NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Draft quality standard for smoking cessation: supporting people to stop smoking

1 Introduction

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

A wide range of diseases and conditions are caused by cigarette smoking, including cancers, respiratory diseases, coronary heart and other circulatory diseases, stomach and duodenal ulcers, erectile dysfunction and infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis.

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

This quality standard covers NHS-provided or NHS-commissioned support for people to stop smoking. For more information please see the topic overview.

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. The quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following frameworks:

- NHS Outcomes Framework 2013–14
- Improving outcomes and supporting transparency: Part 1: a public health outcomes framework for England, 2013–2016
- The Adult Social Care Outcomes Framework.

The table below shows the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving:

NHS outcomes framework 2013–14	
Domain1: Preventing people from dying prematurely.	**Overarching indicators** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare 1b Life expectancy at 75 i males ii females **Improvement areas** *Reducing premature mortality from the major causes of death* 1.1 Under 75 mortality rate from cardiovascular disease 1.2 Under 75 mortality rate from respiratory disease *Cancer* 1.4.i One-and ii Five-year survival from all cancers iii One-and iv Five-year survival from breast, lung and colorectal cancer *Reducing premature death in people with serious mental illness* 1.5 Excess under 75 mortality rate in adults with serious mental illness *Reducing deaths in babies and young children* 1.6.i Infant mortality ii Neonatal mortality and stillbirths *Reducing premature death in people with learning disabilities* 1.7 Excess under 60 mortality rate in adults with a learning disability
Domain 2: Enhancing quality of life for people with long-	**Overarching indicator** 2 Health-related quality of life for people with long-term conditions

term conditions	**Improvement areas** Ensuring people feel supported to manage their condition *Improving functional ability in people with long-term conditions* 2.2 Employment of people with long-term conditions *Reducing time spent in hospital by people with long-term conditions* 2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) 2.3 ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s *Enhancing quality of life for carers* 2.4 Health-related quality of life for carers Enhancing quality of life for people with mental illness 2.5 Employment of people with mental illness
Domain 3: Helping people to recover from episodes of ill health or following injury	**Overarching indicators** 3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital **Improvement areas** *Improving outcomes from planned procedures* 3.1 Patient Reported Outcomes Measures (PROMs) for elective procedures 3.1i Hip replacement 3.1ii Knee replacement 3.1iii Groin hernia 3.1iv Varicose veins *Preventing lower respiratory tract infections (LRTI) in children from becoming serious* 3.2 Emergency admissions for children with LRTI *Improving recovery from injuries and trauma* 3.3 Proportion of people who recover from major trauma *Improving recovery from stroke* 3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months *Improving recovery from fragility fractures* 3.5 The proportion of patients recovering to their previous levels of mobility / walking ability at 3.5i 30 and

	3.5ii 120 days *Helping older people to recover their independence after illness or injury* 3.6 Proportion of older people (65 and over) who were 3.6i still at home 91 days after discharge into rehabilitation 3.6ii offered rehabilitation following discharge from acute or community hospital
Public Health Outcomes Framework 2013–14	
Domain 2: Health improvement	**Objective** *People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities* 2.1 Low birth weight of term babies 2.3 Smoking status at time of delivery 2.9 Smoking prevalence – 15 year olds (Placeholder) 2.14 Smoking prevalence – adult (over 18s)
Domain 4: Healthcare public health and preventing premature mortality	**Objective** *Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities* 4.3 Mortality from causes considered preventable 4.4 Mortality from all cardiovascular diseases (including heart disease and stroke) 4.5 Mortality from cancer 4.7 Mortality from respiratory diseases 4.9 Excess under 75 mortality in adults with serious mental illness (Placeholder) 4.12 Preventable sight loss 4.13 Health-related quality of life for older people (Placeholder)
Social Care Outcomes Framework 2013–14	
Domain 1: Enhancing quality of life for people with care and support needs	**Outcome measures** *Carers can balance their caring roles and maintain their desired quality of life* 1D Carer-reported quality of life *People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation*

