary care) | Statement 5 Question 10 | NA to primary care but it is noted that it will not be appropriate to offer this support within 24 hours for all patients. |
| 119 | NHSE (primary care) | Statement 5 Question 11 | Yes, support to abstain is important post-discharge but will rely upon suitable follow up being in place to support and code abstinence. |
| 120 | NHSE (prevention team) | Statement 5 Question 10 | *For draft statement 5: Process measure a) measures receipt of behavioural support within 24 hours of admission to hospital. How achievable is this for the majority of services?*  A 24 hours one size fits all is not necessarily appropriate.  The NHS long term plan model of care identifies an ideal timescale of within 24 hours. However, not all providers will be of a size, or have prevalence rates to warrant 7-day services including bank holidays etc. This would potentially prejudice against small, low footfall (i.e., MH inpatient) providers – where costs of ensuring service delivery will be prohibitive. In some instances, providers are agreeing pathways based on 48 hours / 1 working day etc based on local circumstances.  Additionally, in Mental Health settings, it may not be clinically appropriate to commence behavioural support within 24 hours.   Would a process measure focussing on initial access to NRT follow admission to manage withdrawal be a more appropriate indicator – this could be issued by a range of staff including nurses upon admission if PGDs are agreed. |
| 121 | NHSE (prevention team) | Statement 5 Question 11 | *For draft statement 5: We have suggested measurement of the proportion of people who smoked on admission to hospital who received stop-smoking support for at least 4 weeks after discharge and abstinence at 4 weeks to support outcomes for this quality statement. Do you agree with the use of these outcome measures and are the data sources appropriate to support these?*  This deviates from traditional measures used by SS who only count once a quit is engaged. Comparative data will with SSS will therefore not be available. However, looking at the total number of smokers admitted is a better measure to help drive service to improve engagement.  Does stop smoking support relate to a combination of behavioural and NRT support – or just any support in isolation?  Current NHS services are funded to provide behavioural support whilst an inpatient and funded NRT following discharge – for this standard to work there need to be services in situ and locally commissioning arrangements in place (incl. funding) to extend behavioural support for the full 4 week period.  The complexity of multiple organisations across health and social care that will potentially support a pathway via differing commissioning, funding and delivery routes will make this difficult to track. There are also a number of queries from NHS and SSS about data sharing between providers. Some services are requesting cross charges in order to share information on the patient journey.  Additionally, in instances of NHS tertiary providers who have high numbers of out of area patients, it may not be possible to refer to specific step down care if it is unknown. In these instances, they may not be able to achieve the quality standard. |
| 122 | Royal College of General Practitioners | Statement 5 Question 10 | This is not a question that we have sufficient knowledge to comment on – but feel that early, timely interventions on TTD are important. That intervention may be appropriate within 24hrs – but may be better placed at a more appropriate time. (For example – patient admitted with confusion and chest infection who smokes would be better provided with behavioural support when the transient confusion settles and they are more receptive of interventions, same with severe trauma and other problems). |
| 123 | Royal College of General Practitioners | Statement 5 Question 11 | We are aware of a recurring debate about the value of 4-week abstinence rates but recognise that the NHS has adopted this as a measure for many years and to change would make previous comparisons difficult.  Regarding collection of data – that would be better answered by our colleagues within the hospital setting – though a single patient record would enhance the follow up and recording of this. |
| 124 | Royal College of Physicians | Statement 5 | For draft statement 5: Process measure a) measures receipt of behavioural support within 24 hours of admission to hospital. How achievable is this for the majority of services?  Interventions for in-patients will be collected via the new NHS data collection- will include behavioural support alone  For draft statement 5: We have suggested measurement of the proportion of people who smoked on admission to hospital who received stop-smoking support for at least 4 weeks after discharge and abstinence at 4 weeks to support outcomes for this quality statement. Do you agree with the use of these outcome measures and are the data sources appropriate to support these?  Yes |
| 125 | Royal College of Physicians and Surgeons of Glasgow | Statement 5 Question 10 | We believe this is feasible. |
| 126 | Royal College of Physicians and Surgeons of Glasgow | Statement 5 Question 11 | We consider this would be labour intensive, but some trusts have smoking cessation services which may be able to track this and may already collect data like this. |
