NICE National Institute for Health and Care Excellence

NICE quality standard

Smoking: reducing and preventing tobacco use

Quality standard

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This standard is based on NG209.

This standard should be read in conjunction with QS22, QS43, QS92, QS102, QS100, QS99, QS95, QS146, QS147 and QS196.

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Statement 9 (placeholder). Preventing access to, demand for and supply of illicit tobacco.

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Quality statement 1: Schools and colleges: interventions

Quality statement

Schools and colleges deliver combined interventions to stop children and young people taking up smoking by improving their social competence and awareness of social influences.

Rationale

Schools and colleges have an important role in helping children and young people to understand the harm associated with tobacco products. Most schools and colleges have already implemented smokefree policies, and teaching about tobacco use and its impact is part of the curriculum. However, children and young people still face substantial pressures to start smoking from their peers, family members, the media and the tobacco industry. Combined interventions to improve social competence and to make students aware of the social influences that support smoking are effective in preventing children and young people from taking up smoking.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of arrangements within local schools and colleges to deliver combined interventions to stop children and young people taking up smoking by improving their social competence and awareness of social influences.

Data source: Data can be collected from information recorded locally by schools and colleges, for example from curriculum plans.

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Process

a) Proportion of schools and colleges that deliver combined interventions to stop children and young people taking up smoking by improving their social competence and awareness of social influences.

Numerator – the number in the denominator that deliver combined interventions to stop children and young people taking up smoking by improving their social competence and awareness of social influences.

Denominator – the number of schools and colleges in a specified geographic area.

Data source: Data can be collected from information recorded locally by local authorities, schools and colleges, for example from audit of curriculum plans.

b) Proportion of children and young people who receive combined interventions to stop them taking up smoking by improving their social competence and awareness of social influences.

Numerator – the number in the denominator who receive combined interventions to stop them taking up smoking by improving their social competence and awareness of social influences.

Denominator – the number of children and young people in schools and colleges in a specified geographic area.

Data source: Data can be collected from information recorded locally by local authorities, schools and colleges, for example from audit or surveys of children and young people.

Outcome

Proportion of children and young people who have tried smoking at least once.

Data source: Statistics on smoking, England covers the national prevalence of smoking among young people aged 16 to 19 and secondary school students (mostly aged 11 to 15).

What the quality statement means for different

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audiences

Schools and colleges deliver combined interventions to stop children and young people taking up smoking by improving their social competence and awareness of social influences.

Children and young people take part in programmes at their school or college that help them to refuse offers of tobacco products by improving their self-esteem, how they cope with stress, and general social and assertive skills.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2025), recommendations 1.6.2 and 1.7.1

Definitions of terms used in this quality statement

Schools and colleges

This covers:

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

[Adapted from NICE's guideline on tobacco, terms used in this guideline; schools]

Social competence interventions

A group of interventions that aim to help children and young people refuse offers to smoke by improving their general social competence. Programmes benefit from including social

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learning processes or life skills such as:

- problem solving and decision making
- cognitive skills for resisting interpersonal or media influences
- increased self-control and self-esteem
- coping strategies for stress
- general social and assertive skills.

These interventions can be peer led or adult led and can have tobacco products as a focus or be more general. [Cochrane review on school-based programmes for preventing smoking and expert opinion]

Social influences interventions

Interventions that aim to increase awareness of social influences that promote tobacco use and help students overcome these influences. Programmes adopt resistance skills training in which students are taught how to:

- deal with peer pressure
- deal with high-risk situations
- effectively refuse direct and indirect attempts to persuade them to use tobacco products.

[Cochrane review on school-based programmes for preventing smoking and expert opinion]

Equality and diversity considerations

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

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Quality statement 2: Schools and colleges: smokefree grounds

Quality statement

Schools and colleges do not allow smoking anywhere in their grounds and remove any areas previously designated for smoking.

Rationale

Most schools and colleges already have a smokefree policy in place, which includes having smokefree grounds. However, some of the smokefree grounds still allow smoking in designated smoking areas and may even provide smoking shelters. Allowing anyone to smoke anywhere in the school grounds at any time, makes it seem an acceptable activity. Providing outdoor smoking areas facilitates smoking.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of arrangements in local schools and colleges to operate smokefree grounds and remove any areas designated for smoking.

Data source: Data can be collected from information recorded locally by schools and colleges, for example from smokefree policies.

Process

a) Proportion of schools and colleges that do not allow smoking anywhere in the grounds.