	1E Proportion of adults with a learning disability in paid employment 1F Proportion of adults in contact with secondary mental health services in paid employment
Domain 2: Delaying and reducing the need for care and support	**Outcome measures** *Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.* *Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.* 2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

2 Draft quality standard for smoking cessation

Overview

The draft quality standard for smoking cessation: supporting people to stop smoking states that services should be commissioned from and coordinated across all relevant agencies encompassing the smoking cessation pathway. A person-centered and integrated approach to provision of services is fundamental to delivering high-quality smoking cessation services.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should cross refer across the library of NICE quality standards when designing high-quality services.

Patients, service users and carers may use the quality standard to find out about the quality of care they should expect to receive; support asking questions about the care they receive; and to make a choice between providers of social care services.

The quality standard should be read in the context of national and local guidelines on training and competencies. All health and social care professionals involved in supporting people to stop smoking should be sufficiently and appropriately trained and competent to deliver the actions and interventions described in the quality standard. This quality standard references specific training modules on brief interventions in the definitions section of quality statements 2 and 3.

No.	Draft quality statements
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.
3	People who have been referred to an evidence-based stop smoking service are offered behavioural support with pharmacotherapy.
4	People who smoke are offered a full course of nicotine replacement therapy (NRT), varenicline or bupropion.
5	Pregnant women are offered carbon monoxide testing to assess exposure to tobacco smoke at the antenatal booking appointment and throughout the pregnancy.
6	People who smoke who have set a quit date are offered carbon monoxide testing 4 weeks after the quit date.

Other quality standards that should also be considered when choosing, commissioning or providing a high-quality service for smoking cessation are listed in section 7.

General questions for consultation:

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

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

Please refer to quality standards in development for additional general points for consideration.

Statement-specific questions for consultation:

Question 3 For draft quality statement 5: Is process measure b) (receiving carbon monoxide testing throughout pregnancy) measurable? If not, are stakeholders able to suggest more specific points during pregnancy at which exposure to carbon monoxide could be tested?

Draft quality statement 1: Identifying people who smoke

Draft quality statement	People are asked if they smoke by their healthcare professional, and those who smoke are offered brief advice on how to stop.
Rationale	There is evidence that people who smoke are more receptive to smoking cessation advice in healthcare settings. It is therefore important that healthcare professionals proactively ask patients if they smoke, and offer those that smoke brief advice to stop, to make the most of this opportunity.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure people are asked if they smoke by their healthcare professional, and those who smoke are offered brief advice on how to stop. **Process:** a) Proportion of people who are asked if they smoke by their healthcare professional. Numerator – the number of people in the denominator who are asked if they smoke by their healthcare professional. Denominator – the number of people who have face-to-face contact with healthcare professionals. b) Proportion of people who smoke who receive brief advice on how to stop. Numerator – the number of people in the denominator who receive brief advice on how to stop. Denominator – the number of people who report that they smoke during face-to-face contacts with healthcare professionals.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people to be asked if they smoke by their healthcare professional, and those who smoke to be offered brief advice on how to stop. **Healthcare professionals** ask their patients if they smoke, and offer those who smoke brief advice on how to stop. **Commissioners** ensure they commission services where healthcare professionals ask their patients if they smoke, and that offer those who smoke brief advice on how to stop. **People using healthcare services** are asked if they smoke by healthcare professionals, and those who smoke are offered brief advice on how to stop.
Source	NICE public health guidance 1 recommendations 1, 2, 3, 4, 8 and 9. NICE public health guidance 10 recommendations 6, 7, 8, 9, 10, 11 and 12. NICE public health guidance 26 recommendations 1, 2 and 8.

