National Institute for Health and Care Excellence

Smoking cessation: supporting people to stop smoking
Quality Standard Consultation Comments Table

Note: "statement no" and "comment on" have been amended/added to by the technical analyst to reflect what they feel the comment most accurately concerns. This enables easier and more consistent categorisation for reviewing.

ID	Stakeholder ID	Stakeholder	Statement No	Comment on	Comments	Responses
1	1	The British Dental Trade Association Ltd	General	Support	The BDTA supports in principle the content and rationale of the Draft quality standard for smoking cessation. The BDTA fully supports the role that dentists can play as healthcare professionals in smoking cessation intervention. We are aware of the compelling evidence that links smoking with periodontitis, and believe that dentists and dental healthcare professionals can play an important part in smoking cessation and implementing this quality standard contributing to the NHS Outcomes framework 2013-14.	Thank you for your comments
20	3	British Dental Association	General	General	In order for the above to be achievable, services must be commissioned appropriately and commissioners must ensure that adequate funding, training and support are in place for dentists and other healthcare practitioners. This must be underpinned by the local Joint Strategic Needs Assessment and form part of the Joint Health and Wellbeing Strategy.	Thank you for your comments
24	4	The Royal College of Ophthalmologists	General	General	There is good evidence (Ref 1-4) that several ophthalmic disorders (age-related macular degeneration (AMD), cataract, thyroid eye disorder) are causally associated with tobacco smoking.	Thank you for your comments
25	4	The Royal College of Ophthalmologists	General	General	There is good evidence that there is low awareness of the risk of eye disease and smoking amongst patients and public and youth in England.(Ref 5-7)	Thank you for your comments

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26	4	The Royal College of Ophthalmologists	General	General	Furthermore there is evidence from England and Australia that the low awareness of this risk is a novel and compelling reason for quitting smoking. (Ref 5-8).	Thank you for your comments
27	4	The Royal College of Ophthalmologists	General	General	However there is room for improvement within the NHS in smoking cessation advice offered in optometry and ophthalmic settings in both community and secondary care.(Ref 9,10)	Thank you for your comments
28	4	The Royal College of Ophthalmologists	General	General	1. Thornton J, Edwards R, Mitchell P, Harrison RA, Buchan I, Kelly SP. Smoking and age-related macular degeneration: a review of association. Eye 2005;19:935-44. http://www.ncbi.nlm.nih.gov/pubmed/16151432; 2. Kelly SP, Thornton J, Edwards R, Sahu A, Harrison R. Smoking and cataract: review of causal association. Journal of Cataract & Refractive Surgery 2005;31:2395-404. http://www.ncbi.nlm.nih.gov/pubmed/16473237; 3. Thornton J, Kelly SP, Harrison RA, Edwards R. Cigarette smoking and thyroid eye disease: a systematic review. Eye 2005http://www.ncbi.nlm.nih.gov/pubmed/16980921; 4. Evans JR, Fletcher AE, Wormald RP. 28,000 Cases of age related macular degeneration causing visual loss in people aged 75 years and above in the United Kingdom may be attributable to smoking. Br J Ophthalmol 2005;89:550-3 http://www.ncbi.nlm.nih.gov/pubmed/15834082; 5. Bidwell G, Sahu A, Edwards R, Harrison RA, Thornton J, Kelly SP. Perceptions of blindness related to smoking: a hospital-based cross 8. http://www.ncbi.nlm.nih.gov/pubmed/16151433; 6. Moradi P, Thornton J, Edwards R, Harrison RA, Washington S, Kelly SP. Teenagers' perceptions of blindness related to smoking - nov British Journal of Ophthalmology 2007 http://www.ncbi.nlm.nih.gov/pubmed/17284473; 7. Moradi P et al Unpublished survey; School pupils' perceptions of blindness related to smoking - novel message to a vulnerable group. 2 of Ophthalmologists; 8. Carroll T, Rock B. Generating Quitline calls during Australia's National Tobacco Campaign: effects of television advertisement executio Control 2003;12:ii40-ii44. http://www.ncbi.nlm.nih.gov/pubmed/12878772; 9. Sahu A, Edwards R,	Thank you for your comments. We have now extended the healthcare practitioners to include ophthalmologists

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					Harrison RA, Thornton J, Kelly SP. Attitudes and behaviour of ophthalmologists to smoking cessation. Eye 2008 http://www.ncbi.nlm.nih.gov/pubmed/17016461; 10. Thompson C, Harrison RA, Wilkinson S, Hemmerdinger C, Kelly SP. Attitudes of community optometrists to smoking cessation: An un Ophthalmic Physiol Opt 2006. http://www.ncbi.nlm.nih.gov/pubmed/17584290	
36	6	Royal College of Paediatrics and Child Health (RCPCH)	General	Disagreement	We feel strongly that this quality standard has been put together without reference to the body of research relating to young people, so that several of the suggestions if implemented literally, would enshrine poor practice.	This quality standard is based on the evidence-based recommendations outlined in Public Health Guidance 1, Public Health Guidance 10 and Public Health Guidance 26. We have sought to note age considerations and have reiterated the advice that young people aged 12–17 should be offered information, advice and support on how to stop smoking and encouraged to use local NHS Stop Smoking Services by providing details on when, where and how to access them. This is consistent with the advice set out in the current published source guidance. In respect to pharmacotherapy, this statement should be implemented in the context of licensing indications and we note that professional judgement should be used to decide whether or not to offer NRT to young people over 12 years with a discussion about risks and benefits. In addition, the quality standard states that all statements should take account of the

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						needs of safety, effectiveness and professional judgment to recognise that full achievement may not always be appropriate in practice.
44	7	Rotherham Doncaster and South Humber NHS Foundation Trust	General	Support	This quality standard is achievable	Thank you for your support.
45	8	British Heart Foundation	General	General	The British Heart Foundation (BHF) is the UK's leading heart charity. We are leading the fight against coronary heart disease - the UK's single biggest killer- which is responsible for almost 74,000 deaths in the UK each year, an average of 200 people each day.[1] [2] Our pioneering research has helped to transform the lives of people living with heart and circulatory conditions, and we are fighting to achieve our vital vision of a world where no-one dies prematurely of heart disease. [1] British Heart Foundation (2013) Our Heart Disease Facts-February 2013 http://heartnet.bhf.org.uk/teams/bu/data/BHF_Health_publications/UK_health_statistics_Feb_2013.pdf [2] British Heart Foundation (2013)BHF statistics update- April 2013 http://heartnet.bhf.org.uk/teams/polcomms/multimedia/healthres/Shared%20Documents/BHF%20Statistics_Update_FINAL_April%202013.pdf	Thank you for your comments.
46	8	British Heart Foundation	General	General	We are actively involved in tobacco control issues because of the strong association between smoked tobacco and ill-health including coronary heart disease (CHD). Smoking is a major risk factor for CHD, and smokers are almost twice as likely to have a fatal heart attack as non-smokers. As the leading campaigning organisation on the issue of heart disease, and the organisation responsible for national No Smoking Day, the BHF has a strong vested interest in the draft quality standard and welcomes the opportunity to respond to the National Institute for Health and Care Excellence's consultation.	Thank you for your comments.

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62	9	Royal College of Surgeons of England	General	Support	This is a well thought out document so it's not surprising we have little to say, and while lots of dentists do smoking cessation, so does almost every other healthcare person so we cannot expect much specific to dentistry.	Thank you for your comments.
73	11	Johnson & Johnson	General	General	Johnson & Johnson welcomes the publication of the draft quality standard for smoking cessation and is pleased to have the opportunity to provide comments on this important document.	Thank you for your comments.
109	13	National Centre for Smoking Cessation and Training	General	Data Source	Stop Smoking Services: England, April 2011-March 2012 Will this source still be available in the future? Clarification on this has not yet been officially notified. This collection doesn't currently published breakdowns of pharmacotherapy use by local area or length of treatment. This collection also only relates to smokers seen through commissioned stop smoking services and therefore will not reflect 'all smokers'.	The data sources section is intended to suggest areas that users may find helpful when trying to demonstrate achievement of the statement. NICE are unable to comment on the future availability of external documents.
114	14	National LGB&T Partnership	General	Equality and diversity	This should include recognition of the health inequalities related to smoking experienced by groups with protected characteristics, such as LGB&T people.	Statement 1 now contains additional information within the equality and diversity considerations section relating to LGBT groups and to recognise that they may experience health inequalities.
115	14	National LGB&T Partnership	General	Equality and diversity	The data collection methods for the proposed quality measures are appropriate. However, due to a lack of sexual orientation and gender identity monitoring across the healthcare system, it is impossible to know whether LGB&T people are accessing stop smoking services in proportions consistent with their higher likelihood of smoking, or whether there are differences in service access and experience between LGB&T people and heterosexual and cis-gendered people. The National LGB&T Partnership recommends the implementation of sexual orientation and gender identity monitoring across the healthcare system in order to tackle health inequalities related to smoking.	The QSAC prioritised the areas of care they felt were most important for patients, based on the development sources listed. The QSAC prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the QSAC who

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						considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.
116	14	National LGB&T Partnership	General	Equality and diversity	Some LGB&T people may respond better to cessation services provided by the voluntary organisations run by and for particular groups with protected characteristics, e.g. LGB&T people	The QSAC prioritised the areas of care they felt were most important for patients, based on the development sources listed. The QSAC prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the QSAC who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to

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						be implemented.
117	14	National LGB&T Partnership	General	Equality and diversity	As part of delivering smoking-awareness and education, GPs should explain to their trans service users that smoking undermines hormone therapy, and may prevent them from undergoing certain surgeries. Smoking-cessation treatment should be offered.	The QSAC prioritised the areas of care they felt were most important for patients, based on the development sources listed. The QSAC prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the QSAC who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.
118	14	National LGB&T Partnership	General	Equality and diversity	One of the QS Key Performance Indicators is reducing smoking among high risk groups. LGB&T people are a high risk group, so it is unclear why the document fails to acknowledge this.	Statement 1 now contains additional information within the equality and diversity considerations section relating to LGBT groups and to recognise that they may experience health inequalities.

