ASH BRIEFING DOCUMENT FOR HM TREASURY
PERFORMANCE MANAGEMENT AND SMOKING CESSATION TARGETS
November 2006

Introduction

1. This document sets out our ideas on how to improve NHS performance management targets for smoking cessation.

Key Recommendations

2. Set targets for services of the numbers of smokers expected to be treated on an annual basis of 8% of total number of smokers in each PCT but within a range of 5% to10%, according to local circumstances. [a]

3. Continue to use 4-week quit rates as the measure of success but ensure they are validated by testing smokers' carbon monoxide (CO) levels. CO-verified quit rates should be around 45%, depending on the type of population ranging from 35% at the low end, to 55% at the top end of the range.[b]

4. If it is not believed to be possible to CO-validate all 4-week quitters then set targets for quitting that match expected levels i.e. between 50% and 65%.

5. It is not recommended that local services be required to follow clients up to 52 weeks on a regular basis for monitoring purposes. This may not always be cost-effective on a service by service basis .

6. Exception reporting should be used to identify unusual performance outcomes and unusually high or low performance outcomes, in terms of percentage of smokers accessed, and proportion of quitters (whether CO-validated or not), should be audited.

7. In order to be able to more effectively monitor performance one possibility might be to introduce telephone counselling as an additional option in place of one to one counselling. There is increasing evidence that it is effective[1], it is more easily varied with demand and more easily performance monitored. Validation of quit rates could be followed up by local GP surgeries.

8. Use GP practices more effectively to give smokers brief advice to quit and refer patients to stop smoking services by rebalancing the QOF to award most of the points to doctors for ensuring that 90% of all smokers are given smoking cessation advice and referred to stop smoking services at least once every fifteen months. This would also be a potentially rich and valuable source of

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[a] The definition of a treated smoker is any smokers receiving at least one treatment session and having agreed to set a definite quit date.

[b] The denominator should be all treated smokers and the numerator should be smokers who report not having smoked for at least 2-weeks approximately 4-weeks after the quit date with an expired-air CO of less than 10ppm. Smokers who are lost to follow-up should be counted as not having stopped smoking.

information about smokers, providing the limitations of the data are acknowledged.[2]

Background

9. The Department of Health's Priorities and Planning Framework (PPF) 2003-2006, published in October 2002, included targets on smoking for the NHS:

   - Reduce the rate of smoking, contributing to the national target of reducing the rate in manual groups from 32% in 1998 to 26% by 2010; 800,000 smokers from all groups successfully quitting at the four-week stage by 2006.

10. The measurement of successful quitting was to be based on self-report. The PPF also included targets on reduction of smoking in pregnancy and the recording of advice to be given to smokers at risk of Coronary Heart Disease.

11. To meet these targets the 'average' Primary Care Trust (PCT) had to produce at least 900 smokers per year who have been treated by their PCT and who stopped smoking at the end of four weeks of treatment. The target for 2001-2 was an average of 167 per PCT and for 2002-3 an average of 333 per PCT.

12. Thus the target of 800,000 quitters by 2006 represented a 170% increase on the target for 2002-3, which was itself a 100% increase on the target for the previous year.

13. Since then the PSA targets on smoking have been updated in the 2004 Spending Review and now require the Department of Health (DH) to reduce the underlying determinants of ill health and health inequalities by:
    - Reducing smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.

14. The placing of the PSA target for reducing population smoking prevalence next to the target for the NHS stop smoking services in the PPF implies that the services have a key role to play in reducing national smoking prevalence.

15. However, the Stop Smoking Services can only realistically make a modest contribution to the overall reduction in smoking prevalence and this is not, and cannot be, the prime reason for their existence. The DH target of 800,000 4-week quitters over three years represented at most 160,000 long-term ex-smokers who would not otherwise have given up smoking during that time frame. This represents a prevalence reduction of only 0.1% a year.[3]

16. This does not mean that the Stop Smoking Services are not doing a necessary and effective job. Smoking is a serious addiction and given that it is legal, requires a comprehensive multi-faceted strategy to reduce the harm that it causes including measures to impact on supply and demand and product regulation. This needs to include policies such as high taxation, a tobacco advertising ban, social marketing, effectively implemented smokefree legislation and product regulation, as well as the Stop Smoking Services.