Data source	**Structure:** Local data collection. **Process:** a) Local data collection. Contained within NICE public health guidance 1 audit support criterion 1 and NICE public health guidance 10 audit support criterion 8. The quality and outcomes framework (QOF) contains indicators related to identification of and support for smokers in primary care. b) Local data collection. Contained within NICE public health guidance 1 audit support criterion 2, NICE public health guidance 10 audit support criteria 3, 4, and 8, and NICE public health guidance 26 self-assessment support. The quality and outcomes framework (QOF) contains indicators related to identification of and support for smokers in primary care.
Definitions	Healthcare professionals include but are not limited to doctors, nurses, midwives, pharmacists and dentists. Brief advice is evidence-based, opportunistic advice offered to smokers about the options and support available to help them stop smoking. The National Centre for Smoking Cessation and Training offers a training module on the delivery of evidence-based stop smoking interventions, to ensure this is done in a sensitive way within the brief available timeframe of patient contact.
Equality and diversity consideration	Advice should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

Draft quality statement 2: Referral to stop smoking services

Draft quality statement	People who smoke are referred to an evidence-based stop smoking service.
Rationale	Stop smoking services provide the most effective route to quitting but many smokers do not use this facility when they try to stop.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure people who smoke are referred to an evidence-based stop smoking service. **Process:** Proportion of people who smoke who are referred to an evidence-based stop smoking service. 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 healthcare setting.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people who smoke to be referred to an evidence-based stop smoking service. **Healthcare professionals** refer people who smoke to an evidence-based stop smoking service. **Commissioners** ensure they commission services that refer people who smoke to an evidence-based stop smoking service. **People who smoke** are referred to an evidence-based stop smoking service.
Source	NICE public health guidance 1 recommendations 3, 4, 5 and 6. NICE public health guidance 10 recommendations, 6, 8, 9, 10, 11 and 12. NICE public health guidance 26 recommendations 1, 2, 3, and 8. NICE technology appraisal 123 recommendations 1.1 and 1.2.
Data source	**Structure:** Local data collection. **Process:** Local data collection. Contained within NICE public health guidance 1 audit support criteria 2-4, NICE public health guidance 10 audit support criterion 3, and NICE public health guidance 26 self-assessment support. The quality and outcomes framework (QOF) contains indicators related to support for smokers in primary care.
Definitions	Healthcare professionals who may refer include but are not limited to doctors, nurses, midwives, pharmacists and dentists.

	The National Centre for Smoking Cessation and Training has training modules for those delivering stop smoking interventions. Evidence-based stop smoking services are local services providing accessible, evidence-based and cost-effective support to people who want to stop smoking.

Draft quality statement 3: Combination therapy

Draft quality statement	People who have been referred to an evidence-based stop smoking service are offered behavioural support with pharmacotherapy.
Rationale	People who smoke are more likely to quit if they are offered a combination of interventions, with combined behavioural support and pharmacotherapy the most likely to be successful.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that people who have been referred to an evidence-based stop smoking service are offered behavioural support with pharmacotherapy. **Process:** Proportion of people who have been referred to an evidence-based stop smoking service who receive behavioural support with pharmacotherapy. Numerator – the number of people in the denominator who receive behavioural support with pharmacotherapy. Denominator – the number of people who have been referred to an evidence-based stop smoking service.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people who have been referred to an evidence-based stop smoking service to be offered behavioural support with pharmacotherapy. **Healthcare professionals** offer behavioural support with pharmacotherapy to people who have been referred to an evidence-based stop smoking service. **Commissioners** ensure they commission services for people who have been referred to an evidence-based stop smoking service that offer behavioural support with pharmacotherapy. **People who have been referred to an evidence-based stop smoking service** are offered behavioural support (either individual or group counselling) with pharmacotherapy.
Source	NICE public health guidance 10 recommendations 2, 4, 7, 8, 9 and 10. NICE public health guidance 26 recommendations 4 and 5. NICE technology appraisal 123 recommendations 1.1 and 1.2.
Data source	**Structure:** Local data collection. **Process:** Local data collection. Contained within NICE public health guidance 10 audit support criterion 7 and NICE public health guidance 26 self-assessment support. Statistics on NHS Stop Smoking Services: England, April 2011 – March 2012 from the Health and Social Care Information Centre reports on smoking cessation interventions.

