NCSCT

Development of an independent audit process for providers of stop smoking support

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Contents

Executive summary

Need for audit and aims of the project

- Stop smoking services in England treat approximately 800,000 smokers each year and represent one of the most cost-effective life-preserving clinical services in the NHS, and one with the widest reach.

- The new funding arrangements for these services require audit procedures to be put in place to ensure quality and value for money, and prevent fraud.

- These audit processes need to be fully independent of service providers and act on behalf of the most important stakeholders, the service users.

- The aims of this project were to: develop an audit procedure for stop smoking service providers, test the procedure in terms of practicability and fitness for purpose, and make available to the field the report and the audit tools.

The audit procedures

- The pilot audit procedure consisted of 1) a questionnaire to be completed by the service provider and 2) follow-up of a sample of claimed successful quitters.

- The provider questionnaire addressed key minimum activities and structures that would be expected in a good quality provider. The follow-up of claimed quitters aimed to verify those claims and ensure that the criteria were being correctly applied.

- A preliminary set of criteria was established for passing or failing the audit. For the provider questionnaire the criteria related to ensuring that the treatment offered matched the current evidence of best practice and that organisational and structural features were conducive to continued high quality of service provision. For the follow-up of claimed quitters, it was initially proposed that a pass would require at least 90% of these to be able to be confirmed.

- The audit process and the evaluation criteria were designed to be as efficient as possible, taking up as little time and resources as would be required to derive the level of assurance needed.

Evaluation of the audit process

- Evaluation of the audit process involved applying the pilot audit procedure to two stop smoking service providers who volunteered their assistance. Information was gathered on the outcome of the audit, issues that arose during the conduct of the audit, and the time and resources required to undertake it. This information and discussion with the service providers involved was used to propose revisions to the audit process and evaluation criteria and outcome reporting.

Key findings

■ The pilot audit process was found to be workable and deliver the kind of information required. However, a number of issues arose that led to revision of the audit procedure, evaluation criteria and outcome reporting.

■ The procedure was found to be efficient. The provider questionnaire took an average of 2.5 hours to complete; the time taken to conduct the audit was 45-50 person hours with most of this time involving contacting claimed quitters.

■ The procedure was found to be effective in identifying issues with claimed success rates. Most importantly:

– The confirmation rate of claimed four-week quitters was less than the 90% threshold originally set. This appeared to result primarily from misunderstandings from service providers about the criteria allowed for a quitter to be claimed.

– Some areas for improvement in service delivery were identified.

– The CO-verification rate was found to be below the 85% threshold recommended in the national service and monitoring guidance, although higher than the national average.

– A significant number of claimed four-week quitters could not be contacted because of incorrect contact details.

■ Specific issues in the conduct of the audit were identified that need to be addressed in future. In particular:

– Stop smoking service providers should routinely ask clients for permission to be followed up by a third party for quality assurance purposes.

– Audit providers need to have access to interpreters.

– A number of the questions in the provider questionnaire required amendment for the purpose of greater clarity.

■ Feedback received from the stop smoking service providers who took part in the pilot audit was mostly positive. In particular:

– The audit process took less resource and time than expected.

– It was believed that such a service would have several benefits for providers and offer a mechanism to prove the quality of their service provision to current and/or future commissioners.

– It was believed that the audit process had motivational value for staff and provided an opportunity for the delivery team to focus on their areas for improvement.

– Both providers reported that they would recommend the audit to other providers.

■ Some concerns were raised. In particular:

– It was suggested that the pass-fail reporting be replaced by a graded system that would encourage providers to improve their performance.

– It was proposed that a discussion between the stop smoking service provider, audit provider and commissioner be routinely included in the audit process to enable the results to be set in context and ways of improving performance discussed.

– It was proposed that the audit process be used as a service development tool rather than as a means of identifying and punishing weak service providers.

– Some evaluation criteria, such as ensuring full access to effective stop smoking medication, were outside the control of the service provider.

Conclusions and recommendations

■ An audit process involving a provider questionnaire together with follow-up of claimed successful quitters was found overall to be effective and efficient and commissioners should require a service of this kind for all significant providers of stop smoking services that they commission. It should be supplemented with provision for structured discussion between the stop smoking service provider, commissioner and audit provider once the audit report has been prepared.