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Numerator – the number in the denominator that do not allow smoking anywhere in the grounds.

Denominator – the number of schools and colleges in the specified geographic area.

Data source: Data can be collected from information recorded locally by local authorities, schools and colleges, for example from audit of smokefree policies or surveys of schools and colleges.

b) Proportion of schools and colleges with no designated areas for smoking.

Numerator – the number in the denominator with no designated areas for smoking.

Denominator – the number of schools and colleges in the specified geographic area.

Data source: Data can be collected from information recorded locally by local authorities, schools and colleges, for example from audit of smokefree policies or surveys of schools and colleges.

Outcome

Schools and colleges with smokefree grounds and no areas designated for smoking.

Data source: Data can be collected from information recorded locally by local authorities, schools and colleges, for example from audit of smokefree policies or surveys of schools and colleges.

What the quality statement means for different audiences

Schools and colleges ensure that smoking is not allowed anywhere in the grounds and that the smokefree policy applies to anyone using the premises for any purpose at any time. They should also remove any existing areas previously designated for smoking in the grounds.

Children and young people attend schools and colleges that do not allow smoking anywhere in the school or the school grounds at any time. The schools and colleges do not

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have any areas in the grounds set aside for smoking.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2025), recommendation 1.5.3

Definitions of terms used in this quality statement

Schools and colleges

This covers:

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

[Adapted from NICE's guideline on tobacco, terms used in this guideline; schools]

Equality and diversity considerations

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

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Quality statement 3: Underage sales

Quality statement

Trading standards identify and take action against retailers that sell tobacco products to people under 18.

Rationale

It is illegal to sell tobacco products to anyone under 18. Trading standards should work in partnership with retailers, police and the wider community to gather reliable information and take action against local retailers who sell tobacco to people under 18. This may include providing advice and guidance to the retailers, test purchasing and taking legal action.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to obtain and interpret information to identify retailers that sell tobacco products to people under 18.

Data source: Data can be collected from information recorded locally by local trading standards, for example from policies and protocols.

b) Evidence of local actions undertaken to prevent retailers from selling tobacco products to people under 18.

Data source: Data can be collected from information recorded locally by local trading standards, for example from campaigns with retailers.

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Process

a) Proportion of tobacco test purchases with a recorded underage sale.

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

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

Data source: Data can be collected from information recorded locally by local trading standards, for example from audit of test purchases. Data on number of test purchases resulting in a sale is reported in the Tobacco Control Survey, England from the Chartered Trading Standards Institute.

b) Proportion of retailers with a recorded underage sale followed up with advice to the retailer.

Numerator – the number in the denominator followed up with advice to the retailer.

Denominator – the number of test purchases with a recorded underage sale in a specified geographic area.

Data source: Data can be collected from information recorded locally by local trading standards, for example from audit of test purchases. Data on actions taken where breaches of the legislation were found are reported in the Tobacco Control Survey, England from the Chartered Trading Standards Institute.

c) Proportion of individuals sanctioned for persistently selling tobacco to people under 18.

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

Denominator – the number of individuals identified as persistently selling tobacco to people under 18 in a specified geographic area.

Data source: Data can be collected from information recorded locally by local trading standards, for example from audit of breaches and actions.

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

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

Denominator – the number of tobacco sales outlets identified as persistently selling tobacco to people under 18 in a specified geographic area.

Data source: Data can be collected from information recorded locally by local trading standards, for example from audit of breaches and actions. Data on numbers of prosecutions where breaches of the legislation were found is reported in the Tobacco Control Survey, England from the Chartered Trading Standards Institute.

Outcome

Incidence of underage tobacco sales.

Data source: Data can be collected from information recorded locally by local trading standards, for example from audit of underage tobacco sales.

What the quality statement means for different audiences

Local trading standards work in partnership with retailers, the police and the wider community to gather reliable information and take action against local retailers who sell tobacco to people under 18.

Local retailers are subject to test purchase operations and if underage tobacco sales are recorded, further action is taken. They work with local trading standards in order to comply with the legislation. If the retailers are found persistently selling tobacco products to people under 18, they can be sanctioned by magistrates' courts.

Children and young people find it hard to buy tobacco products and hard to start or carry on smoking. This means that they are better protected from smoking-related harm.

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Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2025), recommendation 1.3.2

Definitions of terms used in this quality statement

Identifying retailers

Local authorities, trading standards, the police, HM Revenue and Customs, voluntary and community groups work in partnership to identify retailers that sell tobacco products to people under 18.

