

NHS STOP SMOKING SERVICES

*Service and Monitoring Guidance – October
2007/08*



SMOKEFREE

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Contact details:	nicola.willis@dh.gsi.gov.uk		
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1. INTRODUCTION.

Smoking is one of the most significant contributing factors to life expectancy, health inequalities and ill health, particularly cancer and coronary heart disease. Therefore, reducing smoking is a key improvement area within the over-arching Health of the Population PSA Area, SHA Local Delivery Plans as well as within the NHS Operating Framework, and in Social Care Local Area Agreements.

“Tackle the underlying determinants of ill health and health inequalities by: reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.”

A significant reduction in smoking prevalence is required between now and 2010 as current rates in England are 24% overall, and 31% for routine and manual (General Household Survey, 2005). Smoking prevalence is highest in deprived communities. Progress against the PSA target for routine and manual workers (reduction from 33% in 2001 to 26% in 2010) has been slower than that of other population groups. A high level of intervention is vital to deliver effective, cross-social group reach on this, the biggest single public health issue. Reducing smoking prevalence in the Spearhead group Local Authorities and the PCTs which map to them is also a key intervention to meet the health inequalities life expectancy and infant mortality PSA target and inequalities elements of the CVD and cancer PSA targets.

Health reform in England: update and commissioning framework (DH, July 2006) and the *Commissioning Framework for Health and Wellbeing* (DH March 2007) set out the policy framework for commissioning within the wider context of the health reform programme (see Annex C.) The commissioning framework signals a strategic re-orientation towards promoting health and well-being and investing now to reduce future ill health costs.

This updated guidance is intended for everyone involved in managing, commissioning or delivering NHS stop smoking services. It has been developed by means of a collaboration with representatives from SHAs, PCTs, the Information Centre and academics from the field of smoking cessation.

This guidance replaces the guidance issued in 2001/02. Since that time there have been many changes in the stop smoking service network and the smoking cessation field. A new drug treatment has become available for use on the NHS (varenicline, Champix), smokefree legislation has been implemented across the UK and services have developed a range of approaches to service delivery. Change is inevitable and a degree of diversity is to be expected, but given the status of smoking cessation as a potentially life-saving treatment, it is important that the interventions delivered should be evidence-based.

The Healthcare Commission's report on Tobacco Control praised the positive contribution made by the stop smoking service network but also highlighted an unacceptable level of variation with regard to data management practice. This updated guidance will address this issue, by detailing approved data definitions and procedures and will introduce a new data verification and checking procedure (the exception reporting system.) It will also set out quality principles for all service delivery options and recommendations for service level agreements with partner providers in primary care, pharmacy and other settings.

We therefore urge service commissioners, public health and PCT leads to note the changes required for local services and make their implementation a high priority.

The guidance sets out the way services can evolve to standardise their data management procedures. Addressing inequalities in health remains a high priority and services will need to focus on disadvantaged smokers as a priority group. Policy changes such as the availability of varenicline (Champix) on NHS prescription will also contribute to the support available to smokers.

Effective monitoring is an essential duty of the NHS stop smoking services and with greater consistency we can identify good practice, share learning and benefit the network as a whole. We have aimed to adapt the monitoring scheme to take into account feedback from the field and information about the treatment models that are now available in a range of settings. Our key objective is to make the scheme as straightforward as possible, whilst ensuring better consistency. We would ask all concerned with monitoring and commissioning to ensure they are familiar with the new provisions, which are summarised in this document. It should also be recognised that there is currently a wide variation in performance in Spearhead areas. On average Spearhead areas are outperforming England as a whole, but some Spearheads show rates that are twice the national average, whilst others are at around half the national average.

Note: to ensure that guidance remains up to date, this document will remain 'live' and will be revised as necessitated by further policy changes or research developments.

II. NHS STOP SMOKING SERVICES FROM 2007/08.

1. Summary of key points

- NHS stop smoking services have successfully helped many people to quit smoking, however, quit rates are still lower among people in routine and manual groups than among those in higher socio-economic groups. The provision of high quality NHS stop smoking services remains a high priority as a key element of tobacco control policy at local and national level.
- Services should aim to treat at least 5% of their local population of smokers in the course of a year, in line with best practice recommendations contained within draft NICE programme guidance for smoking cessation.
<http://www.nice.org.uk/page.aspx?o=SmokingCessationPGMain>
- Many smokers will need to make multiple attempts to quit before achieving long-term success and it is therefore important that services remain committed to providing repeat interventions for those who are motivated to make a new quit attempt following a relapse.
- Service leads will need to ensure that the revised Russell Standard is applied rigorously to ensure that data reporting is consistent and accurate and are advised to conduct regular audits of data supplied by third parties (e.g. primary care, pharmacy and prisons)
- Carbon monoxide validation at 4 weeks from the quit date should be attempted in at least 85% of cases
- 4 week quits that have not been the result of structured group or 1:1 multi-session interventions delivered by service staff or their trained agents (see glossary) may not be included in monthly or quarterly data returns.
- Services should include data regarding type of intervention and setting in the amended quarterly return from April 2008.
- Service leads and commissioners should undertake quarterly data checks and follow the exception reporting procedure when results fall outside the expected success rate range.
- Local promotion of services will be most effective if full use is made of the national Smokefree brand and resources and local marketing should ideally be carried out in partnership with regional, PCT and local authority communications leads.
- Services will need to focus in particular on increasing access for smokers from routine and manual socio-economic groups and in black and minority ethnic groups (BME) with high smoking rates.
- It is important that primary care play a key role and referrals to stop smoking services will need to be maximised. All GPs should be made aware of local NHS stop smoking service details and referral mechanisms.

