NICE National Institute for Health and Care Excellence

NICE quality standard

Tobacco: treating dependence

Quality standard

Published: 15 December 2022
www.nice.org.uk/guidance/qs207

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This standard replaces QS43 and QS92.

This standard is based on NG209.

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In 2022 the quality standards on smoking: supporting people to stop, and smoking: harm reduction were updated and combined. Statements prioritised in 2013 and 2015 were updated **[2013, updated 2022][2015, updated 2022]** or replaced **[new 2022].** For more information, see update information.

The previous versions of the quality standards for smoking: supporting people to stop and smoking: harm reduction are available as pdfs.

Quality statement 1: Identifying people who use tobacco

Quality statement

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

Rationale

Identifying people who smoke or use smokeless tobacco offers an opportunity to receive advice or support about quitting, or a referral to a tobacco cessation service if needed. Routinely asking people about tobacco use at key points of contact with health or social care services also offers opportunities to re-engage with people who previously did not want to stop or who may have relapsed following a period of abstinence.

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. Some localities may want to focus on equality of care depending on local needs, for example, by assessing care for particular socioeconomic or ethnic groups.

Process

The following process measure denominator uses a key point of contact for measurement purposes only.

Proportion of people who are asked if they smoke or use smokeless tobacco at a key point of contact with a health or social care professional.

Numerator – the number in the denominator who are asked if they smoke or use smokeless tobacco.

Denominator – the number of people attending a key point of contact with a health or social care professional.

Data source: Data on smoking and use of smokeless tobacco can be collected from information recorded locally by health or social care professionals and provider organisations, for example from patient records.

NHS Digital's indicators no longer in QOF (INLIQ) indicator SMOK001 reports the percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months. The British Thoracic Society's national smoking cessation audit collects data on documentation of smoking status in inpatient medical records.

What the quality statement means for different audiences

Service providers (for example, primary care services, secondary care services and social care services) ensure that service specifications include asking people at key points of contact if they smoke or use smokeless tobacco and recording this.

Health and social care professionals (such as GPs, nurses, doctors, allied health professionals, healthcare support workers, maternity support workers and social workers) ask people if they smoke or use smokeless tobacco at key points of contact and record this in patient records.

Commissioners (for example, local authorities and integrated care systems) ensure that they commission services in which people are asked if they smoke or use smokeless tobacco at key points of contact with a health or social care service.

People using a health or social care service are asked if they smoke or use smokeless tobacco at key points of contact with a health or social care professional, for example, after newly registering with a GP, at an NHS health check, before or during admission to hospital, at a first appointment with a social worker or as part of a Care Act assessment.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2022), recommendations 1.11.1 and 1.16.1

Definitions of terms used in this quality statement

Tobacco

Includes smoked tobacco, such as cigarettes and shisha, and smokeless tobacco.

Smokeless tobacco is any product containing tobacco that is placed in the mouth or nose and not burned. It is typically used in England by people of South Asian family origin. It does not include products that are sucked, like 'snus' or similar oral snuff products (as defined in the European Union 2014 Tobacco Products Directive). The types used vary across the country, but they can be divided into 3 main categories based on their ingredients:

- Tobacco with or without flavourants: misri India tobacco (powdered) and qimam (kiman).
- Tobacco with various alkaline modifiers: khaini, naswar (niswar, nass) and gul.
- Tobacco with slaked lime as an alkaline modifier and areca nut: gutkha, zarda, mawa, manipuri and betel quid (with tobacco).

[Adapted from NICE's guideline on tobacco, terms used in this guideline (smokeless tobacco), final scope (2018) and expert opinion]

Key points of contact

Such as:

- a consultation with a newly registered patient
- a consultation about a condition related to smoking or use of smokeless tobacco
- an antenatal appointment
- a dental appointment
- an NHS health check
- an annual review

- a preoperative appointment
- during an inpatient episode
- an outpatient appointment
- at presentation at an emergency department
- at first contact with social care services
- as part of a Care Act assessment
- at presentation after not being in regular contact with a health and social care professional.