Trading standards also work with local retailers to increase awareness of, and compliance with, legislation prohibiting under age tobacco sales. [Adapted from NICE's guideline on tobacco, recommendations 1.3.1, 1.3.3, 1.3.4 and expert opinion]

Taking actions against retailers

Actions taken against retailers include:

- Making test purchases each year, using local data to detect breaches in the law and auditing the breaches regularly to ensure consistent good practice across all local authorities.
- Running campaigns for retailers to publicise legislation prohibiting under age tobacco sales.
- Prosecuting retailers who persistently break the law.

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

Restricted Premises Order – The retail premises is prohibited from selling tobacco

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products for a period of up to 12 months.

Restricted Sale Order – A named person is prohibited from selling tobacco or managing premises in relation to the sale of tobacco products for a period of up to 12 months – the business may still sell tobacco, but the individual may not. [NICE's guideline on tobacco, recommendations 1.3.2 and 1.3.4, Responsible tobacco retailing, 2014 and expert opinion]

Equality and diversity considerations

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

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Quality statement 4: Workplace policy

Quality statement

Employers allow employees to access evidence-based stop-smoking support during working hours without loss of pay.

Rationale

Many employers already have a policy outlining support to help employees to quit smoking. However, in practice, employees find it difficult to get time off to access stop-smoking support when needed. NHS and local authority employers should set an example in implementing this quality statement.

Evidence shows that people who smoke take an average of 30 minutes in cigarette breaks within business hours each day. A typical stop-smoking intervention lasts 30 minutes, once a week for the first 4 weeks after the quit attempt, then less frequently for a further 8 weeks. By enabling employees to access stop-smoking support, employers are likely to realise substantial benefits, such as increased productivity, decreased sickness rates and improved adherence to smokefree policies.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of HR policies that allow employees to access stop-smoking support during working hours without loss of pay.

Data source: Data can be collected from information recorded locally by employers, for example from HR policies.

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Process

a) Proportion of employees who wanted to access stop-smoking support during working hours and did so.

Numerator – the number in the denominator who accessed stop-smoking support during working hours.

Denominator – the number of employees who wanted to access stop-smoking support during working hours.

Data source: Data can be collected from information recorded locally by employers, for example from employee surveys.

b) Proportion of employees who accessed stop-smoking support during working hours without loss of pay.

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

Denominator – the number of employees who accessed stop-smoking support during working hours.

Data source: Data can be collected from information recorded locally by employers, for example from employee surveys.

What the quality statement means for different audiences

Commissioners of stop-smoking support ensure that there is capacity to deliver support to employers who want to help their employees to stop smoking.

All employers encourage employees who smoke (including students, apprentices and volunteers) to access stop-smoking support. They facilitate employees to access stop-smoking support by allowing them to attend during working hours without loss of pay. Employers may choose to organise on site stop-smoking support if that is feasible.

Employees who smoke can attend stop-smoking support during working hours, without

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losing pay.

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

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2025), recommendation 1.9.6

Equality and diversity considerations

Smoking is significantly more prevalent among people in routine and manual occupations. Targeting businesses that employ large numbers of people who work in routine and manual jobs has a potential to make a substantial difference.

Reducing smoking among people who are not employed is not specifically addressed by current guidelines, but smoking prevalence in this group is high. Stop-smoking services, Job Centre Plus and other organisations working with people who are unemployed have an opportunity to work together to enable people who are not employed to access stop-smoking support.

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Quality statement 5: Healthcare services: employee contracts

Quality statement

Healthcare services use contracts that do not allow employees to smoke during working hours or when recognisable as an employee.

Rationale

Healthcare services have a duty of care to protect the health of people who use or work in their services and to promote healthy behaviour among these groups. Healthcare services set an example to the wider community and ensure that 'no smoking' is the norm. Using contracts that do not allow employees (including contractors and volunteers) to smoke during working hours or when recognisable as an employee, reflects the services' commitment to implementing and enforcing a smokefree policy.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of arrangements within healthcare services to use employee contracts (including contractor and volunteer contracts) that do not allow smoking during working hours or when recognisable as an employee.

Data source: Data can be collected from information recorded locally by healthcare services, for example from HR policies and employee contracts.

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Process

Proportion of healthcare services that use employee contracts (including contractor and volunteer contracts) that do not allow smoking during working hours or when recognisable as an employee.

