NHS

NHS STOP SMOKING SERVICES

Service and monitoring guidance – 2007/08

NHS STOP SMOKING SERVICES

Service and monitoring guidance – 2007/08

Prepared by Tobacco Programme

2007

DH Information Reader Box

Policy **HR/Workforce** **Management** **Planning** **Clinical**	**Estates** Performance **IM & T** **Finance** Social care/Partnership working
Document purpose	Best practice guidance for stop smoking services
ROCR ref Gateway ref	ROCR/OR/0028/008 9500
Title	NHS Stop Smoking Services: Service and monitoring guidance – 2007/08
Author	Nicola Willis
Publication date	18 October 2007 revised 10 February 2008
Target audience	Commissioners and service leads for NHS stop smoking services
Circulation list	PCT chief executives and directors of performance, SHA chief executives, directors of public health, stop smoking service leads, tobacco control alliance leads and regional tobacco policy managers
Description	Updated guidance on commissioning and delivery of evidence-based NHS stop smoking services
Cross reference	High Impact Changes for Tobacco Control (publication date to be confirmed)
Superseded documents	NHS Stop Smoking Services – Service and Monitoring Guidance 2001/02
Action required	N/A
Timing	N/A
Contact details	nicola.willis@dh.gsi.gov.uk
For recipient's use	

© Crown copyright 2007
First published: 18/10/07
Updated: 10/02/08

Published on the Department of Health website, in electronic PDF format only
www.dh.gov.uk/publications

Contents

1. Introduction ... 1

2. NHS stop smoking services from 2007/08 ... 3
2.1 Summary of key points ... 3

3. Advice for commissioners and service leads ... 5
3.1 General advice ... 5
3.2 The challenges ... 5
3.3 Throughput and success rates ... 6
3.4 Funding and staff support ... 6
3.5 Stop smoking medicines and the services ... 7
3.6 Service promotion ... 8
3.7 Targeting of sub-populations ... 8
3.8 The role of primary care and pharmacy services ... 8
3.9 Quality principles for financial practice ... 9
3.10 Quality principles for stop smoking interventions ... 10
3.11 Content of interventions ... 11

4. Monitoring NHS stop smoking services ... 13
4.1 Introduction ... 13
4.2 Changes to the monitoring and reporting process for 2008/09 ... 13
4.3 Additions to the quarterly dataset ... 14
4.4 Definitions and procedures ... 15
4.5 Exception reporting system ... 17
4.6 Monthly data reporting ... 19
4.7 Timetable for submission of quarterly returns ... 19
4.8 Gold standard monitoring form ... 20

5. Acknowledgements ... 21

Annex A: Glossary of terms ... 22

Annex B: Gold standard monitoring form ... 23

Annex C: Commissioning policy and implementation ... 25

1. Introduction

Smoking is one of the most significant contributing factors to low life expectancy, health inequalities and ill health, particularly cancer and coronary heart disease. Therefore, reducing smoking is a key improvement area within the overarching Health of the Population public service agreement (PSA) area and strategic health authority (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 groups (General Household Survey, 2005). Smoking prevalence is highest in deprived communities. Progress against the PSA target for routine and manual groups (a 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 primary care trusts (PCTs) which map to them is also a key intervention to meet the health inequalities life expectancy and infant mortality PSA targets and the inequalities elements of the cardiovascular disease and cancer PSA targets.

Health reform in England: update and commissioning framework (Department of Health, July 2006) and *Commissioning framework for health and well-being* (Department of Health, 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 and 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 in the NHS (varenicline or 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 (SLAs) 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, while ensuring better consistency. We would ask all concerned with monitoring and commissioning to ensure that 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, while 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.