17. In order for smoking prevalence to continue to be driven down, investment in a comprehensive tobacco control strategy needs to be maintained over time. There is comparative evidence, primarily from the United States, that the more that is spent on comprehensive tobacco control programmes, the greater the

reductions in smoking, and the longer States invested in such programmes, the greater and faster the impact. For example, between 1990 and 2000 cigarette sales dropped more than twice as much in states that invested heavily in tobacco control programmes (Arizona, California, Massachusetts and Oregon) as in the US as a whole.[4] There is evidence from Australia that levelling off in declines in smoking prevalence were associated with lower per capita investment in mass media antismoking campaigns. [5] [6]

18. The UK is currently a world leader in implementing a comprehensive tobacco control strategy, the lesson to be learned from the evidence base is that investment in this strategy needs to be maintained for it to be effective. One element of this strategy is a high taxation policy, which is effective, but regressive, hitting those on lowest incomes hardest, if they are unable to give up or not given sufficient free help to quit. Also there are major health inequalities, smoking accounts for at least half the difference in life expectancy between social class 1 and social class 5. Therefore ASH, and others in the public health community, have always argued that the Government has a responsibility to help people give up smoking and in particular to try to tackle health inequalities and target resources at the poorest and most disadvantaged smokers.

19. Stop Smoking treatment is also very cost-effective. The average cost per life gained for every smoker successfully treated by the services was only £684, falling to £438 when savings in future health-care costs were counted. This is well below the benchmark of £20,000 per quality-adjusted life-year saved (QALY) that is used by the National Institute for Clinical Excellence and illustrates that the services provide excellent value for money when compared with a range of other health-care interventions.[7]

20. But for the services to be most effective, particularly now that the budget is not ring-fenced, requires the setting of effective performance targets for the Strategic Health Authorities/Primary Care Trusts and services to meet. In addition uptake of the services needs to be stimulated through a regular ongoing programme of social marketing at local and national level involving high profile heavyweight mass media campaigns.

Need to Set Achievable but Challenging Targets

21. The targets should be worked out on a systematic basis to be achievable but challenging.

22. There are data enabling us to work out what would be appropriate targets for each service. At national level we know the proportion of the population that smokes, 25%, and the proportion of smokers that access the services each year has risen from 5% to 8% between 2003 and 2005.[8] On that basis, given that there are around 9.8 million smokers in England [9], a total of around 780,000 smokers should be accessing the services every year by now. However, it should be noted that over the last year numbers coming into the services have begun to fall again, so that for Q1 in 2006/07 the number of successful quitters was down 17% on the same period in 2005, despite the same level of financial spend on services, indicating a need to investigate how services could be more effectively promoted to smokers.[10]

23. One way to do this would be to use GP practices more effectively to give smokers brief advice to quit and refer patients to Stop Smoking Services where appropriate. Over 80% of the population visit GPs at least once a year and the figure is higher for smokers.[11] Brief advice by doctors has a small but definite effect in reducing patients' smoking and NICE guidance has been issued on this topic earlier this year.[12]

24. However, doctors have generally failed to adopt and implement clinical guidelines on smoking cessation practice into their routine work and hence to encourage smokers to use the Stop Smoking Services available to them.[13] The proportion of smokers who recalled receiving advice on smoking cessation from their GP in 1996 was 38% and by 2005 it had only reached 41%.[14]

25. The Quality and Outcomes Framework (QOF), which rewards practices for the provision of quality care, and helps to fund further improvements in the delivery of clinical care, is currently set so that 41 of the 74 points available are for recording smoking status with the remaining 33 points being awarded for giving smoking cessation advice only to patients in specific disease categories. Together with the Royal College of Physicians and the Royal College of General Practitioners ASH recommended that the QOF be rebalanced to award most of the points to doctors for ensuring that 90% of all smokers were given smoking cessation advice and referred to stop smoking services at least once every fifteen months, but our proposals were not accepted.