■ The outcome reporting should involve a graded system that is sufficiently rigorous to identify clear cases of fraud but in most cases provides a basis for motivating services to improve performance and outcome reporting. This could involve a 'RAG' (Red-Amber-Green) system as is used in other areas of performance monitoring.

■ The audit process itself should be kept under review and a system established that will allow experiences of different audit providers, stop smoking services and commissioners to be shared.

1. Background

Independent auditing of healthcare provision is well established in numerous areas of the health system with clinical auditing having been embedded within the NHS for many years. Whilst independent regulation and auditing of services is exercised to safeguard the welfare of those receiving care, it is also accepted as an important quality improvement process. Auditing seeks to improve patient care and outcomes through a systematic review of care against explicit criteria and the implementation of change has been shown to be effective, where accompanied by feedback, in improving professional practice (Jamtvedt et al, 2006).

An independent audit can offer consistency, reinforce and complement existing internal auditing procedures, provide a greater level of assurance and highlight areas of best practice and commendation as well as areas for improvement.

The Care Quality Commission (CQC) is the main independent regulator of health and social care services in England that aims to ensure that services meet Government standards. Registration with the CQC is mandatory for a comprehensive range of services but this currently does not include local stop smoking service providers.

Since their inception in 1999, local stop smoking services have delivered free evidence-based support to smokers across England. The configuration of services is led at a local level and local commissioning arrangements vary with stop smoking services often delivered by one or multiple providers. Services in the main, however, do follow national best practice guidance (DH, 2011), which is updated annually. Currently, primary care trusts (PCTs) are expected to provide quarterly stop smoking service monitoring data to the Department of Health (DH), which includes the number of smokers treated by the services and the number of four-week quitters. The data returned is expected to be in line with a version of the Russell Standard (West, 2005), which states that smokers treated by service providers should be followed-up four weeks (or within 25 – 42 days) after their quit date. Best practice is for a smoker's quit status to be confirmed by testing their level of carbon monoxide (CO), known as a CO-validated quitter. However, self-reported quit status not verified by CO can also be reported.

Despite the existence of national guidance, including relevant NICE guidance, and a comprehensive evidence base, there is considerable variation in the outcomes achieved by services. In 2011/12 self-reported quit rates from the services averaged at 49% (a decline of 4% over the last five years) but ranged by PCT significantly from 34% to 71% (NHS Information Centre, 2012). Large differences across PCTs cannot be explained by different client characteristics but is clearly related to the kind of service provided (Brose et al, 2011). Given that even one year of continued smoking results in an average loss of life expectancy of three months, a failure of services to deliver what is established best practice will result in significant avoidable loss of life.

Besides the issue of service variability, it is important to ensure that the figures for success rates being reported to commissioners are accurate. Where payments are made on the basis of successful quitters (whether through a payment by results system or a block contract) there will be an incentive for providers to seek to maximise their claims within what they consider to be the rules or even, in extreme cases, to commit fraud. Most service providers would be expected to approach the task of reporting outcomes honestly, but in an area such as this, there is considerable scope both for motivated and accidental misconstrual of criteria for reporting success. It is therefore essential that independent verification of claimed successes takes place. Without this there will be insufficient confidence in the outcome figures provided and providers who undertake their reporting rigorously will be penalised.

Some service providers have developed their own internal quality assurance and auditing processes, but presently there is no standard method of externally auditing stop smoking service providers. Independent auditing would therefore provide a mechanism through which stop smoking service provision across England could be systematically assessed offering providers a fair method of benchmarking their performance. Independent auditing could have numerous benefits for both service providers and commissioners.

- Benefits for providers include:
  - Recognition of adherence to minimum quality standards (including those recommended in the national service and monitoring guidance)
  - Indication of how they may improve their provision
  - Demonstration of value for money (e.g. to support tender applications)
  - Verification of data (e.g. to demonstrate integrity to both current and future commissioners)
  - Feedback from clients on satisfaction with the service delivered
  - Identification of good practice and areas for future development

- Benefits for commissioners include:
  - A quality benchmark when commissioning stop smoking providers
  - Reassurance of the quality of service being delivered by existing commissioned providers
  - Time saved during the commissioning process
  - Safeguarding against fraudulent claims and demonstration of value for money
  - Indication of client satisfaction with the content and range of locally commissioned stop smoking services

In 2010, the DH funded the NCSCT Community Interest Company to develop and test a method of auditing stop smoking service providers. This report outlines the audit procedure developed, outcomes from the testing and subsequent recommendations.