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135	18	Royal Pharmaceutical Society	General	General	The Royal Pharmaceutical Society are pleased that pharmacists have been highlighted as healthcare professionals who can support patients to stop smoking. As experts in medicines, pharmacists offer advice on how to take medicines, adverse effects, possible interactions and cautions, to raise patients' awareness and increase their understanding of their therapy, which will encourage medicines adherence and empower self-care. Pharmacists also have a key role in public health promoting the benefits of stopping smoking and raising awareness of the health risks and dangers associated with smoking. An increasing number of pharmacists are qualifying as independent prescribers, and they play an important role in the prescribing of and advising on smoking cessation medication. As the professional body for pharmacists and pharmacy we have produced a quick reference to support our members in helping their patients stop smoking, published guidance about the sale of electronic cigarettes, and worked closely with the British Heart Foundation to support pharmacist in the promotion of national No Smoking Day and the distribution of Quit Kits in England.	Thank you for your comments
141	19	Primary Care Respiratory Society	General	Statement	If the Quality standard is to make a difference, it needs to be strengthened on its application to the acute setting. There is often a key opportunity to impart health promotion messages in the immediate aftermath of an acute event, and these opportunities need to be capitalised upon. Yet such intervention is far from routine in secondary care. Commissioners should expect acute providers to provide interventions such as smoking cessation services, and to document and audit that they are doing so.	Thank you for your comments. Additional information has been added to statement 1 to highlight that this statement is applicable to the acute setting.
161	21	Royal College of General Practitioners	General		As smoking is one of the most cost-effective health care indications and many clinicians are exposed to people who smoke it would be good practice that "Every health care professional undertakes regular updating (every 2 years maximum) on brief interventions and motivational interviewing training (includes primary / secondary / community staff)"	Thank you for your comments. We include a paragraph on training and competencies in the Introductory section, however Quality standards do not typically contain statements on training and development, as this is an assumed aspect for those wishing to

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						achieve the individual statements.
169		Royal College of Nursing	General	General	Made no comment	Thank you for your response.
2	1	The British Dental Trade Association Ltd	General	Support	The BDTA supports the 6 draft quality statements outlined, along with the underlying proviso that all healthcare professionals involved are sufficiently and appropriately trained and competent to deliver the relevant interventions.	Thank you for your response.
23	4	The Royal College of Ophthalmologists	General	Outcomes framework	The Royal College of Ophthalmologists is pleased to see the link made between this Quality Standard and the Public Health Outcomes Framework; Domain 4: Healthcare public health and preventing premature mortality, 4.12 Preventable sight loss.	Thank you for your comments
74	11	Johnson & Johnson	General	Support	Johnson & Johnson is broadly supportive of the draft quality standards as outlined on Page 6 notwithstanding the following comments.	Thank you for your comments
103	13	National Centre for Smoking Cessation and Training	General	Data Source	Stop Smoking Services: England, April 2011-March 2012 Will this source still be available in the future? Clarification on this has not yet been officially notified.	The data sources section is intended to suggest areas that users may find helpful when trying to demonstrate achievement of the statement. NICE are unable to comment on the future availability of external documents.
91	13	National Centre for Smoking Cessation and Training	General	Scope	This section refers to 'NHS-provided' and 'NHS-commissioned' services; how is this going to sit with local authorities who are now responsible for providing / commissioning public health?	Thank you for your comments. We have updated the quality standard to reflect this change in commissioning responsibility. This will also be reflected in the NICE support for commissioning tool for this standard will also reflect the changes in the structure and organisation of smoking cessation services.

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37	6	Royal College of Paediatrics and Child Health (RCPCH)	Introduction		The introduction should include the effects of passive smoking on young people. Reference. Tobacco Advisory Group of the Royal College of Physicians. Passive Smoking and Children, London; RCP 2010.	This scope of this quality standard is support for people to stop smoking and accessing stop smoking services.
3	1	The British Dental Trade Association Ltd	Question 1	Support	We believe that the draft quality standard encompasses the main areas for quality improvement in this area.	Thank you for your comments
15	2	London Respiratory Team	Question 1	Support	1. Yes - the draft QS accurately reflects the key areas for quality improvement, with the additional suggestions above	Thank you for your comments
69	10	Pfizer Limited	Question 1	Addition	Pfizer believes that the draft quality standard does accurately reflect some of the key areas for quality improvement but that the following two areas are important omissions that the NICE expert committee should consider including.	Thank you for your comments
71	10	Pfizer Limited	Question 1	Addition	2. Most smokers will make between 5 and 7 quit attempts before they succeed (Hughes 2004). Therefore where a record of a smoking cessation attempt exists, current smoking status should be recorded where possible at future visits to a health care professional, and if someone is still smoking, it is reasonable to offer them a second smoking cessation intervention. Pfizer therefore proposes a seventh quality statement: People with a record of a previous smoking cessation attempt are asked by their healthcare professional if they smoke and are referred to an evidence-based stop smoking service if they do. Numerator – the number of people in the denominator who are referred to an evidence-based stop smoking service. Denominator – the number of people identified as smokers in any health care setting with a previous quit attempt.	The QSAC prioritised the areas of care they felt were most important for patients, based on the development sources listed. The QSAC prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the QSAC who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements.

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						The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.
72	10	Pfizer Limited	Question 1	Addition	References 1. Ferguson J, Bauld L, Chesterman J, Judge K. The English smoking treatment services: one-year outcomes. Addiction. 2005 Apr;100 Suppl 2:59-69. 2. Hughes JR et al. Addiction 2004; 99: 29–38.	Thank you for your comments
70	10	Pfizer Limited	Question 1	Question 1	1. There is evidence from the UK smoking cessation service that 75% of smokers initiating a quit attempt will be smoking again 1 year after the attempt, with 39% of quit failures responding that they relapsed within 12 weeks of the 4-week quit date (Ferguson, 2005). This suggests that a follow-up appointment to assess smoking status at 12 weeks may motivate a significant number of potential quit failures (more than one third) to remain smoke-free until this time-point which may in turn facilitate a longer-term quit for many of these individuals. Pfizer therefore proposes that quality statement 6 be amended to the following: People who smoke who have set a quit date are offered carbon monoxide testing 4 weeks and 12 weeks after the quit date Additional numerator – the number of people in the denominator who receive carbon monoxide testing 12 weeks after the quit date. Denominator– the number of people who smoke who have set a quit date.	The QSAC discussed several alternative timeframes and felt that recording smoking status using carbon monoxide testing after 4 weeks (as stated in the NICE source guidance) remains a useful and pragmatic time point with which to maintain the engagement of service users. Also, importantly it is noted in the definitions sections in the Quality Standard that this 4 week point does not imply that treatment should stop at 4 weeks. The 4 week time point selected for this particular statement is supported by the current published underpinning source guidance for the quality standard. As with all quality standard measures this is not a mandatory indicator and could be used alongside other follow up

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						timeframes adopted by the smoking cessation service. The statement applies to those providing smoking cessation services and the 4 week quit date can be applied through the statement measures as a marker of quality. The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the smoking cessation services public health guidance (PH10). The quality standards do not seek to reassess or redefine the evidence base as outlined in the national accredited guidance.
90	12	British Thoracic Society	Question 1	Addition	We very much welcome the development of quality standards for smoking cessation and supporting people to stop. However we would have been pleased to see some standards on **minimum service to be provided in hospitals** for in- patient and outpatient smokers. This would reflect, firstly, an acceptance that Stop Smoking is a TREATMENT for sick smokers, and secondly, a commitment to providing this treatment as a core medical intervention.	The QSAC prioritised the areas of care they felt were most important for patients, based on the development sources listed. The QSAC prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the QSAC who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key

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						markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.
92	13	National Centre for Smoking Cessation and Training	Question 1	Addition	The addition of national training standards could be included in relation to evidence-based stop smoking services. These have been researched, identified and published by the NCSCT, and have been referenced by NICE in previous documents: http://www.ncsct.co.uk/publication_ncsct-training-standard-learning-outcomes-for-training-stop-smoking-practitioners.php	Thank you for your comment. In the Definition section for Quality Statement 1 and 2, NCST is signposted.
124	15	Department of Health	Question 1	Addition	Overall this quality standard does reflect well the current standards required of services. I would like to see a further development of these that go beyond what is currently provided and start to indicate what will be optimal in the world of Local Authority commissioned services. For example quality around outcomes, why are we measuring 4 week quits as an outcome, surely they are a stepping stone to the desired outcome of lifelong cessation? What scope is there that looks at appropriate re-engagement as a quality measure, did the person seek the service again because they had such a good experience, or because they felt that they were a hopeless case and only knew that they needed help? Are people being 'recycled' through the same treatment pathways time after time or are they being effectively segmented and offered services according to need rather than geographical or situational location? Is the number of attendances at a stop smoking service linked to increasing or decreasing effectiveness of outcome? Are service users encouraged to set their own goals and objectives or are they subject to the goals and objectives of the service or advisor that attends to them? How do services rate on a national scale of user satisfaction that is independently	Thank you for your comment. The QSAC discussed several alternative timeframes and felt that recording smoking status using carbon monoxide testing after 4 weeks (as stated in the NICE source guidance) remains a useful and pragmatic time point with which to maintain the engagement of service users. Also, importantly it is noted in the definitions sections in the Quality Standard that this 4 week point does not imply that treatment should stop at 4 weeks. The 4 week time point selected for this particular statement is supported by the current published underpinning source

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					audited and not based on how 'nice' they thought the advisor was to them? What if any are the quality standards that can be linked to a reduction in smoking prevalence?	guidance for the quality standard. As with all quality standard measures this is not a mandatory indicator and could be used alongside other follow up timeframes adopted by the smoking cessation service. The statement applies to those providing smoking cessation services and the 4 week quit date can be applied through the statement measures as a marker of quality. The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the smoking cessation services public health guidance (PH10). The quality standards do not seek to reassess or redefine the evidence base as outlined in the national accredited guidance. We have also updated the quality standard to reflect this change in commissioning responsibility. This will also be reflected in the NICE support for commissioning tool for this standard will also reflect the changes in the structure and organisation of smoking cessation services.

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	23	Lundbeck	Question 1	Addition	Lundbeck welcomes the proposed quality standard, particularly quality statement one on healthcare professionals asking people if they smoke, and brief advice being offered as appropriate. However, given the epidemiological overlap between smoking and alcohol consumption and the clinically and cost-effective evidence supporting screening and brief interventions for alcohol misuse we recommend incorporating screening for alcohol misuse within quality statement one. Harmful alcohol use is listed alongside tobacco use as the top 2 risk factors for early death and disability in the UK in Volume One of the Chief Medical Officer's Annual Report (as according to The WHO national burden of disease toolkit. There is a well-established epidemiological overlap between smoking and alcohol consumption, as supported by recent studies: • A US study in 2006 found that smokers drank in higher quantities than non-smokers and had 4.5-fold higher odds of suffering from an alcohol use disorder. The results were consistent with the hypothesis that there is a higher vulnerability to alcohol use disorders among smokers compared to non-smokers drinking equivalent amounts. • Analysis of Welsh population data from 2008 (of approximately 13,000 respondents) found that both current smokers (at 50.2%) and ex smokers (at 49.6%) were more likely to report drinking above the recommended guidelines on at least one day in the previous week, compared to those who had never smoked (at 39.3%). This trend was particularly pronounced amongst men . Furthermore, studies of brain metabolite levels and neurocognition suggest that chronic smoking impairs neurobiological recovery when alcohol-dependent individuals stop drinking. Screening and brief interventions for alcohol misuse have been shown to be both clinically and cost-effective in changing a person's behaviour in reducing their alcohol intake over a period of time, as supported by recent studies: • Kaner et al. identified a total of 29 controlled trials from various countries, in general practice (24 trials) or an emergency setting (five trials). Participants drank an average of 306 grams of alcohol (over 30 standard drinks) per week on entry to the trial. Over 7,000 participants received a brief intervention or a control intervention, including assessment only. After one year or more, people who received the brief intervention drank less alcohol than people in the control group (average difference 38 grams/week, range 23 to 54 grams) . • A US study review of existing evidence suggested that screening and brief counselling was cost-saving from the societal perspective and had a cost-effectiveness ratio of $1755/QALY saved from the health-system perspective.	The QSAC prioritised the areas of care they felt were most important for patients, based on the development sources listed. The QSAC prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the QSAC who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.