Numerator – the number in the denominator that use employee contracts (including contractor and volunteer contracts) that do not allow smoking during working hours or when recognisable as an employee.

Denominator – the number of healthcare services in the specified geographic area.

Data source: Data can be collected from information recorded locally by healthcare services, for example from audit of employee contracts.

Outcome

Staff, contractors and volunteers found smoking during working hours or when recognisable as an employee.

Data source: Data can be collected from information recorded locally by healthcare services, for example from local surveys or audits of incidents.

What the quality statement means for different audiences.

Directors and senior managers of healthcare services or their representatives ensure that contracts that do not to allow smoking during working hours or when recognisable as an employee are used and enforced for all employees (including contractors and volunteers).

Commissioners ensure that they commission healthcare services that use and enforce employee contracts (including contractor and volunteer contracts) that do not allow smoking during working hours or when recognisable as an employee.

People who work in healthcare services (including contractors and volunteers) do not smoke during working hours or when recognisable as an employee as set out in their

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contracts.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2025), recommendations 1.21.2, 1.21.5 and 1.22.11

Definitions of terms used in this quality statement

Healthcare services

All publicly funded community, primary, secondary and tertiary healthcare services. [Adapted from NICE's guideline on tobacco, recommendation 1.21.1 and terms used in this guideline; secondary care]

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Quality statement 6: Healthcare settings: smokefree grounds

Quality statement

Healthcare settings do not allow smoking anywhere in their grounds and remove any areas previously designated for smoking.

Rationale

Healthcare services have a duty of care to protect the health of people who use or work in their services and to promote healthy behaviour among these groups. Healthcare settings set an example to the wider community and ensure that 'no smoking' is the norm. Many healthcare services already have a smokefree policy in place, which includes smokefree grounds. However, some still facilitate smoking in their grounds by providing outdoor smoking areas, such as smoking shelters or designated smoking points.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of arrangements within healthcare settings to operate smokefree grounds and remove any areas previously designated for smoking.

Data source: Data can be collected from information recorded locally by healthcare services, for example from smokefree policies and implementation plans.

Process

a) Proportion of healthcare settings that do not allow smoking anywhere in their grounds.

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Numerator – the number in the denominator that do not allow smoking anywhere in their grounds.

Denominator – the number of healthcare settings in the specified geographic area.

Data source: Data can be collected from information recorded locally by healthcare services, for example from smokefree policies.

b) Proportion of healthcare settings with no designated smoking areas.

Numerator – the number in the denominator with no designated smoking areas.

Denominator – the number of healthcare settings in the specified geographic area.

Data source: Data can be collected from information recorded locally by healthcare services, for example from smokefree policies and implementation plans.

What the quality statement means for different audiences

Directors and senior managers of healthcare settings or their representatives ensure that smoking is not allowed anywhere in the grounds of healthcare settings. They ensure that the smokefree policy applies to anyone using the premises for any purpose at any time. They should also remove any areas in the grounds previously designated for smoking.

Commissioners ensure that their contracts with healthcare services include smokefree grounds and removal of any existing areas designated for smoking in the grounds.

People who work in healthcare services (including contractors and volunteers) are not allowed to smoke anywhere in the grounds of their healthcare setting. The setting does not have any areas set aside for smoking.

Patients and visitors of healthcare settings are not allowed to smoke anywhere in the grounds of the healthcare setting.

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Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2025), recommendations 1.21.1 and 1.21.2

Definitions of terms used in this quality statement

Healthcare settings

All publicly funded community, primary, secondary and tertiary healthcare facilities, including buildings, grounds and vehicles. [Adapted from NICE's guideline on tobacco, recommendation 1.21.1 and terms used in this guideline; secondary care]

Equality and diversity considerations

People who are unable to leave the healthcare setting because of disability, vulnerability or detention under the Mental Health Act will have to abstain from smoking, unlike other people who can leave the grounds to smoke if they wish. Additional support should be provided for people unable to leave the healthcare setting.

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Quality statement 7: Healthcare settings: nicotine-containing products and stop-smoking pharmacotherapies

Quality statement

Secondary healthcare settings ensure that a range of nicotine-containing products and stop-smoking pharmacotherapies is available on site for patients, visitors and employees.

Rationale

Secondary healthcare services have a duty of care to protect the health of people who use or work in their services and promote healthy behaviour among these groups. Most secondary and tertiary healthcare settings already have a smokefree policy in place, which includes smokefree grounds. Facilitating abstinence (long term or temporary) among patients, visitors and employees (including contractors and volunteers) will help ensure compliance with smokefree policies.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to ensure that stop-smoking pharmacotherapies and medicinally licensed nicotine-containing products are stocked by pharmacies within secondary healthcare services.