- Stop smoking service provision for pre-operative patients and hospital in-patients should be developed in partnership with acute trusts.
- Partnership agreements with pharmacy and other, allied health professional providers should be consistent with the advice contained in this guidance and should be extended where practicable.
- Services should be tailored to include the provision of NICE recommended smoking cessation medicines: varenicline (Champix), bupropion (Zyban) and NRT.
- Smoking cessation medicines should be made as widely and readily available as possible. Whenever NRT is being supplied to clients (whether by FP10 prescription, under a PGD, voucher system or by direct supply), the NHS (Charges for Drugs and Appliances) Regulations 2000 must apply and a prescription charge must be made unless the client is exempt.
- Evidence-based guidelines (West, McNeill & Raw: *Thorax*, December 2000) and NICE guidance must inform service provision and the availability of smoking cessation aids.
- The full and accurate completion of individual client data monitoring forms, and their timely submission to the service, is a condition for qualifying as an NHS smoking cessation service provider.
- All smoking cessation advisers need to be trained to carry out their role and training should conform to the standards set out by the HDA Training Standards document or its updates <http://www.nice.org.uk/page.aspx?o=502591>
- All service delivery models should conform to the quality principles set out in this guidance.

II. ADVICE FOR COMMISSIONERS & SERVICE LEADS

2.1 General

Stop smoking services are now well established and are delivering substantial numbers of successful 4 week quitters. They remain a key element of the government's overall tobacco control strategy and have been praised by the Healthcare Commission for the contribution they make to the health inequalities agenda. The primary role of stop smoking services is to provide a high quality smoking cessation service to their local population. **They should not be regarded as the main driver for reducing smoking prevalence, which is affected to a much larger degree by national policy and local tobacco control strategies.**

In recent years, stop smoking services have developed a wide range of treatment models and now operate in a number of settings. This evolutionary process has improved access in many cases, but, as emphasised by the Healthcare Commission report, there remain important concerns about quality standards and comparative performance across the service network. The Healthcare Commission has highlighted an unacceptable variation in data practice and it is now important to address this through specific markers of quality, clear, approved data management procedures and a robust data verification and checking system for use by all services (the exception reporting system).

The exception reporting procedure will provide information about the relative success of different interventions and providers and will identify the reasons for results that are outside the expected success rate range, which is based on the smoking cessation literature. The procedure will enable services to identify and address reporting inconsistencies at local level and will facilitate national analysis of the success of different service delivery methods in a range of settings.

2.2 The Challenges

The main challenges facing commissioners of stop smoking services in 2007/08 (and beyond) include:

- ensuring that stop smoking services are adequately resourced and able to treat at least 5% of the local smoking population per annum (as recommended by NICE.)
- ensuring that Spearhead areas invest sufficiently in stop smoking services to support rapid increases in life expectancy to meet their share of the target.
- ensuring that repeat interventions are made available to smokers who have relapsed and are motivated to make a new quit attempt
- ensuring that stop smoking staff receive ongoing support and continuing professional development.
- adapting to the availability of the new stop smoking aid (varenicline, Champix) and configuring services appropriately.
- ensuring that local service promotion makes full and effective use of national branding and social marketing principles.
- focussing on specific groups - smokers in routine and manual socio-economic groups and in Spearhead Group areas (to tackle inequalities in health) and more specialised groups such as pregnant smokers, BME groups with high smoking rates and vulnerable groups - whilst retaining an appropriate balance of resource and interventions for the general population of smokers.
- reflecting the key role for primary care in the provision of stop smoking services and the importance of partnership arrangements with pharmacies and other allied health professionals.
- engaging with the acute care sector to provide to stop smoking services to pre-operative and in-patient smokers.
- adopting and adhering to the revised data collection methodology and new exception reporting system contained within this guidance
- ensuring that all treatment models conform to approved quality principles

All concerned with the management, commissioning, provision and development of the services are asked to consider these challenges and how they will be met locally.

2.3 Throughput and success rates

Commissioners should strive to ensure that local stop smoking services are equipped to treat at least 5% of the local smoking population and need to be aware of the 4 week success rates that can be expected, based on the available evidence. Spearhead areas may need to do more. Treatment models vary in intensity (greater intensity tending to lead to higher success rates). Results will also vary in line with the type of population being served (more deprived smokers or those with mental health problems are likely to yield lower success rates and services should not be penalised for trying to reach the most deprived and often most addicted smokers.) **The expected success rate range is 35% to 70%. Results that fall outside this range should be investigated using the exception reporting procedure. PCTs that repeatedly submit results outside (or on the margins of) the range will need to address the underlying reasons for this and take appropriate action.**

2.4 Funding and staff support

The Department of Health supplies funding for the purpose of delivering NHS stop smoking services. It is recommended that this funding be used solely to resource services and that these should be managed by full-time leads/coordinators. Given the dynamic nature of smoking cessation research and the need for both expertise and continuity to ensure quality provision, service staff should have a Continuing Professional Development Plan (CPD) that will help them to develop their knowledge and skills (a number of learning options are detailed in the NHS Knowledge & Skills Framework.) This plan should include attendance at relevant local and national events, so that staff are aware of best practice issues and new developments.