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4	1	The British Dental Trade Association Ltd	Question 2	General	Data collection across all health professionals involved in implementation and intervention should be achievable. However, we would wish to see the simplest systems used to collect data to avoid onerous requirements on healthcare professionals, which could be self-defeating in terms of widespread implementation.	Thank you for your comments.
16	2	London Respiratory Team	Question 2	Support	2. Yes - it would be possible to collect the data	Thank you for your comments
93	13	National Centre for Smoking Cessation and Training	Question 2	Support	Having measures for all of the suggested quality measures would enable the effective monitoring and recording of smokers, the interventions offered, uptake of these and outcomes. This is vital in ensuring the on-going commissioning of services relevant to the needs of smokers and maintaining standards for high quality and effective interventions.	Thank you for your comments
125	15	Department of Health	Question 2	Support	Yes these should all be collectable and reportable. The key will be in collection that is sufficiently granular enough to allow sensitive decisions to be made at a local level.	Thank you for your comments
5	1	The British Dental Trade Association Ltd	**S01**	Definitions	The BDTA fully supports this approach to intervention and welcomes the recognition of the role of dentists in implementing the standard. We would also suggest that the definition of healthcare professionals also incorporates all relevantly qualified/trained Dental Care Providers (DCPs).	Thank you for your comments. The list of healthcare professionals is not designed to be exhaustive.
12	2	London Respiratory Team	S01	Source	Suggest refer to http://guidance.nice.org.uk/QS23 (Drug use disorders)	Thank you for your comment. The Drug Use Disorders Quality Standard is not designed to focus on tobacco use and therefore was not felt to be a related source.
11	2	London Respiratory Team	S01	Statement	1. Suggest add "Healthcare professionals should also consider asking people if they smoke other substances in addition to tobacco, especially cannabis and/or heroin" (or mention in introduction)	The QSAC prioritised the areas of care they felt were most important for patients, based on the development sources listed. The QSAC prioritised areas of care where practice is variable, or where

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						implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the QSAC who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.
13	2	London Respiratory Team	S01	Statement	2. Suggest add “This includes at point of admission to hospital where patients should be offered NRT if appropriate. There is evidence of improved quitting in this setting, even if the person hasn’t expressed a desire to quit, by taking advantage of this period of enforced abstinence (since all hospital should be smoke-free)”	Thank you for your comments. The rationale section has been modified to highlight that this statement is equally applicable to secondary care.
21	3	British Dental Association	S01	Statement	The "brief advice" provided by healthcare practitioners including dentists must be followed up by specialist support groups. If networks in each Area Team are available and standard pro formas with all contact details are provided then the system can be made workable.	The QSAC prioritised the areas of care they felt were most important for patients, based on the development sources listed. The QSAC prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential

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						to generate measurable indicators. All suggestions for additional statements were discussed by the QSAC who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.
18	3	British Dental Association	S01	Support	The BDA supports the role of dentists in ascertaining the smoking status of patients, providing brief advice on cessation and referring on to evidence-based stop smoking services, as outlined in Quality statements 1 and 2.	Thank you for your comments
29	5	Royal College of Midwives	S01	Support	Agree.	Thank you for your comments
42	6	Royal College of Paediatrics and Child Health (RCPCH)	S01	Statement	Consider adding in the offer of smoking cessation to parents/carers who bring children to GPs with (secondary smoke) smoking related conditions: asthma/ ear infections/ other respiratory conditions.	This Quality Standard does not constitute guidance document and would not provide this level of detailed advice. Statement 1 provides the starting point for identifying people who smoke.
38	6	Royal College of Paediatrics and Child Health (RCPCH)	S01	Support	An appropriate standard for adults, and probably for young people, although evidence for effectiveness of brief intervention in the latter group is lacking.	This quality standard is based on the evidence-based recommendations outlined in Public Health Guidance 1, Public Health Guidance 10 and Public Health Guidance 26. We have sought to note age considerations and have reiterated the advice that young people

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						aged 12–17 should be offered information, advice and support on how to stop smoking and encouraged to use local NHS Stop Smoking Services by providing details on when, where and how to access them. This is consistent with the advice set out in the current published source guidance. In respect to pharmacotherapy, this statement should be implemented in the context of licensing indications and we note that professional judgement should be used to decide whether or not to offer NRT to young people over 12 years with a discussion about risks and benefits. In addition, the quality standard states that all statements should take account of the needs of safety, effectiveness and professional judgment to recognise that full achievement may not always be appropriate in practice.
48	8	British Heart Foundation	**S01**	Statement	We also agree with the statement *'Support to quit smoking is not offered routinely to people with COPD, particularly during admission to hospital. This is a wasted opportunity to make every contact count.'*	Thank you for your comments. The rationale section has been modified to highlight that this statement is equally applicable to secondary care.
49	8	British Heart Foundation	**S01**	Statement	We would like to extend this standard to include all hospital admissions, in particular all cardiac patients, whether acute or elective. Elective surgical outcomes following smoking cessation prior to operation are improved. The suggested data sources, however, do not appear to cover patients admitted to hospital. Including this in commissioning contracts may act to drive the development of appropriate data collection.	Thank you for your comments. The rationale section has been modified to highlight that this statement is equally applicable to secondary care.

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47	8	British Heart Foundation	**S01**	Support	We agree this is an important first step and is measurable in primary care through the Quality and Outcomes Framework (QOF) data sets.	Thank you for your comments
60	9	Royal College of Surgeons of England	S01	Data Source	With regard to the draft quality statements, 1 and 2 are relevant to the Faculty of Dental Surgery and Faculty of General Dental Practice, Royal College of Surgeons of England: 1. People are asked if they smoke by their healthcare professional, and those who smoke are offered brief advice on how to stop.2. People who smoke are referred to an evidence-based stop smoking service. We would also highlight the Very Brief Advice Training Module offered by the National Centre for Smoking Cessation and Training as an excellent learning tool for those giving smoking cessation advice.	Thank you for your comments. The definitions section provides a link to training available from the NCSCT.
58	9	Royal College of Surgeons of England	S01	Statement	With regard to the draft quality statements, 1 and 2 are relevant to the Faculty of Dental Surgery and Faculty of General Dental Practice, Royal College of Surgeons of England: 1. People are asked if they smoke by their healthcare professional, and those who smoke are offered brief advice on how to stop.2. People who smoke are referred to an evidence-based stop smoking service. We would strongly agree with both of these statements.	Thank you for your comments.
75	11	Johnson & Johnson	S01	Support	Johnson & Johnson is supportive of draft quality statement 1.	Thank you for your comments.
86	12	British Thoracic Society	S01	Statement	There is no standard or guidance about **training** of frontline healthcare professionals in delivering brief advice or in understanding basic principles of supporting behaviour change (motivational interviewing)	Thank you for your comments. We include a paragraph on training and competencies in the Introductory section, however Quality standards do not typically contain statements on training and development, as this is an assumed aspect for those wishing to achieve the individual statements.

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96	13	National Centre for Smoking Cessation and Training	S01	Definitions	The NCSCT statement would be more accurate as: The National Centre for Smoking Cessation and Training offers a 'Very Brief Advice on Smoking' online training module for all healthcare professionals to ensure brief interventions are delivered in a sensitive and effective way within the brief available timeframe of patient contact.	Thank you for your comments. The text has now been modified.
95	13	National Centre for Smoking Cessation and Training	S01	Statement	There is a risk associated with having the identification of smokers plus the delivery of brief advice as a separate quality statement to the referral of smokers. To maximise client contact time and to minimise the burden upon the healthcare professional (HCP), referral has become an integral part of delivering brief advice rather than an adjunct. The referral ('ACT' element in the Ask, Advise, Act 30 seconds very brief advice model) is essential in making the intervention effective – there is little benefit if the HCP only advises a patient about where they could get help if they don't then proactively support the patient to access support. It would therefore be better if these two quality statements could be combined or more clearly linked. If this is not possible, then this statement could be further enhanced e.g. People are asked if they smoke by their healthcare professional, and those who smoke – as a minimum – are provided with brief advice on how to stop	Additional text has now been added to the definitions sections to clarify the link between these two statements.
113	14	National LGB&T Partnership	S01	Equality and diversity	Consideration should also be given to the needs of lesbian, gay, bisexual and trans (LGB&T) people. These groups have higher rates of smoking than the general population (studies suggest LGB&T people could be up to twice as likely to smoke as heterosexual and cis-gendered people [see American Lung Association 2010, Stonewall 2008 and 2012, LGF 2011 and Rooney 2012]). Stop smoking campaigns are often aimed at heterosexual audiences and therefore do not speak to LGB&T people.	Thank you for your comments. Additional text has been added to the equality and diversity section to recognise this.

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126	16	South West Yorkshire NHS Foundation Trust	S01	Definitions	"and those who smoke are offered brief advice on how to stop" **Brief advice encourages smokers to stop, the support available and may include brief information on pharmacotherapies rather than focusing on how to stop.**	The QSAC felt that a discussion of pharmacotherapy would be included when providing advice on how to stop. Pharmacotherapy is included as a standalone statement.
136	18	Royal Pharmaceutical Society	S01	General	Community and hospital pharmacists, and their support staff have a valuable role to play in assisting patients stop smoking, including identification of patients who may want to stop smoking, offering brief interventions, and signposting to specialist services where appropriate. Pharmacists can also offer lifestyle advice help patients manage withdrawal symptoms and offer behavioural support to patients who relapse. Community pharmacies are conveniently located and are readily accessible due to longer opening hours, and there is no need for patients to make an appointment. Premises therefore offer informal settings which could encourage people who may be reluctant to visit their GP or stop smoking clinics to seek support and advice.	Thank you for your comments. The quality statement is not designed to provide an exhaustive list of the specific services that specific healthcare professionals can provide.
150	20	NICE	S01	Data Source	The audit document produced for PH1 was 'audit criteria' rather than 'audit support'. However, I don't think it is very useful to refer to this document as a data source. It only includes audit criteria (that isn't an exact match with the process measure) and doesn't include any practical help to collect data. **The audit criteria is also given as a data source for statements 2 and 4 and I think it should be removed from these statements too.**	The data sources section is intended to suggest areas that users may find helpful when trying to demonstrate achievement of the statement.
151	20	NICE	S01	Data Source	NICE public health guidance 10 audit support criterion 8 is quoted as a data source for process measure a) but this only relates to pregnant women so I'm not sure how helpful it is to refer to it in this standard which refers to anyone in contact with a healthcare professional.	The data sources section is intended to suggest areas that users may find helpful when trying to demonstrate achievement of the statement.
152	20	NICE	S01	Data Source	NICE public health guidance 10 audit support criteria 3, 4, and 8 is quoted as a data source for process measure b). Would all these criteria need to be met for	The data sources section is intended to suggest areas that users may find helpful

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					a person to fall into the numerator (i,e, to have received brief advice on how to stop). If not, perhaps some/all of the criteria should be removed?	when trying to demonstrate achievement of the statement.
153	20	NICE	S01	Data Source	However, the audit team don't think that it is appropriate to reference the self assessment (or baseline assessment) tools in the quality standards. **This document is also given as a data source for statements 2, 3, 4, 5 and 6 and I think it should be removed from these statements too.**	Reference to the self-assessment tool has now been removed
148	20	NICE	S01	Measure	I think the denominator for process measure a) should refer to contact with **a** healthcare professional (rather than healthcare professionals) and the denominator for measure b) should refer to face-to-face contact (rather than contacts). Otherwise, it would be necessary to quantify how many professionals/how many contacts would need to apply before the person was counted in the denominators.	The measure has been amended
149	20	NICE	S01	Rationale	The rationale states that people who smoke are 'more receptive' to smoking cessation advice in healthcare settings. More receptive that what? I think to be meaningful this needs to be put in context.	The rationale section has been amended
160	21	Royal College of General Practitioners	S01	Statement	I think the first standard should be amended or an additional standard added. It is clearly suggested in the documentation that people are more responsive to cessation if counselled in a health care environment. Any patient who has a smoking related (or smoking aggravated) condition (eg bronchitis / asthma / COPD / children's respiratory infections / angina / review of angina / stroke etc) should be specifically targeted and if systems developed to ensure smoking history and appropriate advice given.	Thank you for your comments. The rationale section has been modified to highlight that this statement is equally applicable to secondary care.