Data source: Data can be collected from information recorded locally by healthcare services, for example from local policies and formularies.

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b) Evidence of local arrangements to ensure that a range of nicotine-containing products is available for sale within secondary healthcare services for visitors and employees.

Data source: Data can be collected from information recorded locally by healthcare services, for example from local policies.

Process

a) Proportion of secondary healthcare settings that stock stop-smoking pharmacotherapies and medicinally licensed nicotine-containing products.

Numerator – the number in the denominator that stock stop-smoking pharmacotherapies and medicinally licensed nicotine-containing products.

Denominator – the number of secondary healthcare settings in the specified geographic area.

Data source: Data can be collected from information recorded locally by healthcare services, for example from audit of formularies.

b) Proportion of secondary healthcare settings that sell nicotine-containing products to visitors and employees.

Numerator – the number in the denominator that sell nicotine-containing products to visitors and employees.

Denominator – the number of secondary healthcare settings in the specified geographic area.

Data source: Data can be collected from information recorded locally by healthcare services, for example from audit of hospital shops.

What the quality statement means for different audiences

Directors and senior managers of secondary care services or their representatives ensure that compliance with a smokefree policy is facilitated by a range of nicotine-

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containing products and stop-smoking pharmacotherapies being available on site for patients, visitors and employees.

Commissioners ensure that their contracts with secondary healthcare settings facilitate compliance with a smokefree policy by including on-site provision of nicotine-containing products and stop-smoking pharmacotherapies for patients, visitors and employees.

People who work in secondary healthcare services (including contractors and volunteers) are helped to stick to the smokefree policy by being able to obtain a range of nicotine-containing products and stop-smoking pharmacotherapies on site.

Patients in secondary healthcare services can obtain a range of nicotine-containing products and stop-smoking pharmacotherapies on site at all times. This helps them follow the smokefree policy within the healthcare grounds.

Visitorsin secondary healthcare services can obtain a range of nicotine-containing products on site at all times. This helps them follow the smokefree policy within the healthcare grounds.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2025), recommendations 1.14.25, 1.14.26 and 1.22.14

Definitions of terms used in this quality statement

Secondary healthcare settings

All publicly funded secondary and tertiary care facilities, including buildings, grounds and vehicles. It covers drug and alcohol services in secondary care, emergency care, inpatient, residential and long-term care for severe mental illness in hospitals, psychiatric and specialist units and secure hospitals and planned specialist medical care or surgery. It also includes maternity care in hospitals, maternity units, outpatient clinics and in the community. [NICE's guideline on tobacco, terms used in this guideline; secondary care]

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Nicotine-containing products

Products that contain nicotine but do not contain tobacco and so deliver nicotine without the harmful toxins found in tobacco. This currently includes nicotine replacement therapy which has been medicinally licensed for smoking cessation by the Medicines and Healthcare products Regulatory Agency (MHRA) and nicotine-containing e-cigarettes. Currently there are no licensed nicotine-containing e-cigarettes on the market. Nicotine-containing e-cigarettes on general sale are regulated under the Tobacco and Related Product Regulations by the MHRA. For further details see the MHRA website. Different forms of nicotine replacement therapy include:

- transdermal patches
- gum
- inhalation cartridges
- sublingual tablets
- lozenges
- mouth spray
- nasal spray.

[Adapted from NICE's guideline on tobacco, terms used in this guideline; nicotine-containing products and nicotine replacement therapy]

If alternative nicotine-containing products (such as e-cigarettes) gain licensing authorisation in the future, this quality statement will be reviewed.

Stop-smoking pharmacotherapies

This covers medication licensed for smoking cessation such as cytisinicline, varenicline or bupropion, as well as nicotine-replacement therapy. [NICE's guideline on tobacco, terms used in this guideline; pharmacotherapies]

Equality and diversity considerations

People whose drug treatment is affected by smoking may need to have the dosage of their

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drugs adjusted. This is particularly important for people with mental health problems taking antipsychotic medication.

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Quality statement 8: Media campaigns

Quality statement

Local authorities use regional and local media channels to reinforce national tobacco reduction campaigns.