2. Project aims

The aims of this project were to:

1. develop an audit procedure

2. test the procedure in terms of practicability and fitness for purpose

3. make available to the field the report and the audit tools

3. Methods

3.1 Developing the audit procedure

The development of the audit procedure was informed by a review of the literature and expert input. A number of possible methods of conducting an audit were identified including:

- A self-completion questionnaire completed by stop smoking service providers to capture essential information about service delivery to be assessed against a standardised criteria either by the provider or by an independent entity. Such information would include the client base, the duration and content of support provided, reported success rates, lost to follow-up rates, CO-validation rates, provision of training and professional development for advisers as well as availability of pharmacotherapy.

- Individual client (quitter) follow-up to validate the data claims submitted by a stop smoking service provider and to measure customer satisfaction. This could be conducted through a variety of mediums such as a postal questionnaire, a telephone survey, email or face-to-face follow-up conducted either by the provider or by an independent entity. Responses would be measured against standardised criteria.

- On-site visits to service providers from an independent entity to assess physical evidence of the service provider's adherence to core quality principles as well as interviews with service personnel to assess their understanding of these principles.

- Observation of client support sessions.

Whilst it was acknowledged that the most robust method of auditing would be to visit service providers on-site and observe both clinical practice as well as review the provider's relevant documentation, paperwork and local procedures it was also recognised that this would be both highly time- and cost-intensive. It was felt however that to have greatest impact the audit procedure should be designed so that it was carried out independently to the service provider and should include both an assessment of the infrastructure of the support provided as well as an assessment of the provider's data and client feedback. As a result it was agreed that the audit model would include both a self-completion questionnaire as well as individual client follow-up.

A self-completion questionnaire (Appendix A) was developed to capture information relating to the essential elements of stop smoking behavioural support as identified in the supporting literature including NICE guidance, the national service and monitoring guidance and the NCSCT Training Standard. An accompanying criterion was developed (Appendix B), against which provider responses could be measured to show whether they met the minimum requirement or exceeded these. Where possible, the criteria were based upon the literature, or in the case of the quit and lost to follow-up rates the national average, as calculated from the stop smoking service data published centrally.

Conducting home visits to assess individual client quit data and feedback was considered to be too resource intensive. The least intensive method would have been to implement a postal survey however there were some concerns about the likely response rate and as a result the use of a telephone survey appeared the most appropriate. A telephone script (Appendix C) was developed to assess client responses against the core principles within the Russell Standard in order to verify the reported quit outcome. Two additional questions were added to measure key components of customer satisfaction; the offer to re-refer relapsed clients was also included.

The two customer satisfaction items were:

1. Would you recommend the service to someone who was trying to stop smoking?

   – Yes

   – No (if not, why not)

   – Unsure

2. Overall, how satisfied were you with the support received?

   – Very satisfied

   – Satisfied

   – Unsure

   – Unsatisfied

   – Very unsatisfied

3.2 Testing the audit procedure

In order to test the practicability of the proposed audit procedure a current service provider was required who would be willing to complete the questionnaire and provide access to their client database in order to facilitate the independent client assessment. A number of local service commissioners and providers were interested in piloting the approach (having heard about it at regional network meetings); however, as many providers did not currently obtain consent from clients for third party follow-up this proved restrictive.

Ultimately interest was received from a provider who could provide the required data access. It was agreed with the provider that, due to this being a pilot, it would not be classed as an 'official' audit but would be used to test the process. The initial pilot ran from 8 September to 10 November 2011 and included both provider and individual client elements of the audit.

Subsequent to the initial pilot, revisions to the questionnaire and client script were identified and made. In the interim, interest from more commissioners and providers had been received and a second pilot was undertaken to test the audit, and latest revisions, further. The second pilot ran from 5 March to 2 April 2012 and again included both elements of the audit model.

3.2.1 Provider self-completion questionnaire

For the purposes of the pilots the questionnaire was sent to the providers via email and the allocated timescale for completion was one month. The questionnaire was completed and sent back to the NCSCT with supporting documentation, including the providers' treatment protocols and client record form. The completed questionnaires were then assessed against the agreed criteria based upon specific standards of care (Appendix B).