Definitions	Please see quality statement 4 for further detail regarding pharmacotherapy. Behavioural 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. Typically, it involves weekly sessions over a period of at least 4 weeks after the quit date and is normally combined with pharmacotherapy. NICE public health guidance 10 states that group behaviour therapy involves scheduled meetings where people who smoke receive information, advice and encouragement and some form of behavioural intervention (for example, cognitive behavioural therapy). This therapy is offered weekly for at least the first 4 weeks of a quit attempt (that is, for 4 weeks following the quit date). It is normally combined with pharmacotherapy. 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 women express a clear preference for NRT. Neither varenicline nor bupropion should be offered to pregnant or breastfeeding women.
Equality and diversity consideration	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 women express a clear preference for NRT. Neither varenicline nor bupropion should be offered to pregnant or breastfeeding women.

Draft quality statement 4: Pharmacotherapy

Draft quality statement	People who smoke are offered a full course of nicotine replacement therapy (NRT), varenicline or bupropion.
Rationale	Pharmacotherapy interventions act as an as an aid to help people to quit smoking, increasing the chances of success. It is therefore important that people receive the full course of their chosen pharmacotherapy.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure people who smoke are offered a full course of NRT, varenicline or bupropion. **Process:** Proportion of people who smoke who receive a full course of NRT, varenicline or bupropion. Numerator – the number of people in the denominator who receive a full course of NRT, varenicline or bupropion. Denominator – the number of people who smoke.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people who smoke to be offered a full course of NRT, varenicline or bupropion. **Healthcare professionals** offer people who smoke a full course of NRT, varenicline or bupropion. **Commissioners** ensure they commission services for people who smoke that offer a full course of NRT, varenicline or bupropion. **People who smoke** are offered a full course of NRT, varenicline or bupropion.
Source	NICE public health guidance 1 recommendation 3. NICE public health guidance 10 recommendations 2, 4, 6, 7, 8, 9 and 10. NICE public health guidance 26 recommendation 5. NICE technology appraisal 123 recommendations 1.1 and 1.2.
Data source	**Structure:** Local data collection. **Process:** Local data collection. Contained within NICE public health guidance 1 audit support criterion 5, NICE public health guidance 10 audit support criteria 5-8 and NICE public health guidance 26 self-assessment support. Statistics on NHS Stop Smoking Services: England, April 2011 – March 2012 from the Health and Social Care Information Centre reports on smoking cessation interventions.
Definitions	NICE public health guidance 10 states that NRT, varenicline or bupropion should normally be prescribed as part of an abstinent contingent treatment, in which the smoker makes a commitment to stop smoking on or before a particular date. It should be

	prescribed along with giving advice, encouragement and support, or referral to a smoking cessation service. NICE technology appraisal 123 also states that varenicline should normally be prescribed only as part of a programme of behavioural support. However, 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. NICE public health guidance 10 states that a combination of nicotine patches and another form of NRT (such as gum, inhalator, lozenge or nasal spray) may be considered for people who show a high level of dependence on nicotine or who have found single forms of NRT inadequate in the past. 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 women express a clear preference for NRT. Neither varenicline nor bupropion should be offered to pregnant or breastfeeding women.
Equality and diversity consideration	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 women express a clear preference for NRT. Neither varenicline nor bupropion should be offered to pregnant or breastfeeding women.