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163	22	Optical Confederation and the College of Optometrists	S01	Definitions	In draft quality statement 1 (Identifying people who smoke) the definition statement is: "Healthcare professionals include but are not limited to doctors, nurses, midwives, pharmacists and dentists." Notwithstanding the clear relationship between smoking and cancers, heart and lung disease and low birth weight babies, there is an equally important causal relationship between smoking, sight loss and blindness. Smokers have triple the incidence of age-related macular degeneration compared with non-smokers1 and smoking is strongly associated with cataracts2. Research elsewhere suggest the public have little awareness that smoking increases the risk of sight loss and that such campaigns can be effective3; especially among teenagers who are more scared of losing sight than of lung or heart disease4. A warning that smoking causes blindness will be included on cigarette packets across the EU in the coming years and already exists in Australia5. In our view it is vital that this is highlighted by the inclusion of optometrists and opticians in the list above. Whilst we accept that the broad statement indicates the range of healthcare professionals that could ask their patients whether they smoke, and offer those who smoke brief advice on how to stop, optometrists and opticians have a major and influential role (sight being the sense people of all ages fear losing most). Many eye health consultations already include advising and counselling smokers on their increased risk, the benefits of stopping and, where appropriate, referral to a local stop smoking service. We would be grateful if this could be amended. We have also asked for the same inclusion to be made in draft quality statement 2 and for the same reasons	We have added opticians to the definition section of Statement 1 and optometrists are defined as part of allied health professionals

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164	22	Optical Confederation and the College of Optometrists	S01	Definitions	[1] Cong, R , et al (2008). Smoking and the risk of age-related macular degeneration: a meta-analysis. Ann Epidemiol; 18:647–656. 2 Kelly, SP, et al (2004). Smoking and blindness: strong evidence for the link, but public awareness lags. BMJ; 328:537–8 3 Carroll, T, Rock, B. (2003) Generating Quitline calls during Australia's National Tobacco Campaign: effects of television advertisement execution and programme placement. Tobacco Control ; 12(Suppl II):ii40–ii44 4 Moradi, P, et al (2007). Teenagers' perceptions of blindness related to smoking: a novel message to a vulnerable group. Br J Ophthalmol; 91:605–607. 5 http://www.quitnow.gov.au/internet/quitnow/publishing.nsf/content/warnings-b-eye	Thank you for your response.
6	1	The British Dental Trade Association Ltd	**S02**	Support	We support the principle that healthcare providers are able to refer smokers to an evidence-based stop smoking service.	Thank you for your comments
22	3	British Dental Association	S02	Data Source	The local audit suggested on page 10 would be very time consuming for general dental practitioners, and would be unlikely to be carried out in the absence of recognition within the payment system.	Thank you for your comments. The data sources section is intended to suggest areas that users may find helpful when trying to demonstrate achievement of the statement. Quality standards do not have associated payments however may be used locally as part of locally developed incentive schemes such as CQUIN.
19	3	British Dental Association	S02	Support	The BDA supports the role of dentists in ascertaining the smoking status of patients, providing brief advice on cessation and referring on to evidence-based stop smoking services, as outlined in Quality statements 1 and 2.	Thank you for your comments

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30	5	Royal College of Midwives	**S02**	Statement	Broadly agree, but need to consider that not all pregnant smokers would wish to be referred to cessation services – for example, some recent qualitative research conducted by Tommy's (see http://www.tommys.org/document.doc?id=173) suggests that young pregnant smokers feel judged by these services. In some circumstances, such as where people want to quit on their own, offering quit packs and providing brief interventions may be more appropriate than a full referral.	We appreciate your comments. Please note that the statement is expressed as an offer for referral which emphasises choice and decision making with the pregnant women.
39	6	Royal College of Paediatrics and Child Health (RCPCH)	S02	Measure	Given the evidence base, referral should not be mandatory for young people, who should be excluded from the numerator in the quality measure and from the target audience. Twenty years of age might be a rational cut off point, please see evidence below.	This quality standard is based on the evidence-based recommendations outlined in Public Health Guidance 1, Public Health Guidance 10 and Public Health Guidance 26. We have sought to note age considerations and have reiterated the advice that young people aged 12–17 should be offered information, advice and support on how to stop smoking and encouraged to use local NHS Stop Smoking Services by providing details on when, where and how to access them. This is consistent with the advice set out in the current published source guidance. In respect to pharmacotherapy, this statement should be implemented in the context of licensing indications and we note that professional judgement should be used to decide whether or not to offer NRT to young people over 12 years with a discussion about risks and benefits. In

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						addition, the quality standard states that all statements should take account of the needs of safety, effectiveness and professional judgment to recognise that full achievement may not always be appropriate in practice.
50	8	British Heart Foundation	**S02**	Measure	We agree with the standard reflecting an area for quality improvement. To ensure the standard is accurately monitored, patients referred to smoking cessation services in hospital should be included in the numerator- the number of people identified as smokers in any healthcare setting who are referred to an evidence-based stop smoking service. It is not clear how this will be achieved.	This quality statement applies to all healthcare settings.
61	9	Royal College of Surgeons of England	S02	Source	With regard to the draft quality statements, 1 and 2 are relevant to the Faculty of Dental Surgery and Faculty of General Dental Practice, Royal College of Surgeons of England: 1. People are asked if they smoke by their healthcare professional, and those who smoke are offered brief advice on how to stop.2. People who smoke are referred to an evidence-based stop smoking service. We would also highlight the Very Brief Advice Training Module offered by the National Centre for Smoking Cessation and Training as an excellent learning tool for those giving smoking cessation advice.	Thank you for your comments. The definitions section of statement 1 provides a link to training available from the NCSCT. We also clarify a link between statements 1 and 2.
59	9	Royal College of Surgeons of England	S02	Statement	With regard to the draft quality statements, 1 and 2 are relevant to the Faculty of Dental Surgery and Faculty of General Dental Practice, Royal College of Surgeons of England: 1. People are asked if they smoke by their healthcare professional, and those who smoke are offered brief advice on how to stop.2. People who smoke are referred to an evidence-based stop smoking service. We would strongly agree with both of these statements. However, we would suggest that Statement 2 should say ‘offered a referral to a stop smoking service’, rather than ‘are referred’; the patient must agree to the referral, otherwise we risk damaging the relationship between the practice and patient.	Thank you for your comments. The statement has now been amended.

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63	10	Pfizer Limited	S02	Definitions	Pfizer welcomes the inclusion of a statement focusing on referral of people who smoke to an evidence-based stop smoking service. NICE provides the following definition of an evidence-based stop smoking service on p.11: 'Evidence-based stop smoking services are local services providing accessible, evidence-based and cost-effective support to people who want to stop smoking. ' This is a broad definition which does not fully account for the fact that service configurations are changing (PCT-commissioned smoking cessation services were replaced with local authority commissioned services on 1 April 20131), and many GP surgeries and other providers, in addition to specialist stop smoking services, may be offering behavioural support + pharmacotherapy now or in the near future. In addition, 'evidence-based' presumably refers to the fact that the performance of a specific local smoking cessation service is measured by patient outcomes, e.g. the proportion of smokers with a recorded target quit date (TQD) who have a record of being smoke-free at 4 weeks after TQD. However, this particular metric, used for PCT-commissioned smoking cessation services, is not included in the public health outcomes framework for local authorities.1 Therefore it is unclear what is meant by 'evidence-based stop smoking services' and what performance measures NICE and this quality standard have in mind when this phrase is used. Pfizer therefore requests that as part of this quality statement, NICE provides a clear definition of 'evidence-based stop smoking services'. This should include the types (e,g. specialist services, GP-provided services, pharmacy-provided services, other providers) of local service to be covered by this term, and the types of smoking cessation metrics to be used which are considered to constitute acceptable local evidence.	Thank you for your comments. We have updated the quality standard to reflect this change in commissioning responsibility. This will also be reflected in the NICE support for commissioning tool for this standard will also reflect the changes in the structure and organisation of smoking cessation services.
64	10	Pfizer Limited	S02	Definitions	References 1. Kelly P, 2012. Public Health England: What the future holds for stop smoking services. UKNSCC 2012. http://www.uknscc.org/uknscc2012_presentation_98.php	Thank you for your response.
77	11	Johnson & Johnson	S02	Statement	However, it is concerned that no consideration is given to what should happen where a smoker does not wish to be referred to a stop smoking service. It may be beneficial to include information advising healthcare professionals on	The statement has now been amended.

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					alternative cessation strategies or future follow up to re-assess the smoker's willingness to enter a smoking cessation service.	
78	11	Johnson & Johnson	S02	Statement	It is also important to consider the soon to be published NICE Public Health Guideline on Tobacco Harm Reduction, which is scheduled to be published on June 5th 2013. If, as is anticipated, this guideline will provide healthcare professionals with advice on how to support smokers not yet willing, ready or able to quit smoking immediately but who do wish to modify their smoking behaviour then some element of this could usefully be considered here.	Thank you for your comments. This quality standard is focused on smoking cessation, however a cross-referral has been made within the NICE Support for Commissioning Tool to bring attention to the harm reduction guidance.
76	11	Johnson & Johnson	S02	Support	Johnson & Johnson is supportive of all elements included in draft quality statement 2.	Thank you for your comments
87	12	British Thoracic Society	S02	Statement	Referral to Stop Smoking services : there is no standard or guidance about **feedback to referrers**. Currently this does not happen - unlike any other treatment/intervention for healthcare. Feedback to the referrer of the outcome of the referral (Quit or Failed Quit or DNA and what interventions were used) should be mandatory and would improve further attempts to support a smoker to quit. The phrase 'People who smoke are referred to an evidenced based stop smoking service' should be replaced by 'People who smoke and are willing to attempt to quit are referred to an evidenced based stop smoking service'.	The QSAC prioritised the areas of care they felt were most important for patients, based on the development sources listed. The QSAC prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the QSAC who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key

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						markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. In addition, the statement has now been amended to state that the person who smokes should be offered a referral.
98	13	National Centre for Smoking Cessation and Training	S02	Audience descriptor	Commissioners – also need to commission stop smoking services for smokers to be referred to. Although this is covered in statement 3 it would be worth adding here too. People who smoke – this section reads as if suggesting that all smokers want to be referred. This could create an opt-out situation, which is only appropriate if local services are set up and commissioned to respond in this way. This section could be further enhanced e.g. People who smoke are informed about and referred to an evidence based stop smoking service	The statement has now been amended.
99	13	National Centre for Smoking Cessation and Training	S02	Definitions	NCSCT statement could be further enhanced: The National Centre for Smoking Cessation and Training has identified minimum core competences, national training standards and produced online training modules for all those delivering stop smoking interventions. Practitioners gaining full NCSCT certification can provide evidence that they possess these core competences. NICE public health guidance 26 is too conservative in relation to pregnant women having to have tried and failed with NRT, there isn't time to play with and this will cause additional health problems and deaths.	Thank you for your comments. We include a paragraph on training and competencies in the Introductory section, however Quality standards do not typically contain statements on training and development, as this is an assumed aspect for those wishing to achieve the individual statements.