2.5 Stop smoking medicines and the services

A key challenge for the services will be to make the process of service delivery (counselling and support combined with evidence-based stop smoking medicines) as smooth and seamless as possible for clients. All services will need to make arrangements to facilitate the availability of the relevant evidence-based stop smoking medicines, varenicline (Champix), bupropion (Zyban) and NRT (and any new NICE recommended medicines to come on stream) to clients for whom they are clinically appropriate. The routes of supply will vary according to the type of medicine and the location of the service provider. Voucher systems and PGDs are in operation in many areas to support and simplify patient access to NRT.

Varenicline (Champix) is the latest stop smoking medicine to be licensed for use in the UK and PCTs will be required to fund it from October 2007 (3 months from the issue of NICE guidance). When conducting a cost-benefit analysis of funding for stop smoking medicines, PCT leads and local prescribing committees should be aware that NICE recommended medicines for smoking cessation are extremely cost-effective and that cost-effectiveness studies are published through the NICE website. The numbers needed to treat (NNTs) in order to achieve a long term quitter compare very favourably with other interventions that are routinely delivered in primary care. Evidence-based stop smoking interventions represent excellent value for money as indicated by the following illustration:

Intervention	Outcome	NNT
Statins	Prevent one death over five years	107 ⁽¹⁾
Antihypertensive therapy	Prevent one stroke, MI, death over one year	700 ⁽¹⁾
Cervical cancer screening	Prevent one death over ten years	1140 ⁽²⁾
GP brief advice to stop smoking < five minutes	Prevent one premature death*	80 ⁽³⁾
Add pharmacological support	Prevent one premature death*	38-56 ⁽⁴⁾
Add behavioural support	Prevent one premature death*	16-40 ^(5, 6)

* Over half of all continuing smokers will die prematurely from a smoking-related disease. For every two long term quitters, one premature death is avoided (Doll and Peto) 1. Bandolier 2. Gates, Amer Fam Phys 2001 3. West 2006 4. Bandolier 2006 5. Cochrane 2007 6. Anthosen Ann Inter Med 2005

Clearly the timescales for these NNTs differ markedly but even so, it is apparent that those for stop smoking treatments compare very favourably with other routine medical interventions.

2.6 Service promotion

The Department of Health has now created the new Smokefree campaign brand and is investing significant resource into establishing it as the recognised brand for NHS stop smoking services in England. Use of nationally branded and linked materials provided for local promotion enhances public recognition of the NHS stop smoking services as an entity that they know and that can help them and thereby promotes self-referrals. Templates for local use are available on the website (www.gosmokefree.co.uk/extranet) and are easy to customise. Producing new or different materials for promoting local services represents a duplication of effort, a waste of resources and a missed opportunity to capitalise on the significant impact of national, multi-media campaign messaging. Central campaigns are based on sound, social marketing principles and have proven efficacy in driving footfall through the stop smoking service network. Imaginative use of customised, national materials by services in a variety of local media will ensure that service promotion is effective. Local service promotion strategies will need to be planned in cooperation with tobacco control colleagues and communications leads from PCTs, regional tobacco control leads and local authorities in order to achieve maximum impact.

2.7 Targeting of sub-populations

Smokers from routine and manual social groups, generally the more socially excluded smokers, should be targeted for intervention by stop smoking services as part of the general drive to tackle health inequalities and improve life expectancy. This is especially important in Spearhead areas. Pregnant smokers need more specialised advice and some stop smoking medicines cannot be prescribed to pregnant women. Smoking in pregnancy is a key driver in infant mortality and life expectancy. Current data collection in this area is generally poor and efforts should be made to address this issue at local level.

Care should be taken to improve access for these groups and to be responsive to their needs. Commissioners need to be aware, however, that success rates may be poor with smokers from more deprived communities. In general terms, commissioners should seek to balance the need to target sub-populations against the need to provide a high quality stop smoking service to the wider local population. Services in many disadvantaged communities have been successful in achieving high enough throughput of disadvantaged groups to achieve high overall quit rates.

2.8 The role of primary care & pharmacy services

Primary care is a key setting for stop smoking intervention and an important source of referrals to stop smoking services. Commissioners should ensure that all local GPs are aware of the need to ask their patients about their smoking status, provide brief advice and refer smokers who are motivated to quit to the local stop smoking service. GPs should all be made aware of the details of the local service and local referral options. It is not recommended that primary care staff be paid for stop smoking activity or for the return of data monitoring forms to the stop smoking service, unless the work is being carried out outside normal working hours or by 'bank staff' (see glossary of terms). Helping smokers to quit is a key part of the remit of all primary care staff and payments are already made to practices for this activity under the Quality Outcomes Framework (QOF).

Pharmacies have a good track record of providing stop smoking services to the general public. They are ideally placed to provide this service, based in the heart of communities and accessible to those people who may not access GPs. Commissioners should be encouraged to commission services from pharmacies and should continue to work in partnership with them. Where possible, pharmacy stop smoking services should be extended, in order to improve access for the general public. Hospital-based pharmacies can also play an important role in the development of stop smoking services in acute settings. Pharmacy staff may be paid for providing stop smoking services in order to compensate them for their time and their professional input. PCTs should determine the level of payment, which should fairly reflect the duration of the intervention provided as well as related data handing procedures.

Stop smoking service leads should ensure that service level agreements (SLAs) or local enhanced service contracts (LEs) with **all** service providers include clear criteria for delivery and reporting requirements (with deadlines for data return). All staff involved in this work should be trained to provide stop smoking interventions, either by the service or in-house, provided the in-house training package conforms with HDA standards. Service delivery in all settings should be spot checked at regular intervals, to ensure that the intervention being provided is of acceptable quality and duration. Providers that fail to return data within the prearranged deadlines should be made aware that payments will not be made for late data.