| 127 | The National Hypnotherapy Society | Statement 5 Question 10 | I believe that the structure and staffing is in place, there would merely need to be training for all staff to implement this and be taught the importance of doing so. |
| 128 | The National Hypnotherapy Society | Statement 5 Question 11 | Yes, and yes. |
| 129 | The National Hypnotherapy Society | Statement 5 | I invite you to consider hypnosis as an option in the smoking support to quit upon admission to hospital. This is a short-term, non-pharmaceutical option that can produce lasting changes in motivation to quit.  A study by Hasan et al., (2015) compared the efficacy of hypnosis in comparison with nicotine replacement therapy (NRT) in a randomised controlled trial. The study consisted of 164 patients who had been hospitalized with a cardiac or pulmonary illness. The patients were randomised into one of three treatment groups: NRT for 30 days; a 90-minute hypnotherapy session, and NRT with hypnotherapy. These treatment groups were compared with a control group who declined intervention. The patients provided self-reports alongside biochemical verification for abstinence rates at 12- and 26-weeks post-hospitalisation. The results showed that the hypnotherapy group and hypnotherapy with NRT groups were three times more likely than the NRT group to abstain from smoking at both the 12 and 26-week time points.  Not only does this highlight the potential for hypnotherapy as a powerful tool for smoking cessation, but this study also illustrates the potential for providing the option of hypnotherapy alongside NRT or other smoking-cessation products to people admitted to hospital, as the plan to offer treatment at this time is already in motion to proceed. There is no risk for hypnotherapy on pregnant women or young people, so this method could be applicable for a wide range of ages and people. Hypnosis is also generally a short term, with significant improvements made in as little as 1 session, as seen in the study by Hasan et al., (2015).  Reference:  Hasan, F. M., Zagarins, S. E., Pischke, K. M., Saiyed, S., Bettencourt, A. M., Beal, L., Macys, D., Aurora, S., McCleary, N. (2014). Hypnotherapy is more effective than nicotine replacement therapy for smoking cessation: Results of a randomized controlled trial. *Complementary Therapies in Medicine, 22,*  1-8. Link: <https://pubmed.ncbi.nlm.nih.gov/24559809/> |
| 130 | University College London Hospital | Statement 5 | I agree with measuring outcomes for those that attend hospital at 4 weeks. Though I would go further to say that quit status should be measured beyond 4 weeks and support should be offered for at least 6 months post discharge, in line with the Ottawa model. Quit outcomes should be reviewed at 4 weeks, 3 months and 6 months and potentially at one year post discharge from hospital also. |
| 131 | Association of Respiratory Nurse Specialists | Local Practice Case Studies | Some practices uses Accrux to request smoking data from registered patients and allows for automatic SNOWMED coding based on patient’s response.  Some local PCN refers to patients who consent to smoking cessation support to the community well being team. This team has health care professionals who have received training in smoking cessation advisor & support. They also offer telephone or face to face support. I believe this works well within our PCN as documentation is all on the same IT system – so we are able to review the patient’s progress with their smoking cessation attempt. |
| 132 | British Thoracic Oncology Group | Question 12 | Do you have an example from practice of implementing the NICE guideline that underpins this quality standard?  Only QS statement 5 –data is currently being collected nationally by NHSE |
| 133 | NHSE | Question 12 | Not currently but conversations around integrating pathways (in light of the recent Fuller report) seem a good opportunity to ensure that abstinence in hospital continues to be supported in the community e.g., could be flagged on the discharge note as a new quitter who would benefit from ongoing support. |
| 134 | Royal College of General Practitioners | Question 12 | We are not aware of any specific local practice studies. |
| 135 | Royal College of Physicians | General Question 12 | Do you have an example from practice of implementing the NICE guideline that underpins this quality standard?  Only QS statement 5 - data is currently being collected nationally by NHSE |
| 136 | Royal College of Physicians and Surgeons of Glasgow | Question 12 | Not applicable. |
| 137 | The National Hypnotherapy Society | Question 12 | No. |

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

## Registered stakeholders who submitted comments at consultation

* Action on Smoking and Health (ASH)
* Allen Carr’s Easyway
* Association of Respiratory Nurse Specialists
* British Thoracic Oncology Group
* Department of Health and Social Care, Office for Health Improvement and Disparities
* Diabetes UK
* Kent Community Health NHS Foundation Trust
* NHS England
* Royal College of General Practitioners
* Royal College of Paediatrics and Child Health
* Royal College of Physicians
* Royal College of Physicians and Surgeons of Glasgow
* The National Hypnotherapy Society
* University College London Hospital