3.2.2 Individual client assessment

The pilot site delivered an encrypted list of all claimed four-week quitters from the previous quarter (including both four-week CO-validated and self-reported quitters) to the NCSCT including contact details. The sample was taken from the previous quarter rather than the previous full year in an attempt to reduce the risk of limited client recall. The four-week quit data dated from 1 April – 30 June 2011 in the first pilot and 1 September – 31 December 2011 in the second. The total number of clients recorded as having quit with the service providers during this period was 148 and 467, of which in total 148 and 179 were used respectively. To record the outcomes and comments from the audit contacts a database within SPSS was developed. This was also used to randomly select the initial 50 clients required for the independent data assessment.

The NCSCT contacted the sample of clients by telephone. The timeframe of six weeks was allocated to allow ample time for the auditor to carry out the calls. The calls were carried out between 8 September - 5 October 2011 and 6 March – 26 March 2012. If a client could not be reached after three attempts having been made on varying days and times, s/he was replaced by the next record from the database, with the previous client being excluded. To take into account typical working hours and to ensure there was as high a chance as possible to reach the client, one of the three attempts to contact each client was always made in the evening and the three attempts were spread over different days and at different times to increase the chances of making contact.

It was also agreed that if over 10% of the initial sample taken were not verified, a further 50 clients would be contacted to provide a larger sample. If more than 10 clients were not verified in this larger sample of 100 clients, the service provider would be considered not to have passed the individual client assessment.

Clients who were identified as having gone back to smoking (relapsed) were also asked if they would like to be referred back to the service provider. If they expressed an interest in this then their details were forwarded onto the service for follow-up.

Verified contacts

For the purposes of the audit a client contact was regarded as a pass (verified) if the client:

– recalled visiting the service

– were smoking when they first saw a stop smoking advisor (or if they had already stopped, it was in the 48 hours prior to them accessing the service)

– said that they had set a quit date with the service

– said that they had managed to stop smoking for four weeks and

– said that they had blown into a CO monitor and passed (if they were reported as a CO-validated quitter)

Non-verified contacts

A client contact was not regarded as a pass (non-verified) if the client:

– could not recall accessing the service

– had already stopped smoking when they accessed the service (for longer than 48 hours)

– had only visited the service once and had not received any follow-up from the service

– had smoked in days 15 to 28 of their quit attempt, before the providers four-week follow-up

Following the completion of both of the audit elements a report was developed for each provider outlining the audit outcomes and recommendations where appropriate. The provider reports are included in Appendix D.

4. Findings

4.1 Resources required

4.1.1 Consent

Appropriate consent was an essential requirement for the individual client assessment element of the audit. Delays were incurred at the beginning of the project due to such issues and, in particular, difficulty in finding a provider whose clients had already given the appropriate consent to be contacted for third party follow-up. To overcome this, and for the purposes of the first pilot, an honorary contract was set up between the NCSCT and the pilot site which allowed one member of the NCSCT to access the required data. For the purposes of the second pilot, their current consent wording was checked by the local information governance team who confirmed that this was sufficient for the NCSCT to contact clients.

4.1.2 Time

The audit process required little time resource from the providers, who were required to gather the information needed to complete the questionnaire and ensure access to the client data. For one provider this took merely one hour, for the other it needed four hours (mean 2.5 hours). It was suggested that a version of the questionnaire which could be completed online or electronically would have been useful and further reduced the amount of time required.

A breakdown of the actions, resources and average time used in both of the audit pilots from the auditor's perspective is provided in table 1.

Table 1: Resources required by the auditor

Action	Resources required	Average total time taken per pilot
Initial discussion with the provider	Time	4 hours
Provision of the questionnaire to the provider and responding to queries	Time Questionnaire Email	1 hour
Randomisation of client (quitter) data	Time Data analysis software Client (quitter) data	1 hour
Undertake client calls and re-referral (as appropriate)	Time Telephone Script Interpreter Method of initial data capture (hard copy or electronic) Criteria Referral details / pathway	5 minutes per successful call
Data input	Time Data analysis software Client responses Criteria	5 minutes per successful call
Data analysis	Time Data analysis software Criteria	4 hours
Assessment of provider questionnaire	Time Completed questionnaire Criteria	1 hour
Report writing	Time Audit results	12 hours
Follow-up discussions with provider	Time Meeting room	4 hours

Extra time was also required however to undertake additional calls due to excluded contacts and the need to contact a further sample of clients during the client data assessment (see section 4.2). The total time required to complete the client calls was therefore greater than expected due to the fact that in the end all of the clients provided had to be contacted, with often more than one attempt to contact required and a minimum of three attempts in the case of those recorded as unable to contact.