2.9 Quality principles for financial practice

Where services are entering into service level agreements with third party service providers, it is important to adhere to quality principles for good financial practice in order to guard against the possibility of fraudulent claims for reimbursement. Service leads should, therefore, be aware of the following quality principles:

- When setting up service level agreements with third party providers, procedures and data processing instructions (including deadlines for data submission) should be verified with providers verbally and in writing. It should also be made clear that deviations from the service level agreement are not permitted.
- Third party providers should be required to keep all relevant records for a minimum of 2 years, to allow for possible audit.
- Service level agreements and local enhanced service contracts should stipulate that providers may not subcontract service provision to other parties and that claims made on this basis will not be paid.
- To safeguard the service against the possibility of fraudulent claims, all claim forms (invoices) submitted to the service by third party providers should include the following declaration, which should be signed and dated by the claimant:

'I claim payment for the stop smoking services that I have provided which are shown above. I confirm that the information given on this form is true and complete. I understand that if I provide false or misleading information I may be liable to prosecution or civil proceedings. I understand that the information on this form may be provided to the Counter Fraud and Security Management Service, a division of the NHS Business Services Authority for the purpose of verification of this claim and the preventing, detecting and investigation of fraud.'

- If the stop smoking service lead has reasonable grounds to suspect that fraud or corruption has been committed by other parties/providers of stop smoking services, then he/she should immediately refer details to their Local Counter Fraud Specialist (LCFS), based at their local Health Body. Alternatively, they can report the matter in confidence, to the NHS Fraud and Corruption Reporting Line on 0800 028 4060.

2.10 Quality principles for stop smoking interventions

NICE draft programme guidance on smoking cessation recommends the following stop smoking interventions as being cost effective:

- Brief interventions
- Individual behavioural counselling
- Group behaviour therapy
- Pharmacotherapies - NRT, Zyban (Bupropion) & Varenicline (Champix)
- Self-help materials
- Telephone counselling and quitlines

Services will vary in the types of intervention they choose to provide and are already quite diverse in their approaches to delivery. There is, therefore, a need to set out clear quality principles that can be applied to all intervention models, to ensure quality. The quality principles presented here are based on previous guidance, changes in the evidence base, best practice and new developments. They have been developed in response to the Healthcare Commission's concerns regarding data quality and to improve consistency across the NHS stop smoking service network.

The quality principles are as follows:

- Interventions should have a clear structure and content, which is communicated to clients in advance and to which clients must commit.
- All interventions should be multi-session with total potential contact time with the client being a minimum of 1.5 hours duration (from pre-quit preparation and during the 4 weeks post quit) to ensure continued monitoring, client compliance and ongoing access to medication.
- There should be a strong emphasis on CO (carbon monoxide) verification of quit status at 4 weeks from the quit date. This should be attempted in at least 85% of cases.
- Interventions should offer weekly support for at least the first four weeks of a quit attempt (the 4 weeks following the quit date) and appointments for sessions should be scheduled when clients are booked into treatment.
- All staff involved in delivery should have been trained to HDA standards
- Advisers should adopt an empathic approach to their clients
- Clients should be informed of all available (evidence-based) treatment options both locally and nationally prior to treatment
- Interventions should be efficiently managed and there should be sufficient administrative support for general organisation, client contact processes and data handling.
- New, non-evidence-based delivery models (such as rolling or drop-in groups) may be piloted on a small scale and should be carefully evaluated before being adopted as a significant contributor to overall service delivery
- Staff involved in delivery of 'rolling groups' or 'drop in clinics' should be trained to HDA standards and such groups should be delivered or supervised by experienced specialists with sufficient expertise to support quitters at different stages of the quitting process simultaneously.
- Only methods recommended by NICE should be funded by PCTs.
- Telephone interventions should be based on the existing evidence base (www.cochrane.org/reviews/en/ab002850.html)
- Workplace interventions should follow principles laid down in NICE workplace guidance <http://www.nice.org.uk/page.aspx?o=350204> and should be free to employees.

2.11 Content of interventions

All stop smoking interventions should include the following content:

- Reinforcement of motivation to quit and setting of quit date

- Informing of client expectations in relation to the structure and process of the intervention
- Assessment of nicotine dependence and appropriate feedback to client
- Comprehensive advice about available/appropriate drug treatments and methods of access
- Building of repertoire of coping strategies
- Information on the nature of tobacco withdrawal and advice re management of withdrawal symptoms
- Offer of regular CO checks and feedback on progress
- Ongoing monitoring of use of pharmacotherapy
- Troubleshooting for specific client problems/issues
- CO verification of quit status at 4 weeks from the quit date
- Onward planning (at end of treatment) in relation to coping mechanisms, follow-up/support options and pharmacotherapy
- Assessment of client satisfaction with the intervention provided

III. MONITORING NHS STOP SMOKING SERVICES.

NHS stop smoking services are monitored monthly, by means of the brief, monthly reporting system introduced in 2007 and by means of more detailed, quarterly data collections that are submitted to SHAs, who submit the data to the Information Centre. Changes to the system will be introduced for 2008/09 in order to respond to the Healthcare Commission's concerns regarding data quality. These will include the introduction of a systematic data verification and checking process (the exception reporting system) which will be used by PCT smoking and clinical governance leads, to ensure that the appropriate definitions have been used and will investigate results that fall outside an expected success rate range (derived from the literature on smoking cessation.) Other changes are currently under consideration with regard to capturing data regarding the reach and effectiveness of services in routine and manual groups. A suitable notice period will be given to services with regard to any further changes or additions to the system that are designed to capture socio-economic information, once appropriate approvals have been given by relevant bodies.