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97	13	National Centre for Smoking Cessation and Training	S02	Statement	This statement could be further enhanced e.g. People who smoke are referred to an evidence-based stop smoking service with appropriately trained practitioners who can offer advice, information and behavioural support.	Thank you for your comments. We include a paragraph on training and competencies in the Introductory section, however Quality standards do not typically contain statements on training and development, as this is an assumed aspect for those wishing to achieve the individual statements.
129	16	South West Yorkshire NHS Foundation Trust	S02	Audience descriptor	People who smoke are referred to an evidence-based stop smoking service**.** **Services would like to see clients who smoke, who are ready to stop and want support to stop smoking.**	Thank you for your comment. This statement has now been updated to consider willingness to engage. This is encapsulated in the wording of 'offer a referral'. We however recognise that not everybody will take up this offer.
137	18	Royal Pharmaceutical Society	S02	General	Community and hospital pharmacists, and their support staff have a valuable role to play in assisting patients stop smoking, including identification of patients who may want to stop smoking, offering brief interventions, and signposting to specialist services where appropriate. Pharmacists can also offer lifestyle advice help patients manage withdrawal symptoms and offer behavioural support to patients who relapse. Community pharmacies are conveniently located and are readily accessible due to longer opening hours, and there is no need for patients to make an appointment. Premises therefore offer informal settings which could encourage people who may be reluctant to visit their GP or stop smoking clinics to seek support and advice.	Thank you for your comments. Quality standards do not typically contain statements on training and development, as this is an assumed aspect for those wishing to achieve the individual statements. A specific paragraph is outlined in the supporting text for the quality standard to highlight this, and the definitions section provides links to training resources provided by the NCSCT.
142	19	Primary Care Respiratory Society	S02	Statement	We believe this is really important – and feel that the Quality standard is currently very light touch on the importance of trained staff to deliver effective stop smoking advice and support. There is good UK evidence in primary care settings that staff trained in behavioural change activation skills are particularly effective and we would like to see every smoker in primary care having easy	Thank you for your comments. A specific paragraph is outlined in the supporting text for the quality standard to highlight this however Quality standards do not typically contain statements on training

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					access to someone who is trained to give such advice and support. At present many clinicians have received no training, so their efforts are less successful than they might be with training. We believe that the data are both collectable and measureable in primary care to support implementation of this QS. However, we also believe that secondary care health professionals need to engage with the importance of giving brief advice. We therefore suggest a change of wording of the current draft QS 1 to read: People are asked if they smoke by their healthcare professional, and those who smoke have access to and are offered brief advice on how to stop by someone trained to give advice and support. The documentation for this Quality standard is not entirely clear on whether it relates to tobacco alone. We believe that many clinicians have a blind spot, not just about tobacco smoking but also about smoking of other substances, which can be just as damaging to the lungs. We therefore suggest adding as follows throughout: "People are asked if they smoke tobacco or other substances by their healthcare …."	and development, as this is an assumed aspect for those wishing to achieve the individual statements. The definitions section provides links to training resources provided by the NCSCT.
143	19	Primary Care Respiratory Society	S02	Statement	We would like to reinforce that commissioners in both CCGs and Area Teams should check that staff providing these services have accredited training. We believe that this QS will now be measureable in both primary and secondary care	Thank you for your comments. A specific paragraph is outlined in the supporting text for the quality standard to highlight this however Quality standards do not typically contain statements on training and development, as this is an assumed aspect for those wishing to achieve the individual statements. This statement applies across all healthcare settings.
165	22	Optical Confederation and the College of Optometrists	S02	Definitions	In draft quality statement 2 (Referral to stop smoking services) the definition statement is: "Healthcare professionals who may refer include but are not limited to doctors, nurses, midwives, pharmacists and dentists." Notwithstanding the clear relationship between smoking and cancers, heart and lung disease and low birth weight babies, there is an equally important causal relationship between smoking, sight loss and blindness. Smokers have	Opticians and optometrists have now been added to the list of suggested healthcare professionals

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					triple the incidence of age-related macular degeneration compared with non-smokers1 and smoking is strongly associated with cataracts2. Research elsewhere suggest the public have little awareness that smoking increases the risk of sight loss and that such campaigns can be effective3; especially among teenagers who are more scared of losing sight than of lung or heart disease4. A warning that smoking causes blindness will be included on cigarette packets across the EU in the coming years and already exists in Australia5. In our view it is vital that this is highlighted by the inclusion of optometrists and opticians in the list above. Whilst we accept that the broad statement indicates the range of healthcare professionals that could refer patients who smoke, optometrists and opticians have a major and influential role (sight being the sense people of all ages fear losing most). Many eye health consultations already include advising and counselling of smokers on their increased risk, the benefits of stopping and, where appropriate, referral to a local stop smoking service. We would be grateful if this could be amended. We have also asked for the same inclusion to be made in draft quality statement 1 and for the same reasons	
166	22	Optical Confederation and the College of Optometrists	S02	Definitions	[1] Cong, R , et al (2008). Smoking and the risk of age-related macular degeneration: a meta-analysis. Ann Epidemiol; 18:647–656. 2 Kelly, SP, et al (2004). Smoking and blindness: strong evidence for the link, but public awareness lags. BMJ; 328:537–8 3 Carroll, T, Rock, B. (2003) Generating Quitline calls during Australia's National Tobacco Campaign: effects of television advertisement execution and programme placement. Tobacco Control ; 12(Suppl II):ii40–ii44 4 Moradi, P, et al (2007). Teenagers' perceptions of blindness related to smoking: a novel message to a vulnerable group. Br J Ophthalmol; 91:605–607. 5 http://www.quitnow.gov.au/internet/quitnow/publishing.nsf/content/warnings-b-eye	Thank you for your comments
7	1	The British Dental Trade Association Ltd	**S03**	Support	The BDTA supports the offering of behavioural support with pharmacotherapy, and where appropriate, active intervention by dentists and dental healthcare professionals with suitable training.	Thank you for your comments

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14	2	London Respiratory Team	S03	Equality and diversity	Under equality & diversity consideration suggest add "Patients with severe mental health problems are disproportionately affected by tobacco dependence. Healthcare professionals should consider extended use of NRT if appropriate. Harm reduction through lifelong substitution with medicinal nicotine is highly cost-effective when compared with continuing smoking at £3600-8000 per QALY" Reference: http://www.rcplondon.ac.uk/publications/smoking-and-mental-health-0	Thank you for your comments. This quality standard is based current published smoking cessation guidance recommendations and does not drawn on recommendations from harm reduction. A note has been added within the definitions for the statement relating to pharmacotherapy that drugs affected with a metabolism affected by smoking are monitored and dosage adjusted.
31	5	Royal College of Midwives	**S03**	Statement	Broadly agree, although we note that evidenced-based smoking cessation services are not only about pharmacotherapy or behavioural support. Recent research by Lorencatto, West and Michie has shown that behavioural support interventions do have a significant positive impact on cessation during pregnancy, although they also emphasised the complexity of interventions, particularly the role played by multiple and interacting behavioural change techniques. It is not immediately clear which specific ones are effective or should be recommended for smoking cessation in pregnancy. Particularly effective techniques are those which include incentives and social support and are feasible in their implementation in terms of consideration of time constraints. See Lorencatto, West and Michie (2012) *Specifying Evidence-Based Behavior Change Techniques to Aid Smoking Cessation in Pregnancy* Nicotine & Tobacco Research 14:9, pp 1019–1026	The QSAC prioritised the areas of care they felt were most important for patients, based on the development sources listed. The QSAC prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the QSAC who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to

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						be implemented.
40	6	Royal College of Paediatrics and Child Health (RCPCH)	S03	Statement	There is strong, systematic review level data that pharmacotherapy is not effective overall for young people. This is presumably because of the different context of smoking in this age group rather than because of any physiological or pharmacological differences. In order to avoid encouraging ineffective treatment, which might indeed discourage the use of pharmacotherapy at an age where it is more likely to make a difference; those under 20 years of age should be specifically excluded from the standard, the measure and target audience. References: · Patnode et al, primary care-relevant interventions for tobacco use prevention and cessation in children and adolescents: a systematic evidence review for the US preventive services task force. Annals of Internal Medicine 2013 158 (4) 253-260. · S Lunde Youth tobacco Use Lancet 2013 381 (9864) 357 · Gill M Grimshaw, Alan Stanton. Smoking cessation services for young people, BMJ, 2008;337:a1394 · Gill Grimshaw, Alan Stanton Tobacco Cessation Interventions for Young People, Cochrane database of systematic reviews, 2006 (assessed up to date 2009)	This quality standard is based on the evidence-based recommendations outlined in Public Health Guidance 1, Public Health Guidance 10 and Public Health Guidance 26. We have sought to note age considerations and have reiterated the advice that young people aged 12–17 should be offered information, advice and support on how to stop smoking and encouraged to use local NHS Stop Smoking Services by providing details on when, where and how to access them. This is consistent with the advice set out in the current published source guidance. In respect to pharmacotherapy, this statement should be implemented in the context of licensing indications and we note that professional judgement should be used to decide whether or not to offer NRT to young people over 12 years with a discussion about risks and benefits. In addition, the quality standard states that all statements should take account of the needs of safety, effectiveness and professional judgment to recognise that full achievement may not always be appropriate in practice.

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51	8	British Heart Foundation	**S03**	Measure	We agree with the standard reflecting an area for quality improvement. To ensure the standard is accurately monitored, patients referred to smoking cessation services in hospital should be included in the numerator. It is not clear how this will be achieved.	Thank you for your comments. The concept of this statement is that behavioural support and pharmaotherapy should be offered. Referral is covered in statement 2, which is applicable to all healthcare settings.
65	10	Pfizer Limited	S03	Measure	Pfizer welcomes the inclusion of this quality statement, but on review of the draft quality measures on p.12, notes there are some omissions that will have an impact on the quality of smoking cessation service provision. The only numerator for this measure currently under consideration is: 'The number of people in the denominator who receive behavioural support with pharmacotherapy.' Pfizer suggests the following 3 additional numerators in order to increase the quality of the evidence around provision of smoking cessation therapies: 1) The number of people in the denominator who receive neither behavioural support nor pharmacotherapy 2) The number of people in the denominator who receive behavioural support only 3) The number of people in the denominator who receive pharmacotherapy only. It order to enhance the quality of service provision it would be good to know the proportion of smokers referred to a smoking cessation service who do not receive any type of therapy to understand the extent of this issue. Once identified, this would enable local services to review their data and take action to address this problem if it is found that smokers eligible for assistance are receiving no intervention from services. In addition it would be good to understand the proportions of smokers accessing services who receive behavioural support or pharmacotherapy as monotherapy, to understand the extent to which this occurs. This would enable services to review this data and take remedial action in cases where monotherapy use is judged to be inappropriate.	Quality measures should form the basis for audit criteria developed and used locally to improve the quality of health and social care. The QSAC prioritised the measures they felt were most important in measuring the quality statements, other measures may be defined locally.