4.1.3 Additional resources

The use of an interpreter was required in the initial pilot for a small number of calls (n=5). This suggested that it would be useful for auditors to gather information about the provider(s) prior to auditing including key client demographics so that the need for any additional resources, such as interpreters, could be identified prior to commencing auditing.

4.2 Audit outcomes

In both pilots the providers met the vast majority of the provider data assessment criteria; however CO-validation rates were lower than the 85% minimum (as based upon the DH recommendation) at 83% and 79%. Other criteria not met included lost-to-follow-up rates and minimum training requirements for staff.

During the individual client assessment, 48% (n=158) of the clients on the provider databases had to be excluded due to: no response after three attempts (42%, n=67), incorrect contact details (30%, n=47), no contact details recorded (3%, n=5) or other reasons (25%, n=39). The other category included clients whose responses suggested limited recall. The incidence of poor client recall suggested that the decision to take the client sample from the previous quarter rather than the whole previous year was appropriate.

An additional sample of clients was also required in both pilots due to the level of non-verification in the initial samples being greater than 10%. In total, 17% (n=28) of all clients successfully contacted during both pilots (n=169) could not be verified. The most common reasons for non-verification of contacts in both pilots were:

- The client having already stopped for more than 48 hours prior to their first session with the provider (n=12)

- Clients reporting not having quit for a period of four weeks (n=12)

- Clients reporting having only visited the provider once with no further follow-up to verify quit status at four weeks (n=4)

In total 28 (17%) of the clients contacted requested to be re-referred to the relevant service provider, which included two clients who had reported not previously quitting successfully with the providers and 26 clients who had quit for a minimum of four weeks with the providers but had subsequently relapsed.

Both providers performed well in terms of customer satisfaction with between 87%–94% of clients reporting they were 'very satisfied' and 93%–100% reporting they would recommend the service to another smoker.

4.2.1 Issues identified

Issues relating to the conduct of the audit procedure were identified during testing. For example, initially the telephone script did not include a question about follow-up (e.g. by telephone) if the client reported only visiting the provider once. Following three instances when this information was not captured, an additional question was included within the script part way through the first pilot. Within this group of clients there were also some examples where they had been recorded as a CO-validated quitter, which would appear incorrect given that they were followed-up by alternative means such as telephone contact.

A number of areas within the self-completion questionnaire also required revision. The availability of medication was one area that caused some concern especially where this was subject to local protocols outside of the provider's control. Originally the criteria stipulated that all three medications (nicotine replacement therapy (NRT), varenicline and bupropion) must be available first line treatments; however this was subsequently amended to reflect the fact that bupropion is increasingly used to a lesser extent due to the fact that combination NRT and varenicline are more effective options. A further change was also made to the criteria in relation to the requirement for a support session to be scheduled on the actual quit date. Whilst there is evidence that having a session on a client's quit date is best practice, it was acknowledged that this may not always be practical. This has now been revised to allow a period of three days either side of the quit date and an additional question has been added to the questionnaire to gather this information.

The wording of question 2.1 (section D2) about training received was revised to emphasise that responses should be given as an equivalent to a number of days which may not be consecutive. For example, if the minimum local requirement was for practitioners to complete the NCSCT Training and Assessment Programme including both Stage 1 and 2 assessments (equivalent of up to 1.3 days), attend a local face-to-face training course (equivalent to 1 day) and be observed in practice (equivalent to 1 day) then this criteria would be met but the time taken would span, in all likelihood, a greater number of days.

Minimum requirements in relation to 85% CO-validation rates also merit further consideration. Looking at the national data for 2011/12 only 21% (n=31) of services measured at PCT level would be able to meet this criteria. This is an area where national practice does not meet the required standard so it may be unfair to penalise individual providers. On the other hand, this audit provides an opportunity to improve compliance with this standard.

Finally, there were also some instances where a response to a question was not given by the provider for unknown reasons and as a result could not be assessed. This highlighted the need to communicate more clearly to providers the importance of completing all fields on the questionnaire as not doing so could have a detrimental effect on the audit outcome.