3.1 Changes to the monitoring and reporting process for 2008/09

- The current data monitoring system does not allow for analysis of service results in terms of the type of intervention delivered or the delivery setting. It is also impossible to compare the success rates achieved with those documented in the substantial literature on smoking cessation because of a lack of information. Changes are needed to allow for more detailed analysis of service performance so that examples of good practice can be identified and learnings spread across the network. To address these issues, we need to establish an 'exception reporting system' that will allow for improved assessment of service delivery methods and will institute a series of data checks to improve data quality.
- In order to establish a robust exception reporting system, it is necessary to collect data with regard to the **intervention type** and **delivery setting** for a given quit. Most services are already collecting this type of data for service monitoring purposes, but from 2008/09 it will be a required part of the quarterly return.
- From 2008/09 it will also be a requirement that **prescription status** should be recorded to provide a proxy for socio-economic status. Additional means of identifying and recording the socio-economic status of service users are currently being evaluated and may be introduced subject to approval.
- A gold standard monitoring form has been supplied to ensure that all the required information is recorded in all settings (see Annex B). An electronic version of this form will be available to download from (www.gosmokefree.co.uk/extranet) and in the interests of improving consistency, we would urge services to switch to using this form or adapt their existing forms to include the same content.

3.2 Additions to the quarterly data set

Services will need to collect and record information regarding the throughput and success rates of all the interventions they provide to smokers. The classifications to be used for intervention type will be as follows:

Closed groups (structured, multi-session group courses with pre-arranged start and finish dates and a pre-booked client group)

Open groups (sometimes called 'rolling groups') that have fluctuating membership and are ongoing

Drop-in clinics (multi-session support)

One to one (structured, multi-session support)

Family/couple (structured, multi-session support for small family groups or couples)

Telephone support (structured, multi-session support via telephone)

Other (where an intervention does not fit with any of the above, it should be described using free text).

The settings option will allow services to record the setting in which the intervention was delivered (e.g. stop smoking service venue, pharmacy, prisons, primary care, hospital ward, dental practice, military base). Where the delivery setting does not fit with any of the suggested options, there will be an option to select 'other' and describe the setting involved using free text.

Note: Services may need to amend their databases to allow for retrieval of the required information regarding success rate and throughput by setting and intervention type.

3.3 Monitoring: Definitions and procedures

It is essential that all stop smoking services adopt strict criteria when deciding on who to include in their monitoring return and the 4 week quit status of a service user and that these criteria are consistently applied. This was an area of weakness that the Healthcare Commission identified and we wish to ensure it is clarified in response to their report. The following criteria and definitions (adapted from the Russell Standard) should be used by all services. The Russell Standard was originally developed for use in clinical research and provides a rigorous set of definitions. It is essential that all services adhere to these definitions when recording the numbers of smoking entering treatment and the numbers successfully quit at 4 weeks.

The purpose of the data monitoring system is to monitor and evaluate the effectiveness and reach of NHS stop smoking interventions and services. It is aimed at providing consistent information on people who have sought and received quitting help from an evidence-based NHS stop smoking service. *It is not a mechanism for counting all people who have stopped smoking in a locality, nor is it a prevalence measure.* For this reason, quits that have not been the result of structured stop smoking interventions, delivered by service staff or their trained agents should not be included.

Criteria

A treated smoker = a smoker who has received at least one session of a structured, multi-session intervention on or prior to the quit date and sets a quit date with their adviser. Smokers who participate in an assessment session but fail to attend for treatment should not be counted but those who have consented to a programme of treatment, attended their first session and have set a quit date should be included.

A CO verified 4 week quitter = a self-reported quitter (who has set a quit date as above) whose expired air carbon monoxide (CO) reading is assessed 28 days from their quit date (- 3 days or + 14 days) and whose CO is found to be less than 10ppm. The -3 or + 14 day time range permitted for follow-up allows for cases where it is impossible to carry out the follow-up at the normal 4 week time point, but in most cases it is expected that follow-up will be carried out at 4 weeks from the quit date. This means that follow-up must occur 25 to 42 days from the quit

date. Clients whose follow-up dates fall outside this timing range may not be counted. CO verification should be attempted in at least 85% of cases.

Note: An 'attempt' to carry out CO verification should comprise a minimum of 3 separate attempts to contact the client via telephone, text or e-mail in order to arrange a face to face CO validation.

Note: It is crucial that staff carrying out 4 week quit status checks should phrase their question in such a way as to encourage honesty re any lapses, e.g. "are you sure that you haven't smoked at all in the past 2 weeks? Not even a puff?"
The honesty of client's self-reports may be enhanced by using a multiple-choice question format e.g.

Which option best describes your smoking activity since your quit date?

- I haven't smoked at all since my quit date, not even a puff
- I did have the odd puff/cigarette early on in my quit attempt but haven't smoked at all in the last 2 weeks, not even a puff
- I have had the odd cigarette/puff in the last 2 weeks
- I am still smoking but have cut down
- I am still smoking as much as before my quit date

A self-reported 4 week quitter = a smoker who has received at least one session of a structured, multi-session intervention (delivered by the service or one of its trained agents), whose quit status at 4 weeks from their quit date (or within 25 to 42 days of the quit date) has been assessed (face to face, by telephone or by postal questionnaire).