[Expert opinion]

Equality and diversity considerations

People should be asked about tobacco use in a way that suits their needs and preferences. People should have access to an interpreter or advocate if needed.

Smokeless tobacco is predominantly used by people from a South Asian family background. People should be asked if they use smokeless tobacco using the names that the various products are known by locally. If necessary, use visual aids to show them what the products look like.

For people with additional needs related to a disability, impairment or sensory loss, communication support should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 2: Advice

Quality statement

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

Rationale

People who smoke or use smokeless tobacco should be advised to stop in a way that is sensitive to their preferences and needs. It is important to explain that support is available to help them quit and offer support and treatment if the person wants this or ensure that the person knows where they can find support in the future.

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. Some localities may want to focus on equality of care depending on local needs, for example, by assessing care for particular socioeconomic or ethnic groups.

Structure

Evidence that health and social care professionals undergo training to give advice on how to quit using tobacco.

Data source: Data on training to deliver advice on quitting smoking or smokeless tobacco can be recorded from information recorded locally by health and social care professionals and provider organisations, for example from staff competency records. The National Centre for Smoking Cessation and Training have training resources containing information on delivery of advice on the most effective way of quitting.

Process

The following process measure denominator uses a key point of contact for measurement purposes only.

Proportion of people attending a key point of contact and reporting current smoking or use of smokeless tobacco, who receive advice on quitting.

Numerator – the number in the denominator who receive advice on quitting.

Denominator – the number of people attending a key point of contact who report current smoking or use of smokeless tobacco.

Data source: Data on receipt of advice on quitting smoking or smokeless tobacco can be collected from information recorded locally by health and social care professionals and provider organisations, for example from patient records.

The Quality Outcomes Framework indicator SMOK004 reports the percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support or treatment within the preceding 24 months. This offer of support includes brief intervention and smoking cessation education. The British Thoracic Society's national smoking cessation audit collects data on evidence of provision of very brief advice for current smokers from inpatient medical records.

Outcome

a) Quit rates.

Data source:NHS Digital's statistics on NHS stop smoking services in England collects and reports data on people who smoke setting a quit date with an NHS stop-smoking service including self-reported and carbon monoxide-validated quit rates. No routinely collected national data for this measure has been identified for quit rates outside of NHS stop-smoking services. Quit rates can be collected from information recorded locally by healthcare professionals and provider organisation, for example from patient records.

Self-reported quit rates for people who use smokeless tobacco can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Smoking prevalence.

Data source:NHS Digital's statistics on smoking – England reports smoking prevalence among young people aged between 11 and 15 years. Public Health Outcomes Framework 2019 to 2022 (Public Health Outcome Indicators 2019) includes indicators on smoking prevalence in 15 year olds (indicator number 2.09) and smoking prevalence in adults (indicator number 2.14).

What the quality statement means for different audiences

Service providers (for example, primary care services, secondary care services and social care services) ensure that systems are in place for people who smoke or use smokeless tobacco and want to stop to be provided with advice on how to quit. They ensure that health and social care professionals receive training to deliver advice on quitting smoking and smokeless tobacco.

Health and social care professionals (such as GPs, nurses, doctors, allied health professionals, healthcare support workers, maternity support workers and social workers) are trained to deliver advice on quitting smoking and smokeless tobacco, and provide it in a way that is sensitive to the person's preferences and needs. They are aware of local referral pathways to tobacco cessation services and can refer people if needed.

Commissioners (for example, local authorities and integrated care systems) ensure that they commission services that can provide advice on quitting smoking and smokeless tobacco. They commission training on delivery of advice on quitting smoking and, if local needs assessment shows that it is necessary, they commission training and a range of services to help South Asian people stop using smokeless tobacco.