Rationale

There is evidence that social marketing and media campaigns can stop people from taking up smoking and can be effective in changing smoking behaviour in those who already smoke. National campaigns that aim to reduce smoking in the community are run on a regular basis. These should be communicated to local authorities in advance so that the campaign messages can be promoted and reinforced regionally and locally by all partners working together on tobacco control.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local authorities using regional or local media channels to reinforce messages from national tobacco reduction campaigns.

Data source: Data can be collected from information recorded locally by local authorities, for example from campaigns.

b) Evidence of regional and local activities to reinforce national tobacco reduction campaigns.

Data source: Data can be collected from information recorded locally by local authorities, for example from campaigns.

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What the quality statement means for different audiences

Local authorities supported by government bodies use regional and local media channels to reinforce messages from national tobacco reduction campaigns. They may work in partnership to commission regional providers to improve cost effectiveness and consistency of the messages.

Adults, children and young people come into contact with campaign messages that put them off taking up smoking and encourage them to quit if they already smoke.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2025), recommendations 1.1.1, 1.1.5, 1.2.2, 1.9.1 and 1.9.2

Definitions of terms used in this quality statement

Reinforcing national tobacco reduction campaigns locally

Reinforcing national tobacco reduction campaigns locally is likely to include some or all of the following:

- using regional and local channels
- writing articles, commissioning newsworthy research and issuing press releases
- using posters, brochures and other materials
- production and dissemination of e-information and email footers
- using digital media and dissemination of information through social media streams
- completion of radio and television interviews
- delivery of local promotional events in community settings, for example, sports stadia, supermarkets, shopping centres and markets.

[NICE's guideline on tobacco, recommendations 1.1.5 and 1.2.2 and expert opinion]

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Equality and diversity considerations

Smoking is more common in socially deprived areas and among people in routine and manual jobs. When developing campaigns, consideration should be given about how to target these groups, with what messages and via which media. Local campaigns should use local intelligence to tailor the activities so that they are effective for the local population.

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Quality statement 9 (placeholder): Illicit tobacco

What is a placeholder statement?

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

Rationale

Illicit tobacco products make tobacco more accessible to children and young people, and those from socioeconomic groups already experiencing significant health inequalities. Illicit tobacco products are often half or a third of the price of duty-paid products and can be accessed from a wide range of unregulated suppliers. Preventing children and young people and adults from accessing illicit tobacco is likely to have a significant effect on the rates of smoking and smoking uptake.

Illicit tobacco includes:

- Cigarettes:
  - 'Illicit white' cigarettes have no legal market in the UK. UK duty has not been paid and the appropriate health warnings and images may not be present. Some of these products may be legally sold in countries outside the UK.
  - Counterfeit cigarettes are illegally manufactured and sold by a party other than the original trademark or copyright holder. This can also include the counterfeiting of 'illicit white' cigarettes.
- Genuine cigarettes intended for sale in another country may have been smuggled into the UK or duty-free cigarettes may be sold illegally rather than kept for personal use.
- Hand-rolling tobacco:

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- Non-UK hand-rolling tobacco brands are not intended for sale in the UK.
- Counterfeit hand rolling tobacco is, like cigarettes, illegally manufactured and sold by a party other than the original trademark or copyright owner. It can also include the counterfeiting of non-UK products. Genuine or UK hand-rolling tobacco brands include products intended for both the UK and non-UK markets.

[The Illicit Tobacco Partnership website; What is illegal tobacco?]

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Update information

Minor changes since publication

February 2025: Changes have been made to align this quality standard with the updated NICE guideline on tobacco: preventing uptake, promoting quitting and treating dependence. Cytisinicline has been added as a stop smoking intervention to the definition in statement 7. Source guidance references and data sources have been updated throughout.

November 2021: Changes were made to align this quality standard with NICE's guideline on tobacco. The wording of quality statement 7 has been updated to reflect terminology in the new guideline. The source guidance recommendations and definitions for all quality statements have also been updated to align with the guideline.

March 2018: Source guidance sections have been updated to reflect the NICE guidance on stop smoking interventions and services.

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About this quality standard

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

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

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

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impact work for the source guidance. Organisations are encouraged to use the resource impact products for the NICE guideline on tobacco to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

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

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Endorsing organisation

This quality standard has been endorsed by Department of Health and Social Care, as required by the Health and Social Care Act (2012)

Supporting organisations

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

- Association of Directors of Public Health (ADPH)
- British Thoracic Society (BTS)
- Public Health England
- Royal College of General Practitioners (RCGP)
- Royal College of Physicians (RCP)
- College of General Dentistry

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