2. NHS stop smoking services from 2007/08

2.1 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 National Institute for Health and Clinical Excellence (NICE) programme guidance for smoking cessation (see 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. Service leads are advised to conduct regular audits of data supplied by third parties (eg primary care, pharmacies and prisons).
- Carbon monoxide (CO) validation at four weeks from the quit date should be attempted in at least 85% of cases.
- Four-week quits that have not been the result of structured group or one-to-one multi-session interventions delivered by service staff or their trained agents (see glossary) should not be included in monthly or quarterly data returns.
- Services should include data regarding the 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. 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. In order to monitor progress in these groups data on client socio-economic status will be collected from April 2008 in addition to that collected on ethnic groups since April 2007.

- It is important that primary care plays 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 inpatients should be developed in partnership with acute trusts.

- Partnership agreements with pharmacies 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 nicotine replacement therapy (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 patient group directive (PGD) or 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 and Raw in *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 standard set out in the Health Development Agency (HDA) training standard document or its updates (see www.nice.org.uk/page.aspx?o=502591).

- All service delivery models should conform to the quality principles set out in this guidance.

3. Advice for commissioners and service leads

3.1 General advice

Stop smoking services are now well established and are delivering substantial numbers of successful four-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 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.

3.2 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 year (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 medicine (varenicline or Champix) and configuring services appropriately
- ensuring that local service promotion makes full and effective use of national branding and social marketing principles
- focusing on specific groups – smokers in routine and manual 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 – while retaining an appropriate balance of resources and interventions for the general population of smokers
- reflecting the key role of 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 stop smoking services to pre-operative and inpatient 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 those concerned with the management, commissioning, provision and development of the services are asked to consider these challenges and how they will be met locally.

3.3 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 four-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.**

3.4 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 or co-ordinators. 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 that will help them to develop their knowledge and skills (a number of learning options are detailed in the NHS Knowledge and 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.

3.5 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 medicines recommended by NICE 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 have been required to fund it from October 2007 (three 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 in the following table.

Intervention	Outcome	NNT
Statins	Prevent one death over five years	107[3]
Antihypertensive therapy	Prevent one stroke, myocardial infarction, death over one year	700[1]
Cervical cancer screening	Prevent one death over 10 years	1,140[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.

3.6 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 NHS stop smoking services as an entity that the public knows and that can help them, and thereby promotes self-referrals. Templates for local use are available on the Smokefree 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 co-operation with tobacco control colleagues and communications leads from PCTs, regional tobacco control leads and local authorities in order to achieve maximum impact.

3.7 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. Data on client socio-economic status will be required from all services as part of the quarterly monitoring returns from April 2008. 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 varies considerably across services.

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.

3.8 The role of primary care and 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.

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 handling procedures.

Stop smoking service leads should ensure that SLAs or local enhanced service contracts 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.

3.9 Quality principles for financial practice

Where services are entering into SLAs 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 SLAs 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 SLA are not permitted.

- Third party providers should be required to keep all relevant records for a minimum of two years, to allow for possible audit.

- SLAs 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 prevention, detection 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 or providers of stop smoking services, then they should immediately refer the details to their local counter-fraud specialist, 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 40 60.

3.10 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, bupropion (Zyban) and 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 four weeks post-quit) to ensure continued monitoring, client compliance and ongoing access to medication.
- There should be a strong emphasis on CO verification of quit status at four 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 four 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 empathetic 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 contribution to overall service delivery.
- Staff involved in the 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 (see www.cochrane.org/reviews/en/ab002850.html).
- Workplace interventions should follow the principles laid down in NICE workplace guidance (see www.nice.org.uk/page.aspx?o=350204) and should be free to employees.

3.11 Content of interventions

All stop smoking interventions should include the following content:

- reinforcement of the motivation to quit and setting of a quit date
- informing of client expectations in relation to the structure and process of the intervention
- assessment of nicotine dependence and appropriate feedback to the client
- comprehensive advice about available/appropriate drug treatments and methods of access
- building of a repertoire of coping strategies
- information on the nature of tobacco withdrawal and advice on the management of withdrawal symptoms

- offer of regular CO checks and feedback on progress
- ongoing monitoring of the use of pharmacotherapy
- troubleshooting for specific client problems or issues
- CO verification of quit status at four weeks from the quit date
- onward planning (at the end of treatment) in relation to coping mechanisms, follow-up/support options and pharmacotherapy
- assessment of client satisfaction with the intervention provided.