Draft quality statement 5: Smoking and pregnancy

Draft quality statement	Pregnant women are offered carbon monoxide testing to assess exposure to tobacco smoke at the antenatal booking appointment and throughout the pregnancy.
Rationale	Some pregnant women find it difficult to say that they smoke because the pressure not to smoke during pregnancy is so intense. This, in turn, makes it difficult to ensure they are offered appropriate support. A carbon monoxide test is an immediate and non-invasive biochemical method for helping to assess whether or not someone smokes.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure pregnant women are offered carbon monoxide testing to confirm smoking status at the antenatal booking appointment and throughout the pregnancy. **Process:** a) Proportion of pregnant women who receive carbon monoxide testing at the antenatal booking appointment. Numerator – the number of people in the denominator who receive carbon monoxide testing at the antenatal booking appointment**.** Denominator – the number of pregnant women. b) Proportion of pregnant women who receive carbon monoxide testing throughout their pregnancy. Numerator – the number of people in the denominator who receive carbon monoxide testing throughout their pregnancy. Denominator– the number of pregnant women. **Outcome:** a) Smoking cessation rates in pregnant women. b) Prevalence of smoking in pregnant women. c) Incidence of smoking in pregnant women.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for pregnant women to be offered carbon monoxide testing to assess exposure to tobacco smoke at the antenatal booking appointment and throughout the pregnancy. **Healthcare professionals** offer pregnant women carbon monoxide testing to assess exposure to tobacco smoke at the antenatal booking appointment and throughout the pregnancy. **Commissioners** ensure they commission services for pregnant women that offer carbon monoxide testing to assess exposure to tobacco smoke at the antenatal booking appointment and throughout the pregnancy. **Pregnant women** are offered carbon monoxide testing to assess

	exposure to tobacco smoke at the antenatal booking appointment and throughout the pregnancy.
Source	NICE public health guidance 26 recommendations 1 and 4.
Data source	**Structure:** Local data collection. **Process:** a) Local data collection. Contained within NICE public health guidance 10 audit support criterion 8 and NICE public health guidance 26 self-assessment support. The maternity and children's dataset includes information on smoking. b) Local data collection. **Outcome:** a) Local data collection. b) Local data collection. The smoking status at time of delivery collection covers information on the number of women smoking and not smoking at time of delivery. c) Local data collection.
Definitions	NICE public health guidance 26 states that a carbon monoxide (CO) test is an immediate and non-invasive biochemical method for helping to assess whether or not someone smokes. However, it is unclear as to what constitutes the best cut-off point for determining smoking status. Some suggest a CO level as low as 3 parts per million (ppm), others use a cut-off point of 6–10 ppm. It is important to note that CO quickly disappears from expired breath (the level can fall by 50% in less than 4 hours). As a result, low levels of smoking may go undetected and may be indistinguishable from passive smoking. Conversely, environmental factors such as traffic emissions or leaky gas appliances may cause a high CO reading – as may lactose intolerance. When trying to identify pregnant women who smoke, it is best to use a low cut-off point to avoid missing someone who may need help to quit. 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 healthcare professionals should refer women with a CO reading of 7 ppm or above. (Note: light or infrequent smokers should also be referred, even if they register a lower reading – for example, 3 ppm.) If women have a high CO reading (more than 10 ppm) but say they do not smoke, advise them about possible CO poisoning and ask them to call the free Health and Safety Executive gas safety advice line on: 0800 300 363.
Specific question for consultation	Is process measure b) (receiving carbon monoxide testing throughout pregnancy) measurable? If not, are stakeholders able to suggest more specific points during pregnancy at which

	exposure to carbon monoxide could be tested?

