

# Stop Smoking Service Quality and Delivery Indicators and Targets

A briefing for the Healthcare Commission

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## Background

The English Stop Smoking Services (SCSs) were established following a recommendation that the NHS provide treatment to aid smoking cessation as part of its core service. Four key principles underlay the recommendations on which the current services are founded: 1) most smokers are suffering from a treatable medical disorder, 'nicotine dependence', 2) treatment for this disorder is an extremely cost-effective way of prolonging life in those who wish to use it, 3) the most effective treatment is a combination of multi-session face-to-face psychological support provided by a trained specialist together with either nicotine replacement therapy of bupropion, but 4) only a very small minority of smokers wish to use face-to-face psychological support (1, 2).

It is not known exactly what form of psychological support is most effective but there is a consensus that it should involve at least weekly support lasting until at least 4 weeks after the designated quit date and that the sessions should be long enough to address important issues that arise during the quit attempt, help to sustain the smoker's motivation to remain abstinent and ensure optimal use of the medication (2). The HDA has established a set of basic competencies that counsellors providing this help should possess (3).

Monitoring the quality of the services should strike a balance between effort and resources diverted from actual provision with the need to ensure that the assessment is rigorous, objective and appropriately targeted.

A high quality service in the NHS would normally be one that: 1) achieves high success rates given the characteristics of the patients it treats; and 2) meets the needs of prospective patients.

The current targets for the SCSs do not address these quality markers because they are based on a different philosophy: that the SCSs should contribute significantly to a reduction in smoking prevalence. It is easy to show, however, that under any reasonable assumptions the SCSs could not make more than a very modest contribution to the reduction in smoking prevalence. The current Department of Health target of 800,000 4-week quitters over three years represents at most 160,000 long-term ex-smokers *who would not otherwise have given up* during that time frame and this represents a prevalence reduction of about 0.1% per year.

The focus on sheer numbers of 4-week quitters as a target is creating a 'perverse incentive' to maximise throughput at the expense of quality of service, to focus attention on smokers who already find it easier to give up and to capitalise on the fact that large numbers of smokers are able to give up for at least a short period without help. There are numerous reports of smokers being counted as successes who have either not attended what would be recognised as an adequate treatment service or who have attended only as very minimal service.

## **Proposed quality and delivery markers and targets**

The quality markers should follow the model adopted for clinical care in the NHS rather than being driven by unrealistic public health goals.

### **Quality**

The goal of the treatment services is to create genuine ex-smokers. It is recognised that a smoker who reports having not smoked at all for 12 months and whose abstinence at the 12-month point is verified by an expired air carbon monoxide breath test has only an 8% chance of relapse for the following few years and then a minimal chance of relapse after that (4). Therefore the proportion of smokers who attend an SCS that are '*verified 12-month successes*' would be an ideal quality marker. There are two problems with this, however. First, the latency between treatment and assessment is very long making it difficult to respond to problems in a time manner. Secondly, following up patients long after the end of treatment is impossible to achieve in many cases and expensive in terms of resources.

Abstinence for 4 weeks after the quit date provides some indication of likely long-term success. Complete abstinence during this period, verified by CO breath test can be expected to translate to 12-months of abstinence in some 30%-40% of cases (5). Relying on self-reported abstinence without the breath test makes the translation to 12-month abstinence much more uncertain. It has been argued that smokers should have a two-week grace period after the quit date as long as they manage to achieve complete abstinence for the two weeks after that. Fewer than 30%-40% of successes defined in this way will achieve long-term abstinence but it will prevent SCSs 'giving up on' smokers who lapse early in treatment who might in fact be helped.

It is proposed that the primary quality marker be the proportion of smokers who attended the SCS (at least one session) who were '*CO-verified 4-week abstainers*' (self-report of no smoking at least in the last 2 weeks measured

at 4 weeks from the quit date verified by a breath CO of less than 10ppm at the 4-week assessment point divided by the total number of patients who attended at least one pre-quit SCS session).

SCSs should have an incentive to try to improve longer term abstinence rates and so a secondary quality marker should be proportion of those who attended the service who are verified 12-month abstainers, but not counting patients who cannot be traced.

Clear and detailed protocols for method of follow-up, assessment of self-reported abstinence and CO verification will need to be provided.

Given the importance of helping disadvantaged groups, quality markers should be stratified by a marker of poverty (e.g. eligibility for free prescriptions) and (in relevant localities) ethnic group.

### **Delivery**

For many services in the NHS this is assessed by how long patients have to wait for treatment. This is more complex with the SCSs because in most cases patients are not formally referred. Also, there may be legitimate reasons why treatment should be delayed after the initial enquiry: for example if the patient would not be able to attend all the sessions. SCSs need to respond to requests for treatment quickly before motivation wanes. An additional factor is the need to encourage smokers to seek treatment by making it easy and attractive for them to attend. This is particularly true for low income smokers and smokers from ethnic minorities.

It is not known what the demand for the service should be, were smokers to be fully aware of what was on offer, but it is logical to assume that it would be proportional to the total number of smokers. This can be assessed locally using information on distribution by age, SEG and ethnic mix. Therefore the marker of demand fulfilment should be the

*proportion of smokers who attend the service* (attendance being defined in exactly the same way as for the quality marker). As with quality, this should be stratified by poverty and ethnic group.

## Targets

Targets for quality and delivery should be determined by what is achievable by a well run service operating in the context of a supportive PCT. Targets should stimulate improvements in services but should be achievable. One approach is to set *future minimum* target levels at the *current average* levels.

**Quality:** Evidence indicates that overall 4-week CO-verified abstinence rates average approximately **40%** but that patient characteristics can affect this dramatically. It is possible to use existing data to calculate

targets for smokers according to eligibility for free prescriptions and ethnic group.

**Delivery:** There is very limited information on what can legitimately be achieved in terms of delivery but such evidence as exists suggests that in 2003 approximately **5%** of smokers nationally used the services (6) This could form the basis for an overall target subject to adjustment by ethnic group and free prescription eligibility in the locality.

The above quality and delivery markers and stratifications should be able to be obtained using data that are already being collected. However, it will be necessary to provide more detailed guidance on how the SCSs should arrive at the figures. It will also be necessary to have at least some auditing to check the data provided. This can be achieved by having an independent agency question a small sample of patients who have attended the SCSs.

## References

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