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80	11	Johnson & Johnson	S03	Statement	Johnson & Johnson does however have concerns about the title of the draft statement being “Combination therapy” as there is the potential for this term to be confusing. Whilst the combination of behavioural support with a pharmacotherapy is a form of combination therapy this term is often used to describe the use of more than one format of nicotine replacement therapy (NRT) at the same time in combination, usually a patch to give a constant supply of nicotine with an *ad lib* formulation to manage break through cravings. Rather than run the risk of using terminology that could lead to confusion or misinterpretation Johnson & Johnson suggests an alternative title be given to draft standard 3, perhaps “Complementary behavioural and pharmacological intervention” or similar.	Thank you for your comments. The title has now been amended.
79	11	Johnson & Johnson	S03	Support	Johnson & Johnson is supportive of the content of draft quality statement 3 which is supported by clear evidence and by other NICE guidelines as highlighted.	Thank you for your comments
102	13	National Centre for Smoking Cessation and Training	S03	Audience descriptor	The addition of a line referring to the importance of all pharmacotherapy products being available as “equal first line treatments” would be useful here.	Thank you for your comments. The quality standards advisory committee wanted to retain the focus on the key concept of the statement, that people are offered behavioural support and pharmacotherapy
101	13	National Centre for Smoking Cessation and Training	S03	Rationale	This statement could be further enhanced e.g. People who smoke are more likely to quit successfully if they are offered a combination of evidence-based behavioural support and pharmacotherapy. The NCSCT provides training, assessment and certification in the provision of evidence-based behavioural support.	Thank you for your comments. The quality standards advisory committee wanted to retain the focus on the key concept of the statement, that people are offered behavioural support and pharmacotherapy
105	13	National Centre for Smoking Cessation and Training	S03	Rationale	This section could be further enhanced e.g. ….Therefore it is important that ALL products are available and that people have access to* the full course of their chosen pharmacotherapy. *currently this reads ‘receive’ but only those who remain abstinent (or are still committed to quitting) should receive further supplies of pharmacotherapy	Thank you for your comments. The quality standards advisory committee wanted to retain the focus on the key concept of the statement, that people are offered behavioural support and

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					rather than the full course being supplied all in one go or automatically A note could also be included here to reinforce the importance of offering behavioural support in conjunction with medication to ensure it is most effective.	pharmacotherapy
100	13	National Centre for Smoking Cessation and Training	S03	Statement	Title of this standard could be misleading – commissioners and practitioners will understand the term combination therapy to refer to the combining of medications i.e. patch and gum, rather than of the pharmacotherapy as a whole with behavioural support. Tile could be "Behavioural support & pharmacotherapy"	Thank you for your comments. The title has now been amended.
119	15	Department of Health	S03	Statement	Combination Therapy is the common term used to describe the concurrent prescription of two forms of NRT. To use this term to describe any other activity will create confusion. A different title should be considered such as "Provision of behavioural support with pharmacotherapy".	Thank you for your comments. The title has now been amended.
131	16	South West Yorkshire NHS Foundation Trust	S03	Definitions	People who have been referred to an evidence-based stop smoking service are offered behavioural support (either individual or group counselling) with pharmacotherapy. Behavioral support can be individual behavioural counselling or group behaviour therapy. NICE public health guidance 10 states that individual behavioural counselling involves scheduled face to face meetings between someone who smokes and a counsellor trained in smoking cessation. Stop smoking services provide motivational behavioural support to stop smoking rather than counselling, advisors are not necessarily counsellors.	Thank you for your comments. The text has now been modified.

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144	19	Primary Care Respiratory Society	S03	Statement	We would suggest adding to this QS - 'and smokers admitted to hospital should be both actively identified and offered NRT routinely ' We remain concerned that many opportunities are missed in the acute setting to refer people to appropriate quitting services. This QS is measurable and recordable in practice.	Thank you for your comments. The QSAC wanted to retain the focus on the key concept of the statement, that people are offered behavioural support and pharmacotherapy. Referral is a key aspect of statement 2, which is applicable to all healthcare settings.
155	20	NICE	S03	Data Source	Criterion 7 in the audit support for PH10 requires the client to be offered either an individual treatment or a combination of treatments. This doesn't match the quality statement which relates to combination therapy. The data collection tool would help organisations to gather data for the quality statement but I think it would be better not to reference the audit support given the difference between the audit criteria and the quality statement.	The data sources section is intended to suggest areas that users may find helpful when trying to demonstrate achievement of the statement.
154	20	NICE	S03	Measure	Should the denominator refer to clients of the stop smoking service rather than just people who have been referred? It might be easier to get this figure and presumably some people are referred but never actually become clients.	Thank you for your comments. The text has now been modified.
8	1	The British Dental Trade Association Ltd	**S04**	Support	The BDTA supports in principle the offering of a full course of nicotine therapy (NCT) or other relevant treatment as outlined, and where appropriate, active intervention by dentists and dental healthcare professionals with suitable training.	Thank you for your comments
32	5	Royal College of Midwives	**S04**	Statement	Broadly agree. However, to the extent possible, because of the exceptions for pregnant women identified in NICE public health guidance 26, it may be appropriate to exclude pregnant women from the quality measure.	Thank you for your comments. This quality standard is based on the evidence-based recommendations outlined in PH1, PH10 and PH26. The QS outlines that all measures must take account of safety, effectiveness and professional judgement. The definitions highlight the appropriate exclusions.

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ID	Stakeholder ID	Stakeholder	Statement No	Comment on	Comments	Responses
41	6	Royal College of Paediatrics and Child Health (RCPCH)	S04	Statement	There is strong, systematic review level data that pharmacotherapy is not effective overall for young people. This is presumably because of the different context of smoking in this age group rather than because of any physiological or pharmacological differences. In order to avoid encouraging ineffective treatment, which might indeed discourage the use of pharmacotherapy at an age where it is more likely to make a difference; those under 20 years of age should be specifically excluded from the standard, the measure and target audience. References: · Patnode et al, primary care-relevant interventions for tobacco use prevention and cessation in children and adolescents: a systematic evidence review for the US preventive services task force. Annals of Internal Medicine 2013 158 (4) 253-260. · S Lunde Youth tobacco Use Lancet 2013 381 (9864) 357 · Gill M Grimshaw, Alan Stanton. Smoking cessation services for young people, BMJ, 2008;337:a1394 · Gill Grimshaw, Alan Stanton Tobacco Cessation Interventions for Young People, Cochrane database of systematic reviews, 2006 (assessed up to date 2009)	This quality standard is based on the evidence-based recommendations outlined in Public Health Guidance 1, Public Health Guidance 10 and Public Health Guidance 26. This quality standard states that all statements must take account of safety, effectiveness and professional judgement to recognise that it may not be appropriate for young people. This quality standard has made the following change in its 'Equality and Diversity' section which further highlights that young people aged 12–17 should be offered information, advice and support on how to stop smoking and encouraged to use local NHS Stop Smoking Services by providing details on when, where and how to access them. There is however need for professional judgement to decide whether or not to offer Nicotine Replacement Therapy (NRT) to young people over (under) 12 years. There should also be a discussion about risks and benefits of using NRT with young people aged 12–17.
54	8	British Heart Foundation	**S04**	Definitions	Without a definition of what a 'full course' is, it will be difficult to interpret the data on the number of people who smoke, who receive a full course of NRT, varenicline or bupropion.	Thank you for your comments. Additional text has been added to the definitions in an attempt to clarify this.
53	8	British Heart Foundation	**S04**	Statement	Given the side-effect profile of bupropion and varenicline, these drugs will be contraindicated in some smokers, significant number of smokers will choose not to use these drugs.	Thank you for your comments.

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52	8	British Heart Foundation	**S04**	Support	We agree with the standard reflecting an area for quality improvement.	Thank you for your comments.
66	10	Pfizer Limited	S04	Measure	Pfizer welcomes the inclusion of this statement which reiterates the NICE guidance from PH10 and reinforces that it is important for local smoking cessation services to offer a choice of NRT, varenicline and bupropion. With regard to the draft quality measures on p. 14, Pfizer suggests the following additional numerator measure: 'The number of people in the denominator who receive NRT, varenicline or bupropion but do not complete a full course of treatment.' In order to enhance the quality of service provision this indicator would be crucial to identify the proportion of patients who do not adhere to smoking cessation pharmacotherapy treatment. Lack of adherence and premature discontinuation of treatment is likely to result in failed quit attempts and a consequent waste of service resources. This new quality indicator would allow services to quantify this issue and would encourage the proactive implementation of patient follow-up procedures to facilitate adherence, thereby ensuring a higher quality service and improved patient outcomes.	Quality measures should form the basis for audit criteria developed and used locally to improve the quality of health and social care. The quality standards advisory committee prioritised the measures they felt were most important in measuring the quality statements, other measures may be defined locally.
81	11	Johnson & Johnson	S04	Rationale	Johnson & Johnson is supportive of draft quality statement 4 although would like to point out that the term "It is therefore important that people receive the full course of their chosen pharmacotherapy" under the "Rationale" section is somewhat subjective in light of the most recent changes to the licensed indication of many NRT products which allows for the long-term use of NRT where the alternative is continued smoking.	Thank you for your comments. Additional text has been added to the definitions in an attempt to clarify this.
82	11	Johnson & Johnson	S04	Source	It is also important to consider the soon to be published NICE Public Health Guideline on Tobacco Harm Reduction, which is scheduled to be published on June 5th 2013. If, as is anticipated, this guideline will provide healthcare professionals with advice on how to support smokers not yet willing, ready or able to quit smoking immediately but who do wish to modify their smoking behaviour then some element of this could usefully be considered here.	Thank you for your comments. Additional text has been added to the definitions in an attempt to clarify this. The focus of this quality standard is smoking cessation, and a cross-referral to harm reduction has been added in the NICE support for commissioning tool for this standard

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88	12	British Thoracic Society	S04	Statement	Pharmacotherapy: Would like to see provision made for **'resistant' smokers** (most often sick smokers) who need **additional/ longer duration pharmacotherapy** than that which is currently guidelined. 12 weeks is frequently not long enough and relapse inevitable for these smokers	Thank you for your comments. We have stated that the full course of pharmacotherapy will vary depending on the individual smoker.
107	13	National Centre for Smoking Cessation and Training	S04	Audience descriptor	Healthcare professionals: this could be currently interpreted as offering the full course of pharmacotherapy in one go, which is generally avoided to reduce the risk of wastage and to encourage clients to remain engaged in behavioural support sessions. Also it's unclear as to whether this is encouraging HCPs to prescribe pharmacotherapy as part of a stop smoking service, in conjunction with a stop smoking service(s) or every time they identify a smoker.	Quality standards describe areas for quality improvement, and local services may then determine how they wish to achieve the statements.
108	13	National Centre for Smoking Cessation and Training	S04	Audience descriptor	Commissioners: This section could be further enhanced e.g. Commissioners ensure they commission services for people who smoke that offer a full course of NRT, varenicline or buproprion, with all products available as equal first line options.	Thank you for your comments. The concept of this statement is that people who accept pharmacotherapy receive a full course.
106	13	National Centre for Smoking Cessation and Training	S04	Measure	I am unsure how it will be possible to measure whether a full course was provided and if this would be useful information as for example; a patient can decided not to use pharmacotherapy (despite advice to the contrary), or decide to stop using it early or not quit and therefore receive a shorter supply.	Thank you for your comments. Additional text has been added to the definitions in an attempt to clarify this.
104	13	National Centre for Smoking Cessation and Training	S04	Statement	This statement could be further enhanced e.g. People who smoke are offered a full course of nicotine replacement therapy (NRT), varenicline or buproprion, with all products available as equal first line options	Thank you for your comments. The concept of this statement is that people who accept pharmacotherapy receive a full course.
120	15	Department of Health	S04	Definitions	There is repeated mention that a "full course" of medication should be given, however there is no indication as to what constitutes a full course, nor any reference to where with information can be found.	Thank you for your comments. Additional text has been added to the definitions in an attempt to clarify this.

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130	16	South West Yorkshire NHS Foundation Trust	S04	Definitions	"NICE public health guidance 1 states that pharmacotherapy should also be offered to those unwilling or unable to accept a referral to an evidence based stop smoking service. **This is a quote from Brief interventions and referral for smoking cessation Recommendation 4: "Nurses in primary and community care should advise everyone who smokes to stop and refer them to an intensive support service (for example, NHS Stop Smoking Services). If they are unwilling or unable to accept this referral they should be offered pharmacotherapy by practitioners with suitable training, in line with NICE technology appraisal guidance no. 39, and additional support. Nurses who are trained NHS stop smoking counsellors may "refer" to themselves where appropriate".** **Stop smoking services would not offer pharmacotherapy to smokers unwilling to take part/attend for support be it form Specialist stop smoking services / Pharmacy bases services / GP practice based services / School nurse services.**	Thank you for your comments. The statement has now been amended.
133	16	South West Yorkshire NHS Foundation Trust	S04	Definitions	NICE public health guidance 26 states that there should be a discussion about the risks and benefits of NRT with pregnant women who smoke. Nicotine replacement therapy should be offered if smoking cessation without NRT fails, or professional judgement should be used if a woman expresses a clear preference for NRT. **Need to be clear that 'professional judgement' is key, it is better that a woman (pregnant or breastfeeding) uses NRT (including dually) than smokes. The guidance on NRT use needs to be the same through specialist services and in GP practices/pharmacies etc.**	The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the smoking cessations services public health guidance (PH10). The quality standards do not seek to reassess or redefine the evidence base. The QS outlines that all statements must take account of safety, effectiveness and professional judgement.
127	16	South West Yorkshire NHS Foundation Trust	S04	Statement	"People who smoke are offered a full course of nicotine replacement therapy (NRT), varenicline or bupropion. **Clients attending NHS stop smoking services will be offered a full course of treatment if they are not smoking and stay quit (clients who have slip-ups and smoke but then continue with the quit would continue to receive pharmacotherapy).**	Additional text has now been added to the definitions section to state that subsequent prescriptions should be given only to people who have demonstrated, on re-assessment, that their quit attempt is continuing.