4. Monitoring NHS stop smoking services

4.1 Introduction

NHS stop smoking services are monitored monthly, by means of the brief, monthly reporting system introduced in 2007 and by means of a more detailed, quarterly data collection. From April 2008 quarterly data collection will be submitted directly to the Information Centre by PCTs uploading the quarterly monitoring return form via an interactive website. SHA leads will be able to view the returns that are being uploaded by their PCTs using the website but will be unable to upload or modify data that has already been uploaded. Other 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.) Socio economic data will be collected from April 2008 to enable the effective monitoring of performance of the service in reducing smoking prevalence amongst the routine and manual group. Following a consultation process with primary care trusts a socio-economic classification system has been adopted which will be used to capture the required data. This system is a simplified version of one successfully used by the Office of National Statistics, versions of which have already been used by a number of services for some time. Collection of this data will enable us to monitor performance of the service in reducing smoking prevalence amongst the routine and manual group.

4.2 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 learning 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 on 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** and **socio-economic status** (determined using the modified occupation classifications system described above) should be recorded to provide data for target groups within the population.

- 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.

4.3 Additions to the quarterly dataset

The following classifications will be used in coding client socio-economic status. Further guidance on definitions on how to determine and record this data can be found on the reverse of the gold standard monitoring form

- Full-time student
- Never worked/ long term unemployed
- Retired
- Sick/disabled and unable to work.
- Home carer
- Managerial/ professional
- Intermediate
- Routine & manual
- Unable to code.

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 group** (structured, multi-session group course with pre-arranged start and finish dates and a pre-booked client group)

- **open group** (sometimes called a ‘rolling group’, which has fluctuating membership and is ongoing)

- **drop-in clinic** (multi-session support)

- **one-to-one support** (structured, multi-session support)

- **couple/family** (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 (eg stop smoking service venue, pharmacy, prison, primary care, hospital ward,

dental practice or 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.

4.4 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 four-week quit status of a service user, and that these criteria are applied consistently. This was an area of weakness that the Healthcare Commission identified and we wish to ensure that 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 smokers entering treatment and the numbers who have successfully quit at four 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.

Definitions

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, have attended their first session and have set a quit date should be included.

A CO-verified four-week quitter = a self-reported quitter (who has set a quit date as above) whose expired air 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 four- week time point, but in most cases it is expected that follow-up will be carried out at four 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 three separate attempts to contact the client via telephone, text or email in order to arrange a face-to-face CO validation.

Note: It is crucial that staff carrying out four-week quit status checks should phrase their question in such a way as to encourage honesty about any lapses, eg "Are you sure that you haven't smoked at all in the past two weeks? Not even a puff?"

The honesty of the client's self-reports may be enhanced by using a multiple choice question format, as shown in the example below.

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

A self-reported four-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 four 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 four-week success rate achieved by a service or individual service provider will be the number of successful CO-verified quitters at four 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 four weeks, so 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 four weeks (–3 days or +14 days) should be counted as lost to follow-up.

Calculating self-reported success rates

The self-reported four-week success rate achieved by a service or individual service provider will be the number of successful, self-reported quitters at four 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 be counted as having been 'treated' (for local accounting purposes) only 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 we 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 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 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.

4.5 Exception reporting system

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

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

- The service provider/s (adviser/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 four-week quits should be recalculated using the approved definitions and the data should be re-entered on the service database.)