26. Smoking is fuelled by nicotine dependence which is in itself the 'disease' which needs to be treated and it does not make sense to only give advice to patients once they have developed smoking-related diseases. We recommend that the above proposal be taken up the next time the QOF is revised, as it should ensure that doctors performance in treating smokers improves substantially.

27. To assume that every service can achieve a reach of 8% of their smoking population is over-rigid as a target and assumes that each service faces the same problems. Rather than setting a single overall target it would seem reasonable to set individual services a range that they should be able to achieve.

28. At the low end each service should be able to attract in at least 5% of their smoking population a year, 8% would be good, 10% excellent. Higher than 10% would be suspiciously high and would need to be investigated. This sort of exception monitoring is usual business practice in the private sector. Services that perform outside the 5-10% range need investigation and either support or improvement in their monitoring procedures. Extremely excessive rates could be an indication of fraud.

29. The General Household Survey analyses the proportion of the population likely to be smokers broken down by socio-economic status. Using this analysis the University of Portsmouth has produced synthetic smoking data for ASH broken down to local authority level.[15] Where necessary these could easily be recalculated to the new PCT boundaries, but in 70% of cases the new PCT boundaries mirror local authority boundaries.[16] Services could use this data or their own locally generated figures, but they need to be used consistently.

Quality as well as Quantity

30. There is a ‘perverse incentive’ in the focus of the targets on numbers to maximise throughput at the expense of quality of service, and quality of outcome, in other words the extent to which the service increases a smoker’s chances of success at stopping.

31. This is because there is only one target, which is distorting. It would be equally distorting if the target was to maximise success rates amongst quitters. The danger then would be that there would be cherry picking, the services would discriminate and pick on the easy cases, i.e. smokers most likely to successfully quit, and throughput would go down.

32. What is required to get rid of this perverse incentive is a basket of targets, or at least two targets, firstly the number of smokers accessing the services and secondly the quit rate.

33. Currently the measure of successful quitting is self report and concerns have been expressed about how reliable this is. There is a danger of misunderstanding, while a 4-week quit rate is not the same as successful long-term quitting, complete abstinence for 4-weeks after the quit rate provides a good indication of the likelihood of long-term success.

34. However, relying on self-reported abstinence makes the translation to 12 month abstinence much less reliable. The evaluation of the English smoking treatment services found that while 25.2% of CO-validated 4-week quitters remained quit at one year, only 13.7% of self-reported quitters did.[17] The findings for CO-validated quitters were similar to other studies. The conclusion reached was that, *“The fact that the results are so consistent with other studies suggests that it is possible to estimate 1-year outcomes from 4-week quit rates, but these should be CO-validated rather than self-reported quit rates.”*

35. Statistics from the NHS Stop Smoking Services in England show the 4-week CO-validated quit rate to average 40%.[18] However, the self-reported quit rates in the same survey range from 32% to 90%. And while only 4 PCTs reported quit rates below 40%, 26 were above 70%, 5 above 80% and 1 reached 90%.[18] We understand the Information Centre has checked out some of the more unrealistic figures but this needs to built into the performance measurement process.

36. The evaluation of the English smoking treatment services which looked in detail at nearly 7,000 recipients of treatment services between October 2001 and March 2003 found 4-week CO-validated quit rates of 53%, rising to 60.7% when self-reported cases were included.[19] Therefore success rates as reported by some PCTs of above 70% would seem suspiciously high. This seems to reinforce the idea that CO-validated monitoring is necessary to ensure effective performance measurement, although CO-validation also needs to be monitored and audited on an exception monitoring basis, as it too could be fraudulent.