People who smoke or use smokeless tobacco are advised about the best way to quit and how they can be supported to do this. This should be provided in a way that is sensitive to their preferences and needs.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2022), recommendations 1.11.2, 1.11.4, 1.12.7, 1.13.1 and 1.16.6

Definitions of terms used in this quality statement

Tobacco

Includes smoked tobacco, such as cigarettes and shisha, and smokeless tobacco.

Smokeless tobacco is any product containing tobacco that is placed in the mouth or nose and not burned. It is typically used in England by people of South Asian family origin. It does not include products that are sucked, like 'snus' or similar oral snuff products (as defined in the European Union 2014 Tobacco Products Directive). The types used vary across the country, but they can be divided into 3 main categories based on their ingredients:

- Tobacco with or without flavourants: misri India tobacco (powdered) and qimam (kiman).
- Tobacco with various alkaline modifiers: khaini, naswar (niswar, nass) and gul.
- Tobacco with slaked lime as an alkaline modifier and areca nut: gutkha, zarda, mawa, manipuri and betel quid (with tobacco).

[Adapted from NICE's guideline on tobacco, terms used in this guideline (smokeless tobacco), final scope (2018) and expert opinion]

Advice on quitting

People who smoke should be advised that stopping smoking in one go is the best approach. Advice should be provided in a way that is sensitive to the person's preferences and needs and should include information on how stop-smoking support and treatment can help. There should be a discussion about any stop-smoking aids that the person has used before, and advice given on using nicotine-containing products including nicotine replacement therapy and nicotine-containing e-cigarettes, and medication licensed for smoking cessation. Consider nicotine replacement therapy alongside behavioural support to help women stop smoking in pregnancy and for young people aged 12 and over who are smoking and dependent on tobacco. Varenicline, when available, and bupropion should not be offered to pregnant or breastfeeding women or people under 18.

In August 2022, varenicline was unavailable in the UK. See the MHRA alert on varenicline.

People who use smokeless tobacco should have the health risks explained to them and should be advised to quit using a brief intervention. This involves discussion, negotiation or encouragement. It is carried out when the opportunity arises, typically taking no more than a few minutes for basic advice. [Adapted from NICE's guideline on tobacco, recommendations 1.11.2 to 1.11.4, 1.12.3, 1.12.4, 1.12.7, 1.16.2, 1.20.6 and 1.20.11 and NICE's glossary (brief intervention)]

Key points of contact

Such as:

- a consultation with a newly registered patient
- a consultation about a condition related to smoking or use of smokeless tobacco
- an antenatal appointment
- a dental appointment
- an NHS health check
- an annual review
- a preoperative appointment
- during an inpatient episode
- an outpatient appointment
- at presentation at an emergency department
- at first contact with social care services
- as part of a Care Act assessment
- at presentation after not being in regular contact with a health and social care professional.

[Expert opinion]

Equality and diversity considerations

People who use tobacco should be given advice that they can easily understand themselves, or with support, so they can communicate effectively with health and social care services. Advice should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed.

Smokeless tobacco is predominantly used by people from a South Asian family background. People should be asked if they use smokeless tobacco using the names that the various products are known by locally. If necessary, visual aids should be used to show them what the products look like. People who use smokeless tobacco should be referred to specialist tobacco cessation services, including services specifically for South Asian groups where they are available. These services should take into account the needs of different South Asian communities, for example, by using staff with relevant language skills or translators and by providing translated materials or resources in a non-written format.

For people with additional needs related to a disability, impairment or sensory loss, communication support should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 3: Tobacco cessation support and treatment

Quality statement

People who want to stop using tobacco are offered tobacco cessation support and treatment by a healthcare professional. **[2013, updated 2022]**

Rationale

People who want to stop smoking or using smokeless tobacco should have access to a range of tobacco cessation support and treatment so that they can make their own choice of intervention based on their preferences, health and social circumstances, and previous experience of tobacco cessation aids. Although a combination of behavioural support with either varenicline, when available, short-acting and long-acting nicotine replacement therapy or nicotine-containing e-cigarettes (as appropriate for their age) is more likely to result in a successful quit attempt for those who smoke cigarettes, individual factors and preferences are also likely to be important.