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138	18	Royal Pharmaceutical Society	S04	General	We would like to see pharmacists specifically mentioned in this section. Patients can obtain a range of NRT in pharmacies and receive additional advice about how to use these products effectively from trained healthcare support staff. Many community pharmacists supply NRT products via through NHS voucher schemes, and local PGDs. A number of community pharmacies have completed accredited training as a Level 2 Community Stop Smoking Advisor to supply varenicline via local NHS PGDs.	Thank you for your comments. The quality statement is not designed to provide an exhaustive list of the specific services that specific healthcare practitioners can provide.
145	19	Primary Care Respiratory Society	S04	Statement	Sick smokers with higher addiction and relapse risk should be offered extended courses of therapy and enhanced services to achieve this This QS is measurable and recordable in practice.	Thank you for your comment. The quality aspect is that a full course is given where smokers demonstrate that a quit attempt is continuing. We do note in the text that a full course will vary depending on the individual smoker.
158	20	NICE	S04	Data Source	The focus of this standard is that people who smoke are offered a full course of pharmacotherapy. The only audit criteria that focuses on the length of time that pharmacotherapy is prescribed for is criteria 6 in the PH10 audit support. However, the audit tool looks at whether patients have been prescribed NRT, varenicline or bupropion for a period that extends beyond 2 weeks after their target stop date. This doesn't appear to be the same thing that as being offered a 'full course', so I don't think that this criteria should be referred to either.	The data sources section is intended to suggest areas that users may find helpful when trying to demonstrate achievement of the statement.
156	20	NICE	S04	Statement	What is meant by a 'full course'? Does this refer to the course recommended in the summary of product characteristics? What does it mean to 'receive a full course'? Is it adequate to prescribe a full course or should services ensure that the full course is taken/adhered to?	Thank you for your comments. Additional text has been added to the definitions in an attempt to clarify this.
157	20	NICE	S04	Statement	PH10 state that the prescription should be sufficient to last until 2 weeks after the target stop date and subsequent prescriptions should be given only to people who have demonstrated, on re-assessment, that their quit attempt is continuing. This doesn't seem to tally with the quality standard which recommends that people are offered a 'full course'.	The data sources section is intended to suggest areas that users may find helpful when trying to demonstrate achievement of the statement.

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9	1	The British Dental Trade Association Ltd	**S05**	Support	We support the offering of the intervention suggested (carbon monoxide testing) for pregnant women at the antenatal booking appointment and throughout pregnancy.	This statement has not progressed for the final Quality Standard
17	2	London Respiratory Team	S05	Measure	3. For draft QS statement 5, "throughout the pregnancy" is not measureable. It should include the minimum number of data points. CG62 suggests 7-10 appointments and that smoking cessation advice should (quite rightly) take place at first contact with healthcare professional, i.e. before booking appointment. Suggest (b) "Proportion of pregnant women who receive CO testing at the majority of appointments with healthcare professionals throughout the pregnancy and at the post-natal check (for those with a reading above the cut-off point at initial assessment)" and "Proportion of pregnant women who receive CO testing on at least one further occasion in the pregnancy (for those with a reading below the cut-off point at initial assessment)"	This statement has not progressed for the final Quality Standard .
34	5	Royal College of Midwives	**S05**	Audience descriptor	The RCM would like to see this reflected in the description of what this quality statement means to various audiences, with an emphasis on service providers and commissioners ensuring that healthcare professionals have the time, resources and training needed to use CO monitoring effectively as part of their wider efforts to address smoking in pregnancy.	This statement has not progressed for the final Quality Standard
33	5	Royal College of Midwives	**S05**	Disagreement	The RCM has previously expressed concern about the potential negative impact of CO monitoring on the midwife-woman relationship. This is particularly the case if testing occurs in the context of insufficient training for midwives, incipient midwife-woman relationships, and inadequate time to sensitively discuss smoking. Trying to get women to stop smoking involves a complex set of highly developed communications skills that enable an individual clinician to be non-judgemental when discussing smoking, its effects and quitting issues. As such, we disagree that CO monitoring at the antenatal booking appointment should be prioritised as a quality statement, however we believe that CO monitoring can play an appropriate role throughout the pregnancy.	This statement has not progressed for the final Quality Standard
43	7	Rotherham	S05	Measure	Process measure b) (receiving carbon monoxide testing throughout pregnancy)	This statement has not progressed for

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		Doncaster and South Humber NHS Foundation Trust			is measureable at certain points throughout pregnancy e.g. every week until 4 weeks quit and then asked to repeat CO reading at 2 monthly intervals until birth.	the final Quality Standard
55	8	British Heart Foundation	S05	Measure	We agree with the standard reflecting an area for quality improvement. We note that one of the data outcomes is smoking status at the time of delivery. If adopted, this data set will not measure the number of foetuses exposed to the products of smoked tobacco during gestation. This will not improve the prospects of the unborn child.	This statement has not progressed for the final Quality Standard
56	8	British Heart Foundation	S05	Statement	We suggest that carbon monoxide testing is undertaken at the *earliest opportunity* during pregnancy, at the very latest at the midwife booking appointment. This would enable the health care professional to refer and support cessation in line with draft statements 2, 3 and 4.	This statement has not progressed for the final Quality Standard
83	11	Johnson & Johnson	S05	Support	Johnson & Johnson is supportive of draft quality statement 5.	This statement has not progressed for the final Quality Standard
94	13	National Centre for Smoking Cessation and Training	S05	Measure	It is important to measure CO throughout pregnancy as both initial cessation and the maintenance of any quit attempt may be difficult for the pregnant women to achieve. Therefore smoking status should be monitored throughout and advice/interventions offered if/when the need is identified, at whatever stage of pregnancy and from all HCPs. The NCSCT has developed guidance on this which could be referenced. As an initial opportunity to measure – the GP could be requested to carry out a CO reading when women initially present at the start of pregnancy in order to identify and refer smokers as soon as possible?	This statement has not progressed for the final Quality Standard
111	13	National Centre for Smoking Cessation and Training	S05	Question 3	It is important to measure CO throughout pregnancy as both initial cessation and the maintenance of any quit attempt may be difficult for the pregnant women to achieve. Therefore smoking status should be monitored throughout and advice/interventions offered if/when the need is identified, at whatever stage of pregnancy.	This statement has not progressed for the final Quality Standard

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					As an initial opportunity to measure – the GP could be requested to carry out a CO reading when women initially present at the start of pregnancy in order to identify and refer smokers as soon as possible?	
110	13	National Centre for Smoking Cessation and Training	S05	Statement	Should this section include a statement about the importance of accurately explaining to pregnant women the risks of continued smoking for her, the foetus and baby/young child? It should also be made clear as to what the next step(s) should be if exposure is identified as this isn't currently obvious.	This statement has not progressed for the final Quality Standard
122	15	Department of Health	S05	Disagreement	Apart from the major issue around testing which is the potential for re-enforcing smoking behaviour in low level smokers who may understand a low reading of CO as a permission to smoke, this method does not attempt to solve the problem. The crux of the problem as described is that women feel uncomfortable in admitting that they smoke when they are pregnant. Until a recommendation is made, that serious application to discovering the components of the conversation which results in the woman believing that it is okay for her to tell the truth, there is no solution only an application of paper over the cracks.	This statement has not progressed for the final Quality Standard
121	15	Department of	S05	Measure	Some discussion of the evidence around uptake due to opt-in 'v' opt-out	This statement has not progressed for

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		Health			processes for CO monitoring would be of benefit.	the final Quality Standard
132	16	South West Yorkshire NHS Foundation Trust	S05	Definitions	Pregnant women are offered carbon monoxide testing to assess exposure to tobacco smoke at the antenatal booking appointment and throughout the pregnancy. **Who will fund monitors? Do midwives then have enough time to provide appropriate support /information following the reading and deal with pregnant women's potential reactions to the reading. If support is not in place should the reading be done at all? The availability of Maternity Support Workers to help will differ throughout each locality. Each midwife would be made aware of the NCSCT "Smoking Cessation:a briefing for Midwifery Staff", and local policies. They would also need Brief Intervention Training and CO Monitor Training - not sure how this would be monitored, this would need to be made mandatory by the Hospital Trust. The priority of this varies from Trust to Trust, CHFT currently do not prioritise Smoking Cessation within Midwifery Update Training. Inaccurate data on Smoking at time of Delivery remains and depends on local systems to capture data.** **NICE public health guidance 26 recommendation 1 states that all women who smoke or who have stopped smoking within the last 2 weeks should be referred to NHS stop smoking services. It also states that health care professionals should refer women with a CO reading of 7ppm or above. (Note light or infrequent smokers should also be referred, even if they register a low reading-for example 3ppm.) Current NICE guidance for pregnancy includes the opt out approach to referring. This is not practical in all areas. It is important that women are given the appropriate level of support when trying to Stop Smoking in pregnancy (due to potential complex needs) – Level 2 advisors need to be aware of their limitations and when to refer on to a Specialist Service.**	This statement has not progressed for the final Quality Standard
134	17	Action on Smoking and Health	S05	Definitions	We are currently working with a number of organisations to write a report for the Minister of Health, outlining recommendations on how smoking in pregnancy rates can be reduced. As part of this, we are recommending that a CO result of 4pmm or higher should trigger a discussion about smoking and a referral to stop smoking	This statement has not progressed for the final Quality Standard

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					services. Women who have a CO reading of 4pmm or higher but say they do not smoke should be advised about possible CO poisoning and asked to call the Health and Safety gas safety line (draft quality standard currently states 10pmm should be the cut off). This recommendation is based on the following research paper: Bauld, L, Hackshaw,L, Ferguson, J, Coleman, T, Taylor, G and Salway, R (2012) Implementation of routine biochemical validation and an 'opt out' referral pathway for smoking cessation in pregnancy, Addiction, 107, S2, 53-60. We are aware that NICE are planning to update their guidance (PH26) and believe there should be a cross referral to the future update. [1] Organisations include the UK Centre for Tobacco Control Studies, The Lullaby Trust and other baby charities, the National Centre for Smoking Cessation Training, royal colleges and regional tobacco offices.	
139	18	Royal Pharmaceutical Society	S05	General	We would like to see pharmacist specifically mentioned in this section. Pharmacists are able to offer carbon monoxide testing to patients to help monitor health outcomes and reinforce the benefits of stopping smoking.	This statement has not progressed for the final Quality Standard
146	19	Primary Care Respiratory Society	S05	Statement	'Pregnant women are offered carbon monoxide testing to assess exposure to tobacco smoke at the antenatal booking appointment and throughout the pregnancy if they have tested positive on the initial test' We suggest this is amended to recognise that many women do not smoke during pregnancy. So we suggest that only those who test positive at initial antenatal booking should continue to be offered CO testing throughout pregnancy. Ie – it is probably unnecessary to offer ongoing testing to women who don't test positively initially. This QS is measurable and recordable in practice.	This statement has not progressed for the final Quality Standard
159	20	NICE	S05	Data Source	The quality standard is about pregnant women being offered carbon monoxide testing but this isn't directly covered in criteria 8 in the PH10 audit support so I think that reference to this document should be removed.	This statement has not progressed for the final Quality Standard
10	1	The British Dental Trade	**S06**	Measure	We believe that outcome measurements are important in measuring the implementation and success of quality standards, and that, where appropriate,	Thank you for your comments