Calculating CO verified, self-reported success rates

The CO verified 4 week success rate achieved by a service or individual service provider will be the number of successful CO verified quitters at 4 weeks (as previously defined) divided by the number of smokers treated (as previously defined). For example: 100 smokers have been treated and 45 have been CO verified as quit at 4 weeks, the calculation will be $45/100 = 0.45$ (45%).

CO verification should be attempted in at least 85% of all treated smokers and any clients who cannot be contacted at 4 weeks (- 3 days or + 14 days) should be counted as lost to follow-up.

Calculating self-reported success rates

The self-reported 4 week success rate achieved by a service or individual service provider will be the number of successful, self-reported quitters at 4 weeks (as previously defined) divided by the number of smokers treated (as previously defined).

Spontaneous quitters:

Smokers who have already stopped smoking, when they first come to the attention of the service, may only be counted as having been 'treated' (for local accounting purposes) if they have quit within the last 14 days and attend their first session of a structured multi-session intervention within 14 days of their spontaneous quit date (which should be recorded as the designated quit date.) Services should note the results of spontaneous quitters separately for local information purposes, but they should not be included in monthly or quarterly data returns, as they will have higher success rates than other service users. We do not anticipate that there will be significant numbers of such quitters but will keep this issue under review.

Renewed quit attempts

Some people fail to stop and then set a new quit date as part of a single treatment programme. In these cases, where the renewed quit date is all part of a single treatment programme, the first quit date should be used as the anchor for subsequent reporting. Typically, the renewed quit date will occur more than 14 days from the quit date, so that a person setting a renewed quit date, even if they subsequently establish abstinence, will still be counted as a treatment failure, even if they have are successful from day 15-28 after the second quit date. This may seem odd, but it makes it possible to compare NHS figures across services and to quit rates reported in research.

3.4 Exception reporting system

Prior to the submission of quarterly data, service leads should examine their data and, if appropriate (if outlying data are found) carry out the exception reporting procedure set out in this guidance. This should be done in cooperation with an appropriate PCT lead (a clinical governance or data lead) and the information lead at the relevant Strategic Health Authority (SHA) should be notified of the results before data is submitted to the Information Centre (IC).

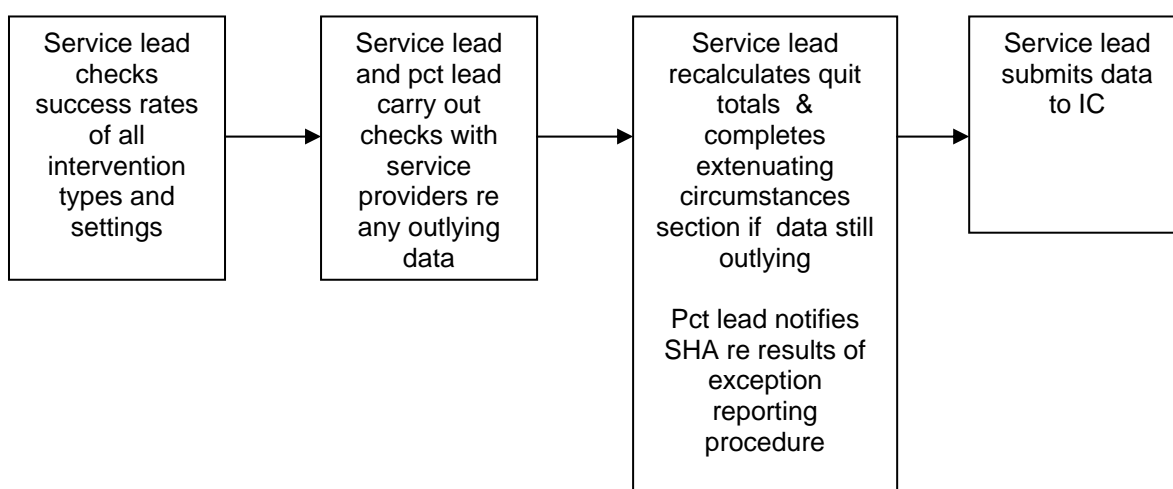
Results for all intervention types and settings should be checked by the PCT lead to determine whether the 4 week quit rates fall between 35% and 70%. If the overall service results (or those for a specific intervention type/setting) fall outside this range then the following checks should be carried out:

- The service provider/s (advisor/s) should be contacted and asked to confirm that all definitions contained within the adapted Russell Standard have been followed with regard to the data they have submitted. (If this is not the case, then the total number of successful 4 week quits should be recalculated using the approved definitions and the data should be re-entered onto the service database.)
- If the service provider/s (advisor/s) assert that the approved definitions have been used, a minimum of 3 random checks of smokers treated by the service provider/s concerned should be carried out by telephone (or face to face if possible), to establish that they met with the criteria for self-reported or CO verified 4 week quits at the 4 week follow-up point and that they have received an approved intervention of the required content and duration, as described in this guidance. A minimum of 3 successful random calls to clients must be made, so if attempts to contact one client fail, another client should be selected. If the random checks indicate that recorded quits are unreliable, all cases received from this provider should be checked using the approved definitions and the total number of 4 week quits should be re-entered onto the service database. If, after the required checks have been carried out, the results are still outside the expected range, an assessment should be made of the most likely causes.
- All service providers should maintain adequate client records (to include all client contacts, medications used and smoking status) to facilitate service audits and comply with clinical governance. **Service providers should return data on *all* clients treated (not just on successful outcomes) so that success rates may be accurately calculated. These requirements should be specified in service level agreements.**
- Service provider/s (advisor/s) that repeatedly submit incorrect or incomplete data, should be provided with refresher training around the approved definitions and procedures to be followed. Any data they submit should be subject to regular spot checks until the service lead is satisfied that the correct procedures and definitions are

being used. It is especially important to monitor the data supplied by providers who are paid for activity or for successful 4 week quit data under a service level agreement (SLA), to ensure that quitters are receiving the appropriate treatment and the service is getting value for money.