37. To show that they are attracting serious quitters the services should be getting 4-week CO-verified quit rates of at least 45%, 35% or lower would be a sign of problems in the quality of the service and rates above 60% could indicate fraud.

38. Differences in the type of client need to be taken into account which is why a variation needs to be allowed for. The evaluation found that key indicators of success were age and motivation to quit, whereas women, users with lower

socio-economic status, those smoking more than 31 cigarettes daily and those with relatively poor health status were all less likely to quit.[19]

39. Whether quit rates are CO-validated as a performance measure or not, they need to be audited and care needs to be taken in their use. Success rates of above 65% for self-report and 60% for CO-monitored quit rates would need to be audited as they are unusually high, again this should and could be done on an exception monitoring basis. If services and localities (including pharmacy-based and other types of provision) knew that exceptionally high figures would be investigated it would discourage malpractice.

40. It is costly and often difficult to try to follow all quitters up longer-term and since good predictions can be made from short-term success rates, it is not necessary to require services to monitor quitters on a regular basis for 52 weeks.[17] Services may wish to undertake long-term follow up for their own monitoring, for example to assess the potential benefits of relapse prevention initiatives, but it would not be cost-effective to require them to do this.

Tackling Health Inequalities

41. To reiterate the key point made above at a population level, there is no chance that the services can significantly reduce health inequalities, but given the disadvantages of certain groups in the population, and the regressive effect of tobacco taxation on those who don't give up smoking, it is important that the services make particular efforts to reach them. It has also been shown that the services can do this effectively.

42. The findings of the evaluation of the services were that the services were reaching smokers from the most disadvantaged areas. Nearly a third of all smokers in receipt of treatment services lived in the most disadvantaged quintile of areas while less than one in ten lived in the most advantaged quintile.[20] An indicator of 'positive discrimination' was calculated for each health authority area, which quantified the extent to which the proportion of disadvantaged smokers being treated was greater than that in the population and this ranged from just under 0% to 18%.[20]

43. The findings of the evaluation are supported by the survey figures from the ONS studies which show that in 2005 8% of routine and manual workers said they had been referred or self-referred to a stop smoking service, compared to 4% of professional and managerial workers (and 10% of intermediate workers).

44. There is a similar variation in the use of NRT, with 16% of professional and managerial workers having bought non-prescription NRT, compared to only 9% of routine and manual workers, while 11% of routine and manual workers had received NRT on prescription compared to only 8% of professional and managerial workers. The overall percentages of those who had used NRT or other prescribed drugs to help them stop smoking were very similar at 21% for professional and managerial workers and 19% for routine and manual workers.

45. There is a simple measure for the effectiveness of individual services in reaching less affluent groups and that is the proportion of those accessing the services on free prescriptions. However, this is only a rough indicator and a more accurate means of doing this would be to collect postcode data. This would be a good indicator to services whether they are reaching routine and

manual smokers and would enable the DH and Treasury to monitor this more effectively at national level. However, it might be best to set a range rather than single targets for individual services, based on these data, as with overall targets.

46. In addition, social and economic inequality is only one measure of inequality when it comes to smoking and access to free prescriptions is a blunt measure when it comes to targeting particular groups with high smoking rates.

47. For example, there are significantly higher smoking rates amongst those with mental health problems than amongst the general population. Studies have shown smoking rates to be as high as 80% amongst people with a diagnosis of schizophrenia and people with serious depression are more likely to smoke and have difficulty giving up.[21]

48. The QOF could be used to help develop better statistics on the proportion of those with serious mental health problems who smoke, as well as those with other diseases. If the QOF were revised to reward doctors for giving all smokers smoking cessation advice and referring them to stop smoking services at least every fifteen months it would ensure that the majority of all smokers were regularly given brief advice to stop smoking, and given information about and referred to, the stop smoking services. This would be another means of more effectively tackling health inequalities.

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