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. Some localities may want to focus on equality of care depending on local needs, for example, by assessing care for particular socioeconomic or ethnic groups.

Process

The following process measure denominator uses a key point of contact for measurement purposes only.

Proportion of people attending a key point of contact who want to stop smoking or using smokeless tobacco, who are offered tobacco cessation support and treatment by a

healthcare professional.

Numerator – the number in the denominator who are offered tobacco cessation support and treatment by a healthcare professional.

Denominator – the number of people attending a key point of contact who want to stop smoking or using smokeless tobacco.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

The Quality Outcomes Framework indicator SMOK004 reports the percentage of patients aged 15 or over who are recorded as current smokers who have a record of support and treatment within the preceding 24 months. The offer of support includes provision of pharmacotherapy or referral for support.

Outcome

a) Quit rates.

Data source:NHS Digital's statistics on NHS stop smoking services in England collects and reports data on people who smoke setting a quit date with an NHS stop-smoking service including self-reported and carbon monoxide-validated quit rates. No routinely collected national data for this measure has been identified for quit rates outside of NHS stop-smoking services. Quit rates can be collected from information recorded locally by healthcare professionals and provider organisation, for example from patient records.

Self-reported quit rates for people who use smokeless tobacco can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Smoking prevalence.

Data source:NHS Digital's statistics on smoking – England reports smoking prevalence among young people aged between 11 and 15 years. Public Health Outcomes Framework 2019 to 2022 (Public Health Outcome Indicators 2019) includes indicators on smoking prevalence in 15 year olds (indicator number 2.09) and smoking prevalence in adults

(indicator number 2.14).

What the quality statement means for different audiences

Service providers (for example, primary care services and stop-smoking services) ensure that systems are in place for people who want to stop using tobacco to have a discussion with a healthcare professional about the range of support and treatment available to help them quit. They ensure healthcare professionals are trained to provide tobacco cessation options and advice. They ensure that people have access to the range of tobacco cessation support and treatment, including referral to local specialist tobacco cessation services if available.

Healthcare professionals (such as GPs, providers of stop-smoking support and tobacco dependence specialists) are aware of the full range of tobacco cessation support and treatment available and can provide information on their use, effectiveness and how to access them, including providing support and treatment if possible or referral pathways to local specialist tobacco cessation services if needed. They can give advice on nicotine-containing products on general sale including nicotine replacement therapy and nicotine-containing e-cigarettes and how to use them properly. They give advice on nicotine-containing e-cigarettes that is clear, consistent and up to date.

Commissioners (for example, local authorities and integrated care systems) ensure they commission services that can provide information on and access to a range of tobacco cessation support and treatment. If local needs assessment shows that it is necessary, a range of services should be commissioned to help South Asian people stop using smokeless tobacco. This can be within existing stop-smoking support, part of services offered within a range of healthcare and community settings, or a stand-alone service tailored to local needs.

People who want to stop smoking or using smokeless tobacco are given information on a range of approaches to help them quit. They discuss these and their circumstances and preferences with their healthcare professional to choose the approach that is right for them.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2022), recommendations 1.12.1, 1.12.2 and 1.13.1

Definitions of terms used in this quality statement

Tobacco

Includes smoked tobacco, such as cigarettes and shisha, and smokeless tobacco.

Smokeless tobacco is any product containing tobacco that is placed in the mouth or nose and not burned. It is typically used in England by people of South Asian family origin. It does not include products that are sucked, like 'snus' or similar oral snuff products (as defined in the European Union 2014 Tobacco Products Directive). The types used vary across the country, but they can be divided into 3 main categories based on their ingredients:

- Tobacco with or without flavourants: misri India tobacco (powdered) and qimam (kiman).
- Tobacco with various alkaline modifiers: khaini, naswar (niswar, nass) and gul.
- Tobacco with slaked lime as an alkaline modifier and areca nut: gutkha, zarda, mawa, manipuri and betel quid (with tobacco).