- Extenuating circumstances that may clarify the reasons for otherwise unexplained outlying data should be selected from the drop down menu provided in the exception reporting section of the quarterly return. If the extenuating circumstances in a given case are not contained within the drop down menu, the service lead should select 'other' and explain the circumstances using free text.

Flow chart showing the exception reporting procedure:



3.5 Monthly data reporting

Since August 2007, services have been required to submit the following two monthly data items;

- The number of clients entering treatment who have set a quit date
- The number of clients who have been recorded as successful 4 week quits

This data is to be uploaded onto the Unify2 system by the PCT information lead. Whilst it is understood that this data is unlikely to be complete because of late data, over time, it will provide a further, early indicator of year on year service performance and trends.

3.6 Timetable for submission of quarterly returns

In the interests of providing more timely data on performance, the timetable for submission of quarterly returns was amended for 2007/08 and the new system will remain in place in 2008/09

Timetable for the collection and dissemination of Stop Smoking Services in 2007/08
(dates for 2008/09 TBC)

Quarter	End of 6 week follow up period	SHA deadline to submit data to IC and elapsed weeks	Deadline for data collection team to submit data to Lifestyles team and elapsed weeks
April to June	11/08/2007	07/09/2007 (4wks)	14/09/2007 (1wk)
July to September	11/11/2007	07/12/2007 (4wks)	14/12/2007 (1wk)
October to December	11/02/2008	07/03/2008 (4wks)	14/03/2008 (1wk)
January to March	12/05/2008	13/06/2008 (5wks)	20/06/2008 (1wk)

At the end of the monitoring period (a quarter plus six weeks), SHAs have a further four weeks to submit data to the IC for quarters 1 to 3 and five weeks to submit quarter 4 data. This means that at the end of the quarter, SHAs have a total of ten weeks to submit returns for quarters 1, 2 and 3 and 11 weeks to return quarter 4.

Revisions of previous quarters (to allow for late data) are permitted for quarters 1, 2 and 3 but not for quarter 4 (due to the deadline for the Healthcare Commission's Annual Health Check) although under this system, more time is available for submission of quarter 4 data than for any other quarter. Late data from quarter 4 may not be carried over into the first quarter of the next reporting year.

For the first three quarters of the year, the IC produces reports in the form of short bulletins which contain a core set of tables and summary text accompanies the report. Within the quarter 4 annual report all provisional figures from previous quarters are confirmed and figures are deemed final. Extensive analysis is conducted at this point and a much more comprehensive report is produced.

3.7 Gold standard monitoring form

It is important to strive for greater consistency with regard to data collection practice across the stop smoking service network and to help achieve this, we have devised a gold standard monitoring form (see Annex B) for use by all services. This form will be available to download from the website (www.gosmokefree.co.uk/extranet). Services should either switch to using this form, or should amend their existing forms to include the same data. We have restricted the form to one side of A4 to make it quick and straightforward to complete, as we are aware that service providers from many different settings will need to use it and that time will be an issue for many. It is, of course, crucial that all sections of the form should be completed before the data is submitted to the stop smoking service.

Services will already have more detailed client record forms that provide information about each stage of treatment as well as client motivation and quit history. It is planned that a gold standard client record form will also be made available via the website in due course.

IV. ACKNOWLEDGEMENTS

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Nicky Willis – Tobacco Policy Team, Department of Health
Sandeep Manku - Information Centre, Leeds
Shirley Merrett - Stop Smoking Service & Tobacco Control Manager
Joanne Locker - Regional Tobacco Policy Manager, London
Andy Graham - Fresh North East Tobacco Control
Marie Meredith - National Support Team for Tobacco Control, Department of Health
Julia Thomas – Stop Smoking Service Lead, Medway
Julie Humphries – North East SHA
Professor Robert West - UCL Health Behaviour Unit
Fiona Bower – South East Coast SHA

V. ANNEX A – GLOSSARY OF TERMS

The following terms have been used within this guidance and should be interpreted according to the definitions set out in this appendix:

Bank staff – Indicates staff involved in the delivery of NHS stop smoking interventions who have been trained (to HDA standards) and who are paid to provide these services outside their normal working hours.

Exception reporting system – A data verification and checking system designed to improve data quality and identify the reasons for outlying data (i.e. data that falls outside the expected success rate range derived from the evidence base on smoking cessation)

Monthly monitoring – The monthly collection and reporting system, introduced in 2007, whereby local stop smoking services collect and report data on the numbers of smokers entering treatment and setting a quit date and the numbers recorded as quit.

Quarterly dataset – Stop smoking service data that is submitted to the Information Centre on a quarterly basis

Routine and manual groups – as defined by the National Statistics Socio-economic Classification (NSEC) Office of National Statistics, 2005 (www.statistics.gov.uk)

Trained agents – personnel from a variety of settings, who have been trained (to HDA standards) to provide NHS stop smoking interventions on behalf of a stop smoking service according to clear, local protocols and who are committed to returning data via appropriate local agreements.