- If the service provider/s (adviser/s) assert that the approved definitions have been used, a minimum of three 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 the criteria for self-reported or CO-verified four-week quits at the four-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 three 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 that provider should be checked using the approved definitions and the total number of four-week quits should be re-entered on the service database. If, after the required

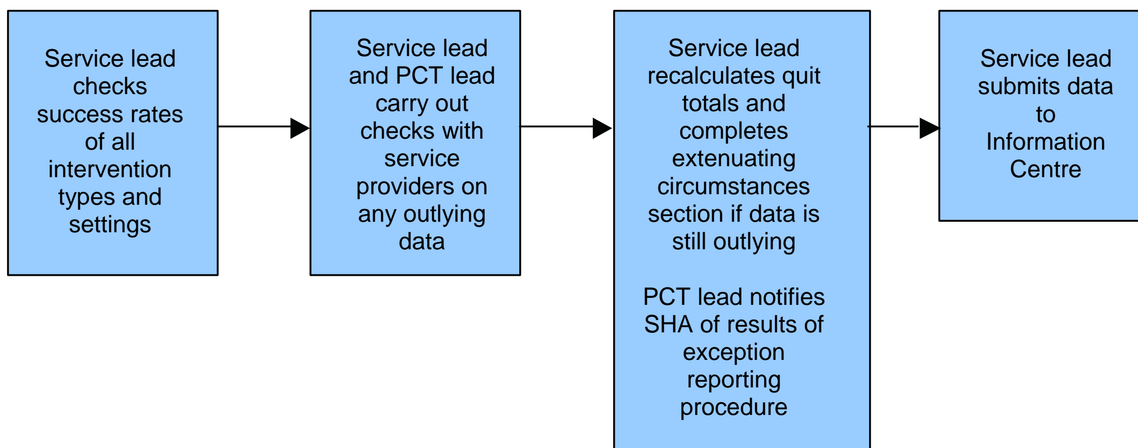
checks have been carried out, the results are still outside the expected range, an assessment should be made of the most likely causes.

- 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 SLAs.**

- Service provider/s (adviser/s) that repeatedly submit incorrect or incomplete data should be provided with refresher training on 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 that are paid for activity or for successful four-week quit data under an SLA, to ensure that quitters are receiving the appropriate treatment and that the service is getting value for money.

- Extenuating circumstances that clarify the reasons for otherwise unexplained outlying data should be recorded in the exception reporting section of the quarterly return explaining briefly the circumstances using free text box entitled ‘reason for exception’. Additionally the tick box next to this explanation should be checked confirming that the exception reporting process has been undertaken.

Flowchart showing the exception reporting procedure



4.6 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 four-week quits.

This data is to be uploaded onto the Unify2 system by the PCT information lead. While 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.

4.7 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 to be confirmed)

Quarter	End of six-week follow-up period	SHA deadline to submit data to Information Centre 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 (4 wks)	14/09/2007 (1 wk)
July to September	11/11/2007	07/12/2007 (4 wks)	14/12/2007 (1 wk)
October to December	11/02/2008	07/03/2008 (4 wks)	14/03/2008 (1 wk)
January to March	12/05/2008	13/06/2008 (5 wks)	20/06/2008 (1 wk)

At the end of the monitoring period (a quarter plus six weeks), SHAs have a further four weeks to submit data to the Information Centre 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 10 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 Information Centre produces reports in the form of short bulletins that contain a core set of tables with summary text accompanying 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.

4.8 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. The data entry section of the form has been restricted to one side of A4 to make it quick and straightforward to complete. The collection of socio-economic data has been incorporated into the new gold standard monitoring form. Further guidance on the definitions of these groups is described on the reverse of the form. If you do not wish to print a double sided version of the form advisors may wish to print a single copy of the reverse side for their own use in determining client socio-economic classification.

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.