[Adapted from NICE's guideline on tobacco, terms used in this guideline (smokeless tobacco), final scope (2018) and expert opinion]

Tobacco cessation support and treatment

Support and treatment may include behavioural support, pharmacotherapy, advice on using nicotine-containing e-cigarettes or referral to local tobacco cessation services.

The following should be accessible to adults who smoke:

- behavioural interventions:
  - behavioural support (individual and group)
  - very brief advice
- medicinally licensed products:
  - bupropion (see BNF information on bupropion hydrochloride)
  - nicotine replacement therapy (NRT) – short and long acting
  - varenicline (see NICE's technology appraisal guidance on varenicline for smoking cessation and the BNF information on varenicline)
- nicotine-containing e-cigarettes
- Allen Carr's Easyway in-person group seminar.

In August 2022, varenicline was unavailable in the UK. See the MHRA alert on varenicline.

Consider nicotine replacement therapy alongside behavioural support to help women stop smoking in pregnancy and for young people aged 12 and over who are smoking and dependent on tobacco. Varenicline, when available, and bupropion should not be offered to pregnant or breastfeeding women or people under 18.

People who use smokeless tobacco who want to quit should be referred to local specialist tobacco cessation services, including services specifically for South Asian groups, where they are available. [Adapted from NICE's guideline on tobacco, recommendations 1.12.2, 1.12.3, 1.12.4, 1,16.3, 1.20.6 and 1.20.11]

Key points of contact

Such as:

- a consultation with a newly registered patient
- a consultation about a condition related to smoking or use of smokeless tobacco
- an antenatal appointment
- a dental appointment

- an NHS health check
- an annual review
- a preoperative appointment
- during an inpatient episode
- an outpatient appointment
- at presentation at an emergency department
- at first contact with social care services
- as part of a Care Act assessment
- at presentation after not being in regular contact with a health and social care professional.

[Expert opinion]

Healthcare professional

People trained to provide tobacco cessation support. For training requirements see the National Centre for Smoking Cessation and Training (NCSCT) standard for training in smoking cessation treatments. [Adapted from NICE's guideline on tobacco, section 1.12 and expert opinion]

Equality and diversity considerations

People who want to stop smoking should be provided with information during the discussion that they can easily understand themselves, or with support, so they can communicate effectively with healthcare services. Information given should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, communication support should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

People with severe mental health conditions who may need additional support to stop using tobacco should be offered support by a specialist adviser with mental health expertise that is tailored in duration and intensity to the person's needs.

People who are experiencing homelessness should be supported to access services, for example, by providing outreach services, flexible opening and appointment times and drop-in services. [NICE's guideline on integrated health and social care for people experiencing homelessness, recommendations 1.5.1 and 1.5.15]

People who use smokeless tobacco who want to quit should be referred to local specialist tobacco cessation services, including services specifically for South Asian groups, where they are available.

Quality statement 4: Harm-reduction approach

Quality statement

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

Rationale

Stopping using tobacco reduces the risks of developing tobacco-related illnesses or worsening conditions affected by its use, however some people may not want, or be ready, to stop in one go. It is important that they are encouraged and supported to adopt a harm-reduction approach, such as smoking less or using less smokeless tobacco or stopping temporarily. People who reduce their tobacco use are more likely to stop in the future. Harm-reduction approaches should not detract from tobacco cessation approaches, but should support and extend the reach and impact of tobacco cessation support.

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. Some localities may want to focus on equality of care depending on local needs, for example, by assessing care for particular socioeconomic or ethnic groups.

Process

The following process measure denominator uses a key point of contact for measurement purposes only.

Proportion of people given advice on stopping smoking or using smokeless tobacco at a key point of contact who do not want, or are not ready, to stop in one go who receive

support to adopt a harm-reduction approach.