VI ANNEX B: GOLD STANDARD MONITORING FORM



(INSERT SERVICE NAME & ADDRESS) STOP SMOKING SERVICE

Note: All patient data will be kept securely and in accordance with Caldicott guidelines. Information can only be passed to another healthcare professional if this contributes to the provision of effective care.

ADVISER DETAILS			
Department/Ward		Location/setting	
Name		Venue	
Contact Tel. No.		Adviser code/ref	

CLIENT DETAILS					
Surname		First Name	Mr/Mrs/Ms/Other		
Address					
Postcode		NHS ID. No.			
Daytime tel no.		Mobile no.			
Alternative contact number (friend/relative)					
Date of Birth		Age (in years)		Gender	Male / Female
Exempt from prescription charge		Y / N			
Pregnant	Y / N	Breast feeding	Y / N		

ETHNIC GROUP: (please tick relevant group)					
a] White		b] Mixed		c] Asian or Asian British	
British	<input type="checkbox"/>	White and Black Caribbean	<input type="checkbox"/>	Indian	<input type="checkbox"/>
Irish	<input type="checkbox"/>	White and Black African	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
Other white background	<input type="checkbox"/>	White and Asian	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
		Other mixed groups	<input type="checkbox"/>	Other Asian background	<input type="checkbox"/>
a] Black or Black British		e] Other ethnic groups		f] Other	
Caribbean	<input type="checkbox"/>	Chinese	<input type="checkbox"/>	Not stated	<input type="checkbox"/>
African	<input type="checkbox"/>	Other ethnic group	<input type="checkbox"/>		
Other black background	<input type="checkbox"/>				

HOW CLIENT HEARD ABOUT THE SERVICE (please tick relevant box)					
GP	<input type="checkbox"/>	Friend/relative	<input type="checkbox"/>	Pharmacy	<input type="checkbox"/>
Other health professional	<input type="checkbox"/>	Advertising	<input type="checkbox"/>	Other (specify)	

Agreed quit date		Date of last tobacco use		Date of 4 wk follow-up	
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TYPE OF INTERVENTION DELIVERED: (please tick all relevant boxes)					
Closed group	<input type="checkbox"/>	Telephone support	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>
Open (rolling) group	<input type="checkbox"/>	Couple/family	<input type="checkbox"/>		
One to one support	<input type="checkbox"/>	Drop-in clinic	<input type="checkbox"/>		

TYPE OF PHARMACOLOGICAL SUPPORT USED: (please tick all relevant boxes. Use 1 or 2 to indicate consecutive use of more than one medication – e.g. Champix followed by NRT product)					
None	<input type="checkbox"/>	Zyban	<input type="checkbox"/>	NRT – Gum	<input type="checkbox"/>
NRT – Lozenge	<input type="checkbox"/>	NRT – Inhalator	<input type="checkbox"/>	NRT – Patch	<input type="checkbox"/>
NRT – Microtab	<input type="checkbox"/>	NRT – Spray	<input type="checkbox"/>	Champix	<input type="checkbox"/>

TREATMENT OUTCOME					
Quit CO verified	<input type="checkbox"/>	Quit self report	<input type="checkbox"/>	Not Quit	<input type="checkbox"/>
				Lost to follow up	<input type="checkbox"/>

Adviser signature:		Client signature (indicating consent to treatment and follow-up and pass on of outcome data to GP)	
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VII. ANNEX C: COMMISSIONING POLICY AND IMPLEMENTATION

Health reform in England: update and commissioning framework (DH, July 2006) and *Commissioning Framework for Health and Well-being* (DH March 2007) set out the policy framework for commissioning within the wider context of the health reform programme.

Health reform in England set out how the health reform programme is refocusing the NHS to meet the challenges of rising expectations, the demographic challenge, the revolution in medical technology, and continuing variations in the safety and quality of care. To address these challenges, we have a clear vision: to develop a patient-led NHS that uses available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest possible healthcare.

The new NHS will not be created in the old way through command and control. In the next stage of improvement and reform, we need a decisive shift from top-down to bottom-up as we develop a devolved and self-improving health service where the main drivers of change are patients, commissioners and clinicians, rather than national targets and performance management.

This revitalised, patient-led and locally-driven NHS is designed to achieve a central goal: improving dramatically the quality of patient care and the value we get from the public money spent on health services.

The Commissioning Framework set out a range of measures to strengthen commissioning. These included:

- Stronger clinical leadership through practice based commissioning
- A stronger voice for people and local communities
- Better information to underpin commissioning decisions
- New incentives available for commissioners to attract new service providers and improve service quality
- More effective levers for commissioners to secure financial stability, including new model contracts
- Measures to build commissioning capacity and capability.

The *Commissioning Framework for Health and Well-being* provides guidance for health and local authorities in commissioning community health care, social care, public health, well-being, and primary care (with the exception of the nationally negotiated GMS contract), as well as other relevant services, support and interventions.

This framework signals a clear commitment to greater choice and innovation, delivered through new partnerships. Its key aims are to achieve:

- A shift towards services that are personal, sensitive to individual need and maintain independence and dignity;
- A strategic re-orientation towards promoting health and well-being, investing now to reduce future ill health costs;
- A stronger focus on commissioning the services and interventions which will achieve better health, across health and local government, everyone working together to promote inclusion and tackle health inequalities.

Guidance for practice based, PCT, specialist, joint and local authority commissioners has an important role in driving up the quality of care to patients and the public but guidance is just that. The responsibility for taking decisions about the scope and range of services rests with

local commissioners based upon their local needs assessment and evidence of how to maximise the health gain for their population.