4.3   Feedback from the pilot providers

Feedback on the audit process was sought from both providers involved in testing the model. Initially the providers expected the audit to require a greater amount of their time and resources than was actually the case, and the process was deemed to be fairly straightforward.

Neither provider identified any key areas that they thought were missing from the provider and / or individual client assessments and both had used the outcomes and recommendations from their audit to outline and implement improvement action plans. One provider noted that it was reassuring to see that for many of the areas where improvement was suggested, activity had already been proactively planned by the provider and was underway.

The providers also expressed the view that an independent audit service would have important benefits for providers of local stop smoking support. It was felt for example that this would provide reassurance that the quality of service delivery from other providers was being scrutinised to the same degree. Whilst both providers had internal quality assurance procedures in place, they believed that an independent assessment of the service they provided would offer greater assurance not only to themselves but also importantly to their current and / or potential commissioners. Motivational benefits were also identified by one of the providers stating that an audit provides an opportunity to measure improvement, identify achievements to date and share positive feedback with the team; whilst also stimulating further commitment to improving service delivery and providing a clear focus for action planning. Furthermore, it was very encouraging that both providers involved in the pilots reported that they would use an independent auditing service again and would recommend such a service to other providers.

4.3.1 Provider reservations and suggestions for improvement

There were a small number of concerns raised by the providers, which generally related to how the audit outcomes would be reported and, in turn, how they may be interpreted by commissioners.

Whilst the audit model developed is as comprehensive as possible accounting for the resources required it does have some limitations. This includes provider interpretation of the questions within the questionnaire which could affect the response given and ultimately the 'score'. This therefore suggests a need for a named contact from the auditor to be available to the provider to respond to queries as they complete the questionnaire. Specific suggestions for areas where the questionnaire could be improved were provided as summarised in section 4.2.1.

Although updates were given fortnightly to the provider, it was suggested that even more regular reports would have been useful in order to track progress and manage follow-up of re-referred clients.

In addition, the providers felt that once the audit outcomes and recommendations were reported back, it would be important for the provider to be able to discuss these with their commissioner so that further context, where necessary, could be given. This led to further consideration about how the audit outcome was presented. Initially it was assumed that a provider would meet or not meet the minimum criterion and therefore either pass or fail the audit. However following further discussion with both commissioners and providers, who clearly considered the audit process to be a learning opportunity for driving service improvement rather than punitive action; this did not appear to be the best way of reporting the audit result. It was therefore suggested that alternatively providers, dependent upon the audit outcomes, could be rated as either red, amber of green (RAG). This would more accurately reflect the aim of the auditing process i.e. to encourage and support service improvement and quality, and clearly distinguish providers who were near to meeting the minimum standards versus those that were significantly lower. Appropriate action (which may need to include penalising providers or terminating contracts if there is substantial cause for concern) can then be discussed and implemented. A revised criterion was subsequently developed to reflect this method of assessment (Appendix B).

The concept of certification was also identified as being important to providers, who reported wanting to be able to clearly show when they had achieved 'green status'. Suggestions included receiving a certificate for display purposes as well as the use of a bespoke logo for documentation and websites similar to other signs used within health, such as the QISMET quality mark for providers of chronic disease self-management programmes for example.

5. Conclusion

The results of both pilots demonstrate that the audit model developed is feasible to deliver and that both elements are important. It is reasonable to assume that the two volunteer providers used to test the model were among the higher performing service providers and, given that the audit still identified important areas for improvement particularly in relation to the reporting of claimed successes, this further highlights the need for independent auditing on a national scale.

Furthermore, feedback from commissioners and providers involved in the pilots as well as anecdotally suggests that there is interest at a local level for independent audit services and, where this is the case, it is important that providers ensure that the consent they currently obtain from clients is sufficient to allow third party follow-up to avoid delays.

The audit process should be considered primarily as a development tool but also provides a safeguard against fraud. The use of a RAG rating system therefore seems to better reflect the aims of the audit, which allows for development whilst still safeguarding smokers and the taxpayer from ineffective practice as the principal objective. To gain maximum benefit from the auditing process it would be important that commissioners and providers use the outcomes to develop local action plans to support service improvement.

It should also be recognised that auditing can be used to emphasise good practice as well as areas for improvement and it was encouraging that high rates of customer satisfaction were achieved by both of the pilot providers audited, and that many clients requested to be re-referred.