Numerator – the number in the denominator who receive support to adopt a harm-reduction approach.

Denominator – the number of people given advice on stopping smoking or using smokeless tobacco at a key point of contact who do not want, or are not ready, to stop in one go.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers (such as primary care services, secondary care services and stop-smoking services) ensure that harm-reduction approaches are available for people who do not want, or are not ready, to stop smoking in one go. They ensure the availability of self-help materials that include advice on choosing a harm-reduction approach and details of where to find more help and support. They ensure that medicinally licensed nicotine-containing products are available for people who smoke, and there are referral pathways to local and specialist tobacco cessation services for people who smoke or use smokeless tobacco.

Healthcare professionals (such as GPs, providers of stop-smoking support and tobacco dependence specialists) are aware of harm-reduction approaches. They discuss the approach that might be most suitable for the person, based on their behaviour, previous attempts to stop, health and social circumstances, and preferences. They provide advice on the use of medicinally licensed nicotine-containing products and, if possible, prescribe or supply them to people who smoke. They are aware of referral pathways to local and specialist tobacco cessation services for people who smoke or use smokeless tobacco.

Commissioners (such as local authorities and integrated care systems) ensure they commission services that provide support for people to adopt a harm-reduction approach. They commission services that offer medicinally licensed nicotine-containing products on a long-term basis to people who smoke. If local needs assessment shows that it is

necessary, a range of services should be commissioned to help South Asian people who use smokeless tobacco. This can be within existing stop-smoking support, part of services offered within a range of healthcare and community settings, or a stand-alone service tailored to local needs. They should ensure that harm-reduction approaches support and extend the reach and impact of tobacco cessation support.

People who do not want, or are not ready, to stop smoking or using smokeless tobacco in one go receive advice on reducing the number of cigarettes or amount of smokeless tobacco they use, or temporarily stopping. People who smoke are offered products that contain nicotine such as patches, gum, tablets for under the tongue, lozenges or sprays, or are told where they can get them. People who use smokeless tobacco are offered referral to local specialist tobacco cessation services.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2022), recommendations 1.15.2 to 1.15.7 and 1.22.7 to 1.22.9

Definitions of terms used in this quality statement

Tobacco

Includes smoked tobacco, such as cigarettes and shisha, and smokeless tobacco.

Smokeless tobacco is any product containing tobacco that is placed in the mouth or nose and not burned. It is typically used in England by people of South Asian family origin. It does not include products that are sucked, like 'snus' or similar oral snuff products (as defined in the European Union 2014 Tobacco Products Directive). The types used vary across the country, but they can be divided into 3 main categories based on their ingredients:

- Tobacco with or without flavourants: misri India tobacco (powdered) and qimam (kiman).
- Tobacco with various alkaline modifiers: khaini, naswar (niswar, nass) and gul.

- Tobacco with slaked lime as an alkaline modifier and areca nut: gutkha, zarda, mawa, manipuri and betel quid (with tobacco).

[Adapted from NICE's guideline on tobacco, terms used in this guideline (smokeless tobacco), final scope (2018) and expert opinion]

Harm-reduction approach

Approaches that aim to reduce harm to people who smoke by smoking less or abstaining temporarily. The following approaches should be discussed to determine which might be most suitable.

Cutting down before stopping:

- with the help of 1 or more medicinally licensed nicotine-containing products (the products may be used as long as needed to prevent relapse to previous levels of tobacco use)
- without using medicinally licensed nicotine-containing products.

Reduction:

- with the help of 1 or more medicinally licensed nicotine-containing products (the products may be used as long as needed to prevent relapse to previous levels of tobacco use)
- without using medicinally licensed nicotine-containing products.

Temporarily stopping:

- with the help of 1 or more medicinally licensed nicotine-containing products
- without using medicinally licensed nicotine-containing products.