Draft quality statement 6: Outcome measurement

Draft quality statement	People who smoke who have set a quit date are offered carbon monoxide testing 4 weeks after the quit date.
Rationale	Recording smoking status after 4 weeks provides an incentive for people who are attempting to quit, and is an objective way to measure individual and service level outcomes.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure people who smoke who have set a quit date are offered carbon monoxide testing after 4 weeks. **Process:** Proportion of people who smoke who have set a quit date who receive carbon monoxide testing 4 weeks after the quit date. Numerator – the number of people in the denominator who receive carbon monoxide testing 4 weeks after the quit date. Denominator– the number of people who smoke who have set a quit date. **Outcome:** Proportion of people achieving 4 week quit.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people who smoke who have set a quit date to be offered carbon monoxide testing 4 weeks after the quit date. **Healthcare professionals** offer people who smoke who have set a quit date carbon monoxide testing 4 weeks after the quit date. **Commissioners** ensure they commission services for people who smoke who have set a quit date to be offered carbon monoxide testing 4 weeks after the quit date. **People who smoke who have set a quit date** are offered carbon monoxide testing 4 weeks after the quit date.
Source	NICE public health guidance 10 recommendation 1. NICE public health guidance 26 recommendation 4.
Data source	**Structure:** Local data collection. **Process:** Local data collection. Contained within NICE public health guidance 26 self-assessment support. The Health and Social Care Information Centre's Indicator Portal collects data on the number of smokers who successfully quit at the 4 week follow-up per 100,000 population. **Outcome:** Local data collection.
Definitions	NICE public health guidance 10 states success should be validated by a CO monitor reading of less than 10 ppm at the 4-week point. This does not imply that treatment should stop at 4 weeks.

3 Status of this quality standard

This is the draft quality standard released for consultation from 11 March to 10 April 2013. This document is not NICE's final quality standard on smoking cessation. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 10 April 2013. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will then be available on the NICE website from August 2013.

4 Using the quality standard

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered by commissioners, providers, health and social care professionals, patients, service users and carers alongside the documents listed in section 8.

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

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice when taking account of safety, choice and professional judgement and so desired levels of achievement should be defined locally.

We have illustrated where national indicators currently exist and measure the quality statement. National indicators include those developed by the Health and Social Care Information Centre through theirIndicators for Quality Improvement Programme. If national quality indicators do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of care.

For further information, including guidance on using quality measures, please see What makes up a NICE quality standard.

5 Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments will be published on the NICE website with the final version of the quality standard.

Good communication between healthcare services and people who smoke is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People who smoke should have access to an interpreter or advocate if needed.

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

6 How this quality standard was developed

The evidence sources used to develop this quality standard are listed in section 8, along with relevant policy context. References for the definitions and data sources for the quality measures are also included. Further explanation of the methodology used can be found in the Quality standards process guide.

7 Related NICE quality standards

Antenatal care. NICE quality standard 22 (2012).
Patient experience in adult NHS services. NICE quality standard 15 (2012).
Chronic obstructive pulmonary disease (COPD). NICE quality standard 10 (2011).

8 Development sources

Evidence sources

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

National Institute for Health and Clinical Excellence (2010) Quitting smoking in pregnancy and following childbirth. NICE public health guidance 26.

National Institute for Health and Clinical Excellence (2008) Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. NICE public health guidance 10.

National Institute for Health and Clinical Excellence (2007) Smoking cessation – varenicline. NICE technology appraisal 123.

National Institute for Health and Clinical Excellence (2006) Brief interventions and referral for smoking cessation. NICE public health guidance 1.

Policy context

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

Department of Health (2012) Local stop smoking services – key updates to the 2011/12 service delivery and monitoring guidance for 2012/13.

Department of Health (2011) Healthy lives, healthy people: a tobacco control plan for England.

Department of Health (2011) Stop smoking service delivery and monitoring guidance 2011/12.

Department of Health (2010) A smokefree future: a comprehensive tobacco control strategy for England.

Department of Health (2009) Tackling health inequalities: targeting routine and manual smokers in support of the Public Service Agreement smoking prevalence and health inequality targets.

Department of Health (2008) Excellence in tobacco control: 10 high impact changes to achieve tobacco control.

Definitions and data sources for the quality measures

References included within the definitions and data sources sections:

Quality and outcomes framework (QOF)

Health and Social Care Information Centre statistics on NHS Stop Smoking Services: England, April 2011 – March 2012

Health and Social Care Information Centre smoking status at time of delivery.

Health and Social Care Information Centre Maternity and children's dataset

Health and Social Care Information Centre Indicator Portal