It is important that audit service providers recognise that delivering such a service is likely to be a learning process within itself and continue to be so for a considerable period of time. Therefore capturing client (provider) feedback is essential to allow for further development of the audit process and associated tools. It would be useful to have a national system so that experiences from audit provider, service provider and commissioner perspectives can be collated and shared to inform progress in this area.

Additional consideration is required as to how auditing of sub-commissioned providers and providers with very low annual throughput can work most effectively whilst ensuring that the minimum standards are measured. Likewise, further consideration also needs to be given as to how the certification of qualified providers can be best managed to ensure that there is consistency between the criterion and method of assessment used by what could potentially be multiple audit service providers. A plethora of varying standards and quality marks will ultimately be confusing for commissioners and providers and undermine the purpose of auditing.

Whilst it is recognised that independent auditing of local stop smoking service providers would ideally be delivered via a public sector organisation, as it currently is for other healthcare providers, this is not the case. Given the increase of providers moving into smoking cessation and the even greater emphasis on cost efficiency as well as quality it appears reasonable to suggest that a systematic method of ensuring service delivery meets minimum standards is required. The audit model described within this report provides one method of introducing a governance process for stop smoking service providers.

6. Recommendations

Following the testing of the audit process and tools the following recommendations are made.

Audit service providers:

1. should use the lessons learnt from the testing undertaken to date by the NCSCT to develop their processes. The tools (provider questionnaire, telephone script and criteria) are available at www.ncsct.co.uk

2. should consider further development of the tools including an electronic version of the provider self-completion questionnaire

3. need to ensure that they build in regular progress updates (to the provider being audited) within their audit process and provide a named contact who can offer support to the provider throughout

4. need to further consider how the auditing of sub-commissioned providers and / or providers with low throughput can be managed

Stop smoking service providers:

1. seeking independent auditing should be encouraged to ensure that clients provide consent to third party follow-up during their first support session. [Note: Consent wording may need to be agreed with local information governance leads]

Stop smoking service commissioners:

1. should ensure that service providers are required to include independent auditing as part of their tender

2. should consider how providers can best be supported post audit to improve any elements of their service delivery as identified through the auditing process

3. should take immediate action where service providers are found to be performing consistently below the expected minimum standards or where there is evidence of fraud

DH / Public Health England (PHE)

1. should consider funding an evaluation of audit providers after 12 months to assess implementation and outcomes

2. should consider the need for national management of audit providers to ensure consistency regarding the quality of provider assessment and certification

3. should continue to publish the annual service and monitoring guidance for stop smoking service commissioners and providers. These pilots have highlighted common areas where service delivery is not meeting national standards. This therefore emphasises the importance of the DH's stop smoking service delivery and monitoring guidance. It is therefore important that this document, which provides quality standards and key definitions, continues to be written and effectively communicated to local stop smoking service commissioners, managers and practitioners

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Appendix A:
Provider self-completion questionnaire

NCSCT   **Provider self-completion questionnaire**

NCSCT Quality Standard
Provider self-completion questionnaire

We estimate that, leaving aside the time required to gather the supporting documentation, the questionnaire will take approximately 30 minutes to complete.

Name of Service Provider	

Type of service intervention (please indicate percentage breakdown of service provision from your most recent annual figures)

	One-to-one support by appointment		Drop-in		Internet
	Closed group		Couple / Family		SMS Text
	Open group		Telephone		Other

Address of Service Provider	
Contact person	
Job Title	
Email address	
Website	
Telephone number	

Setting (please indicate percentage of clients seen in the following settings from your most recent annual figures)

	Primary care		Specialist clinic		Prison
	Pharmacy		Secondary care		Other

A Client base

Give percentages of clients that fall into each of the following categories (most recent annual figure)?
In each case state whether the figure comes from recorded figures (as opposed to being estimated).
If the percentage is not known leave blank.

Client	Percentage	Actual (A) or Estimated (E)
i) Pregnant		
ii) Eligible for free prescription		
iii) Under 25 years of age		
iv) Unemployed		
v) Black and Minority Ethnic (BME)		
vi) Being treated for alcohol or substance misuse disorder		
vii) Being treated for other mental health problem		

1

NCSCT Provider self-completion questionnaire

B Support provided

According to your local protocol please answer all the questions below. If the answer is not known leave it blank.