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		Association Ltd			people who have set a quit date are offered carbon monoxide testing 4 weeks after their quit date.	
35	5	Royal College of Midwives	**S06**	Support	Agree.	Thank you for your comments
57	8	British Heart Foundation	**S06**	Statement	We agree with the standard reflecting an area for quality improvement. As this is most likely to occur in primary care, rather than an acute setting, the data collection is already in place. Our impression is that carbon monoxide testing is not routinely offered or available in primary care. To achieve this standard carbon monoxide testing equipment will need to be routinely available in GP surgeries, pharmacy and other community settings.	Quality standards describe areas for quality improvement, and local services may then determine how they wish to achieve the statements.
67	10	Pfizer Limited	S06	Statement	Pfizer supports the use of a carbon monoxide-confirmed measure of smoking cessation 4 weeks after the quit date, since this is a sound evidence-based measure of the quality of a smoking cessation service. However, the metric of 4-week quit rates which is used to measure outcomes in PCT-commissioned smoking cessation services, is not included in the public health outcomes framework for local authorities.[1,2] Since PCT-commissioned smoking cessation services have been replaced with local authority commissioned services as of 1 April 2013[1] it is unclear how this quality statement will apply to local authority commissioned smoking cessation services. Pfizer believes that NICE should provide clarity around this issue to ensure that this important metric is retained as a mandatory benchmark of quality for local authority-commissioned smoking cessation services. If the status of this quality statement is not clarified there is the risk that the entire smoking cessation quality standard will have limited relevance to and impact on the quality of smoking cessation services in future.	The QSAC discussed several alternative timeframes and felt that recording smoking status using carbon monoxide testing after 4 weeks (as stated in the NICE source guidance) remains a useful and pragmatic time point with which to maintain the engagement of service users. Also, importantly it is noted in the definitions sections in the Quality Standard that this 4 week point does not imply that treatment should stop at 4 weeks. The 4 week time point selected for this particular statement is supported by the current published underpinning source guidance for the quality standard. As with all quality standard measures this is not a mandatory indicator and could be used alongside other follow up timeframes adopted by the smoking

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						cessation service. The statement applies to those providing smoking cessation services and the 4 week quit date can be applied through the statement measures as a marker of quality. The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the smoking cessation services public health guidance (PH10). The quality standards do not seek to reassess or redefine the evidence base as outlined in the national accredited guidance. Thank you for your comments. We have updated the quality standard to reflect this change in commissioning responsibility. This will also be reflected in the NICE support for commissioning tool for this standard will also reflect the changes in the structure and organisation of smoking cessation services.
68	10	Pfizer Limited	S06	Statement	References 1. Kelly P, 2012. Public Health England: What the future holds for stop smoking services. UKNSCC 2012. http://www.uknscc.org/uknscc2012_presentation_98.php 2. Healthy lives, health people: Improving outcomes and supporting transparency. Part 1: A public health outcomes framework for England, 2013-2016. Department of Health, 2012. https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency	Thank you for your response.

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84	11	Johnson & Johnson	S06	Statement	Johnson & Johnson has concerns about draft quality standard 6 in its present form. It acknowledges that 4 week quit measurements and previously targets have been used by the NHS and within smoking cessation services, but 4 weeks is not an optimal point at which to measure the likelihood of long-term quit. Johnson & Johnson does not believe that this measure sufficiently motivates or incentivises healthcare professionals to focus on long-term cessation outcomes and as such does not ensure the best long-term outcome for the NHS or for smokers by supporting long-term cessation.	The QSAC discussed several alternative timeframes and felt that recording smoking status using carbon monoxide testing after 4 weeks (as stated in the NICE source guidance) remains a useful and pragmatic time point with which to maintain the engagement of service users. Also, importantly it is noted in the definitions sections in the Quality Standard that this 4 week point does not imply that treatment should stop at 4 weeks. The 4 week time point selected for this particular statement is supported by the current published underpinning source guidance for the quality standard. As with all quality standard measures this is not a mandatory indicator and could be used alongside other follow up timeframes adopted by the smoking cessation service. The statement applies to those providing smoking cessation services and the 4 week quit date can be applied through the statement measures as a marker of quality. The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the smoking cessation services public

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						health guidance (PH10). The quality standards do not seek to reassess or redefine the evidence base as outlined in the national accredited guidance.
85	11	Johnson & Johnson	S06	Statement	It is not uncommon for a standard pharmacological treatment period to be 12 weeks where an abrupt cessation strategy is employed, as such recording smoking status with carbon monoxide testing at 12 weeks is likely to improve treatment compliance and yield better long-term outcomes than only reviewing and recording at 4 weeks. Where possible 6 month follow up would also be advantageous or optimal.	The QSAC discussed several alternative timeframes and felt that recording smoking status using carbon monoxide testing after 4 weeks (as stated in the NICE source guidance) remains a useful and pragmatic time point with which to maintain the engagement of service users. Also, importantly it is noted in the definitions sections in the Quality Standard that this 4 week point does not imply that treatment should stop at 4 weeks. The 4 week time point selected for this particular statement is supported by the current published underpinning source guidance for the quality standard. As with all quality standard measures this is not a mandatory indicator and could be used alongside other follow up timeframes adopted by the smoking cessation service. The statement applies to those providing smoking cessation services and the 4 week quit date can be applied through the statement measures as a marker of

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						quality. The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the smoking cessation services public health guidance (PH10). The quality standards do not seek to reassess or redefine the evidence base as outlined in the national accredited guidance.
89	12	British Thoracic Society	S06	Measure	Outcome measurement: This remains the weakest standard - **4 weeks** is a meaningless target and meaningless outcome, and should be extended to 12 weeks (minimum) or even 6 months.	The QSAC discussed several alternative timeframes and felt that recording smoking status using carbon monoxide testing after 4 weeks (as stated in the NICE source guidance) remains a useful and pragmatic time point with which to maintain the engagement of service users. Also, importantly it is noted in the definitions sections in the Quality Standard that this 4 week point does not imply that treatment should stop at 4 weeks. The 4 week time point selected for this particular statement is supported by the current published underpinning source guidance for the quality standard. As with all quality standard measures this is not a mandatory indicator and could be used alongside other follow up timeframes adopted by the smoking cessation service.

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						The statement applies to those providing smoking cessation services and the 4 week quit date can be applied through the statement measures as a marker of quality. The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the smoking cessation services public health guidance (PH10). The quality standards do not seek to reassess or redefine the evidence base as outlined in the national accredited guidance.
112	13	National Centre for Smoking Cessation and Training	S06	Definitions	There is no mention of the Russell Standard which provides the current definitions for data collection amongst the English stop smoking services: http://www.ncsct.co.uk/publication_The-Russell-Standard.php	Thank you for your comments. Quality standards are designed to be person-focused.
123	15	Department of Health	S06	Measure	Recording smoking status after 4 weeks by CO verification does not provide an incentive for people who are trying to quit, it provides a measurable outcome by which services can by set targets and a steady relapse curve for prediction of long-term outcomes on a grander scale. Undertaking and recording CO levels at each and every appointment combined with skilful interpretation and reporting of the results to the individual, followed by a conversation around past and future successes provides incentive for people who are trying to quit.	The QSAC discussed several alternative timeframes and felt that recording smoking status using carbon monoxide testing after 4 weeks (as stated in the NICE source guidance) remains a useful and pragmatic time point with which to maintain the engagement of service users. Also, importantly it is noted in the definitions sections in the Quality Standard that this 4 week point does not imply that treatment should stop at 4 weeks.

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						The 4 week time point selected for this particular statement is supported by the current published underpinning source guidance for the quality standard. As with all quality standard measures this is not a mandatory indicator and could be used alongside other follow up timeframes adopted by the smoking cessation service. The statement applies to those providing smoking cessation services and the 4 week quit date can be applied through the statement measures as a marker of quality. The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the smoking cessation services public health guidance (PH10). The quality standards do not seek to reassess or redefine the evidence base as outlined in the national accredited guidance.
128	16	South West Yorkshire NHS Foundation Trust	S06	Statement	"People who smoke who have set a quit date are offered carbon monoxide testing 4 weeks after the quit date". **Clients attending stop smoking services are offered carbon monoxide monitoring at each session they attend, usually weekly. A minimum standard would be carbon monoxide monitoring at quit date and 4 weeks later to verify smoking status.**	Thank you for your comment.
140	18	Royal Pharmaceutical Society	S06	General	We would like to see pharmacist specifically mentioned in this section. Pharmacists are able to offer carbon monoxide testing to patients to help monitor health outcomes and reinforce the benefits of stopping smoking.	Thank you for your comments. The quality statement is not designed to provide an exhaustive list of the specific services that specific healthcare professionals can provide.

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147	19	Primary Care Respiratory Society	S06	Support	We agree	Thank you for your comments
162	21	Royal College of General Practitioners	S06		I think that NICE should look very carefully at the widely criticised 4 week stop rate evaluation - I think started around 2000 - as part of an unevidenced based government target. The majority of evidence would suggest 6-12w quit rates or 52w - why are we persisting with 4 weeks which is against the evidence?	The QSAC discussed several alternative timeframes and felt that recording smoking status using carbon monoxide testing after 4 weeks (as stated in the NICE source guidance) remains a useful and pragmatic time point with which to maintain the engagement of service users. Also, importantly it is noted in the definitions sections in the Quality Standard that this 4 week point does not imply that treatment should stop at 4 weeks. The 4 week time point selected for this particular statement is supported by the current published underpinning source guidance for the quality standard. As with all quality standard measures this is not a mandatory indicator and could be used alongside other follow up timeframes adopted by the smoking cessation service. The statement applies to those providing smoking cessation services and the 4 week quit date can be applied through the statement measures as a marker of quality. The quality standards are based

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						on evidence-based recommendations from national accredited guidance, i.e. the smoking cessation services public health guidance (PH10). The quality standards do not seek to reassess or redefine the evidence base as outlined in the national accredited guidance.
168	24	Kick It Stop Smoking Service NOT REGISTERED YET	S06	Definitions	I suggest revising and simplifying the verified 4 week quitter definition (found in the Monitoring Guidance). The current definition is too complex, impractical, and thus prone for misinterpretations.	The QSAC discussed several alternative timeframes and felt that recording smoking status using carbon monoxide testing after 4 weeks (as stated in the NICE source guidance) remains a useful and pragmatic time point with which to maintain the engagement of service users. Also, importantly it is noted in the definitions sections in the Quality Standard that this 4 week point does not imply that treatment should stop at 4 weeks. The 4 week time point selected for this particular statement is supported by the current published underpinning source guidance for the quality standard. As with all quality standard measures this is not a mandatory indicator and could be used alongside other follow up timeframes adopted by the smoking cessation service. The statement applies to those providing smoking cessation services and the 4

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						week quit date can be applied through the statement measures as a marker of quality. The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the smoking cessation services public health guidance (PH10). The quality standards do not seek to reassess or redefine the evidence base as outlined in the national accredited guidance.

These organisations were approached but did not respond:

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