5. Acknowledgements

This guidance has been produced with the help of a range of colleagues from PCTs, SHAs, the academic sector and the Department of Health, all of whom have considerable practical experience of the subject. Consultation has also been undertaken with a wider cross-section of colleagues from relevant organisations to whom thanks are due. The members of the core working group were as follows:

Nicky Willis – Tobacco Policy Team, Department of Health

Sandeep Manku – Information Centre, Leeds

Shirley Merrett – Stop Smoking Service and Tobacco Control Manager

Joanne Locker – Assistant 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

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 annex.

Bank staff – 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 (ie data that falls outside the expected success rate range derived from the evidence base on smoking cessation).

Monthly reporting – 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, Office for 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

NHS

(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

Occupation code (*see reverse for further information*)
- Full-time student ☐
- Never worked/long term unemployed ☐
- Retired ☐
- Home carer ☐
- Sick/disabled and unable to work ☐
- Managerial/professional ☐
- Intermediate ☐
- Routine & manual ☐
- Unable to code ☐

ETHNIC GROUP: *(please tick relevant group)*

a] White
- British ☐
- Irish ☐
- Other white background ☐

b] Mixed
- White and Black Caribbean ☐
- White and Black African ☐
- White and Asian ☐
- Other mixed groups ☐

c] Asian or Asian British
- Indian ☐
- Pakistani ☐
- Bangladeshi ☐
- Other Asian background ☐

d] Black or Black British
- Caribbean ☐
- African ☐
- Other black background ☐

e] Other ethnic groups
- Chinese ☐
- Other ethnic group ☐

f] Other
- Not stated ☐

HOW CLIENT HEARD ABOUT THE SERVICE: *(please tick relevant box)*

- GP ☐
- Other health professional ☐
- Friend/relative ☐
- Advertising ☐
- Pharmacy ☐
- Other (please specify) ☐ ----------------------------

Agreed quit date		Date of last tobacco use		Date of 4 wk follow-up	

TYPE OF INTERVENTION DELIVERED: *(please tick all relevant boxes)*

- Closed group ☐
- Open (rolling) group ☐
- One to one support ☐
- Telephone support ☐
- Couple/family ☐
- Drop-in clinic ☐
- Other (please specify) ☐ ----------------------------

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	☐	Zyban	☐	NRT – Gum	☐
NRT – Lozenge	☐	NRT – Inhalator	☐	NRT – Patch	☐
NRT – Microtab	☐	NRT – Spray	☐	Champix	☐

TREATMENT OUTCOME:

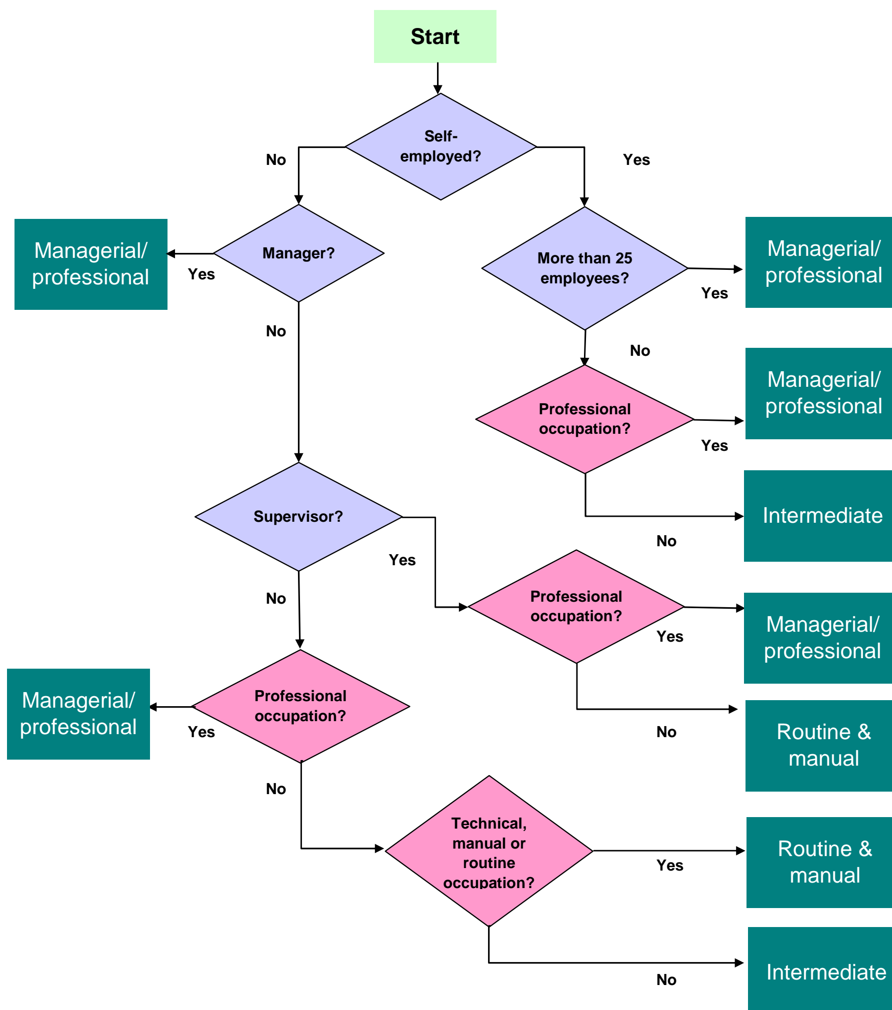
Quit CO verified ☐ Quit self report ☐ Not Quit ☐ Lost to follow up ☐

Adviser signature --	Client signature (indicating consent to treatment and follow-up and pass on of outcome data to GP) --

Notes:

1. A client is classified as long term unemployed if they have currently been unemployed for one year or more. If unemployed for less than a year last known occupation should be used for classification.
2. Home carer - i.e. looking after children, family or home
3. If a client is self-employed please use the flowchart below to determine classification.
4. Managerial and professional occupations, examples include: accountant, artist, civil/mechanical engineer, medical practitioner, musician, nurse, police officer (sergeant or above), physiotherapist, scientist, social worker, software engineer, solicitor, teacher, welfare officer. Those usually responsible for planning, organising and co-ordinating work for finance.
5. Intermediate occupations, examples include: call centre agent, clerical worker, nursery auxiliary, office clerk, secretary
6. Routine and Manual occupations, examples include: electrician, fitter, gardener, inspector, plumber, printer, train driver, tool maker, bar staff, caretaker, catering assistant, cleaner, farm worker, HGV driver, labourer, machine operative, messenger, packer, porter, postal worker, receptionist, sales assistant, security guard, sewing machinist, van driver, waiter/waitress

For further assistance in determining socio-economic classifications please see the flowchart below. If you are still unable to establish this, please record as unable to code.



Annex C: Commissioning policy and implementation

Health reform in England: update and commissioning framework (Department of Health, July 2006) and *Commissioning framework for health and well-being* (Department of Health, 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 for health and well-being sets out a range of measures to strengthen commissioning. These include:

- 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 healthcare, social care, public health, well-being and primary care (with the exception of the nationally negotiated General Medical Services 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 and 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 that will achieve better health, across health and local government, with everyone working together to promote inclusion and to 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 on their local needs assessment and evidence of how to maximise the health gain for their population.

© Crown copyright 2007

284929 1p 1.5k Nov 07 (CWP)
Produced by COI for the Department of Health

If you require further copies of this title quote *284929/NHS Stop Smoking Services: Service and monitoring guidance – 2007/08* and contact:

DH Publications Orderline
PO Box 777
London SE1 6XH
Email: dh@prolog.uk.com

Tel: 08701 555 455
Fax: 01623 724 524
Textphone: 08700 102 870 (8am to 6pm Monday to Friday)

284929/NHS Stop Smoking Services: Service and monitoring guidance