People who use smokeless tobacco should be referred to local specialist tobacco cessation services. [Adapted from NICE's guideline on tobacco, box 1, recommendation 1.16.3 and expert opinion]

Key points of contact

Such as:

- a consultation with a newly registered patient
- a consultation about a condition related to smoking or use of smokeless tobacco
- a dental appointment
- an NHS health check
- an annual review
- a preoperative appointment
- during an inpatient episode
- an outpatient appointment
- at presentation at an emergency department
- at first contact with social care services
- as part of a Care Act assessment
- at presentation after not being in regular contact with a health and social care professional.

[Expert opinion]

Equality and diversity considerations

People should be provided with advice that they can easily understand themselves, or with support, so they can communicate effectively with healthcare services. It should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, communication support should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 5: Treatment to stop smoking in hospital

Quality statement

People who smoke receive treatment to stop smoking on admission to hospital. **[new 2022]**

Rationale

Admission to hospital brings people who smoke into contact with healthcare professionals who can provide advice and help to stop smoking completely or temporarily during admission. Hospitals are smoke-free environments without the usual cues and prompts to smoke and so admission to hospital offers an opportunity to quit. The NHS Long Term Plan includes an action that all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services by 2023/24.

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 local arrangements to ensure that people who smoke have access to a hospital- or community-based smoking cessation service when admitted to hospital.

Data source: Data can be collected locally by provider organisations, for example from service specifications. The British Thoracic Society's national smoking cessation audit collects data on whether hospital trusts have a hospital-based smoking cessation service on the premises or access to a community-based smoking cessation service. It also collects data on whether there is a formal referral pathway to a hospital or community-based smoking cessation service and whether a hospital has a dedicated smoking

cessation practitioner.

Process

a) Proportion of people who smoked on admission to hospital who receive stop-smoking pharmacotherapy.

Numerator – the number in the denominator who receive stop-smoking pharmacotherapy.

Denominator – the number of people who smoked on admission to hospital.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

The British Thoracic Society's national smoking cessation audit collects data from inpatient medical records of evidence that people who smoke were offered the use of licensed pharmacotherapy for tobacco addiction and the pharmacotherapy received (single nicotine replacement therapy [NRT], combination NRT, varenicline, bupropion, or decline of pharmacotherapy). NHS Digital's data collection on tobacco dependence collects data on whether current smokers aged 16 and over admitted for an overnight stay to a provider with an inpatient tobacco dependence treatment service had referral to an in-house tobacco dependence service, date of the referral, date of attendance at an in-house service, the tobacco dependence care plan which includes quit attempt with licensed medication and the type of pharmacotherapy received.

b) Proportion of people who smoked on admission to hospital who receive behavioural support within 24 hours of admission.

Numerator – the number in the denominator who receive behavioural support within 24 hours of admission.

Denominator – the number of people who smoked on admission to hospital.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

NHS Digital's data collection on tobacco dependence collects data on whether current smokers aged 16 and over admitted for an overnight stay to a provider with an inpatient tobacco dependence treatment service had referral to an in-house tobacco dependence service, date of the referral, date of attendance at an in-house service and the tobacco dependence care plan which includes quit attempt with behavioural intervention.

Outcome

Proportion of people who smoked on admission to hospital who are abstinent at 4 weeks after discharge.

Numerator – the number in the denominator who are abstinent at 4 weeks after discharge.

Denominator – the number of people who smoked on admission to hospital.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

NHS Digital's data collection on tobacco dependence collects data on tobacco care plan outcome at 28 days including carbon monoxide confirmed quit and self-reported only quit. This is measured at 28 days following the start of their agreed quit window (the date of discharge from hospital for most inpatients).

The British Thoracic Society's national smoking cessation audit collects data on whether patients are abstinent from smoking at 4 weeks after discharge (chemically validated or self-reported).

What the quality statement means for different audiences

Service providers (for example, acute services, maternity services and inpatient mental health services) ensure that systems are in place to provide stop-smoking treatment to people who smoke when they are admitted to hospital. They ensure that staff in secondary care are trained to give advice and interventions for quitting, including the provision of pharmacotherapy, and there are referral pathways to behavioural support.

Healthcare professionals (such as doctors, nurses, healthcare support workers, and stop-smoking advisors) offer stop-smoking treatment to people who smoke when they are admitted to hospital, including provision of pharmacotherapy for temporary abstinence and to help with nicotine withdrawal. They undergo training to give advice and interventions for quitting and are aware of referral pathways to stop-smoking support within the hospital setting and when people are discharged. Those who are trained to provide behavioural support to stop smoking undertake regular continuing professional development. They offer to measure exhaled carbon monoxide level during each contact to motivate and provide feedback on their progress.

Commissioners (such as integrated care systems) ensure that they commission services in which people who smoke are supported to temporarily stop when admitted to hospital and offered support and treatment to quit permanently, which is continued after discharge.

People who smoke and are admitted to hospital receive medicines that can help them to stop temporarily while they are in hospital. They receive help to quit that is continued after discharge including information, practical advice and encouragement, and medicines that can help.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2022), recommendations 1.14.5, 1.14.13, 1.14.15 and 1.14.20 to 1.14.22

Definitions of terms used in this quality statement

Treatment to stop smoking

Treatment includes:

- discussion about current and past smoking behaviour and development of a personal stop-smoking plan
- information about the different types of stop-smoking options and how to use them
- information on the types of behavioural support available

- offer and supply of prescriptions of medicines licensed for smoking cessation or nicotine replacement therapy
- offer to measure exhaled carbon monoxide level during each contact to motivate and provide feedback on progress.

People admitted to hospital who smoke should be offered behavioural support and stop-smoking pharmacotherapy to stop smoking during their inpatient stay. Behavioural support should be provided immediately, if necessary, or within 24 hours of admission for an inpatient. Stop-smoking pharmacotherapy should be provided immediately.

Consider nicotine replacement therapy alongside behavioural support to help women stop smoking in pregnancy and for young people aged 12 and over who are dependent on tobacco. Varenicline or bupropion should not be offered to pregnant or breastfeeding women or people under 18. [Adapted from NICE's guideline on tobacco, recommendations 1.12.3, 1.12.4, 1.14.5 to 1.14.11, 1.14.13, 1.14.15, 1.14.17, 1.20.6 and 1.20.11]

Hospital

All acute, maternity and mental health services inpatient admissions. It covers emergency care, inpatient 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 and in maternity units. [Adapted from NICE's guideline on tobacco, section 1.14 and terms used in this guideline (secondary care)]

Equality and diversity considerations

People who smoke who are admitted to hospital should be provided with stop-smoking information that they can easily read and understand themselves, or with support, so they can communicate effectively with healthcare services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

People with severe mental health conditions who may need additional support to stop smoking should be offered support by a specialist adviser with mental health expertise that is tailored in duration and intensity to the person's needs.

Update information

December 2022: This quality standard updates and replaces NICE's quality standards on smoking: supporting people to stop and smoking: harm reduction. Statements prioritised in 2013 and 2015 were replaced. The topic was identified for update following a review of quality standards. The review identified:

- updated guidance on tobacco
- that the quality standards on smoking: supporting people to stop and smoking: harm reduction should be combined.

Statements are marked as:

- **[new 2022]** if the statement covers a new area for quality improvement
- **[2013, updated 2022]** if the statement covers an area for quality improvement included in the 2013 quality standard on smoking: supporting people to stop and has been updated
- **[2015, updated 2022]** if the statement covers an area for quality improvement included in the 2015 quality standard on smoking: harm reduction and has been updated.

The previous versions of the quality standards for smoking: supporting people to stop and smoking: harm reduction are available as pdfs.

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

impact work for the source guidance. Organisations are encouraged to use the resource impact report 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.

ISBN: 978-1-4731-4835-2

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.

- Action on Smoking and Health
- British Thoracic Society
- Primary Care Respiratory Society
- Royal College of Paediatrics and Child Health