B1 Support sessions

1.1 What is the minimum number of sessions offered to each client (per quit attempt) by intervention type?
(Please indicate N/A if intervention type is not provided)

i) One-to-one support	
ii) Closed group support	
iii) Open group	
iv) Drop in	
v) Telephone support	
vi) Other (please specify)	

1.2 What is the minimum expected client contact for the first session for each intervention type?
(Please indicate time in minutes and enter N/A if intervention type is not provided)

i) One-to-one support	
ii) Closed group support	
iii) Open group	
iv) Drop in	
v) Telephone support	
vi) Other (please specify)	

1.3 What is the minimum expected client contact for follow-up sessions for each intervention type?
(Please indicate time in minutes and enter N/A if intervention type is not provided)

i) One-to-one support	
ii) Closed group support	
iii) Open group	
iv) Drop in	
v) Telephone support	
vi) Other (please specify)	

1.4 Is a session scheduled prior to the quit date?   ☐ Never ☐ Sometimes ☐ Always

1.5 Is a session scheduled for the quit date itself?   ☐ Yes ☐ No ☐ Sometimes

i) if you answered sometimes or no to question 1.5, what is the minimum number of days before or after the quit date that a session is scheduled?

1.6 Are the sessions at least every week for the first four weeks?   ☐ Yes ☐ No

1.7 Are clients given a clear expectation that they should attend all sessions?   ☐ Yes ☐ No

2

NCSCT   Provider self-completion questionnaire

B2	**Behavioural support provided**		
2.1	**Is the support delivered based upon a written treatment protocol describing what should be done at each session?** (Please attach your treatment protocol when submitting the questionnaire to the NCSCT, including additional protocols if you have more than one, for example different intervention types or client groups.)	Yes	No
2.2	**Does this protocol follow the NCSCT Standard Treatment Programme?** (www.ncsct.co.uk/Content/FileManager/documents/NCSCT_STP_ed2.pdf)	Yes	No
2.3	**Do client records provide evidence that practitioners are adhering to the treatment protocol?**	Yes	No
2.4	**Does the treatment protocol emphasise the importance of:**		
	i) setting a definite quit date	Yes	No
	ii) giving clear advice on the relative effectiveness and side effects of different medication options	Yes	No
	iii) clearly explaining how to use the medication selected (e.g. 'It is very important that you use enough of it and go the full length of the course, even if you feel that you are doing OK'), and creating positive but realistic expectations of what it can provide (e.g. 'It cannot make you stop smoking; you will still need a lot of determination; but it will make it easier by reducing the cravings and withdrawal symptoms')	Yes	No
	iv) at each session, identifying barriers that may come up and discussion of specific practical ways of avoiding or addressing these	Yes	No
	v) ensuring that clients have an opportunity to raise issues and concerns and that these are fully addressed?	Yes	No
	vi) use of expired-air CO both as a motivational tool and a means of checking abstinence	Yes	No
	vii) adopting a friendly, respectful and professional attitude to all clients	Yes	No
	viii) getting the client to commit to 'not-a-puff no matter what'?	Yes	No
B3	**Medication**		
3.1	**Which of the following medication options are available on prescription (or without charge) to clients for the full recommended duration as licensed by the MHRA *as first line treatment*?**		
	i) Champix (if no or unsure, please explain local prescribing arrangements on page 6)	Yes	No
	ii) Combination NRT (two NRT products at the same time)	Yes	No
	iii) Single form NRT (just one NRT product at a time)	Yes	No
	iv) Zyban (if no or unsure, please explain local prescribing arrangements on page 6)	Yes	No
3.2	**Are clients informed that the best success rates are achieved with either Champix or combination NRT?**	Yes	No

3

NCSCT   Provider self-completion questionnaire

C Throughput and success rates

Please give the numbers of clients for each question below, not the percentages.

1.1 **What was you annual throughput last year (2011–12)?** (Number setting a quit date)	
1.2 **How many of these were CO-verified 4-week quitters?** (See Appendix A for definitions)	
1.3 **How many were self-reported 4-week quitters but not CO-verified?**	
1.4 **How many were lost to follow up?**	

D Infrastructure

Please answer all the questions below and in each case indicate whether the figure is based on records or is estimated.

D1 **Staffing**	Number	Actual (A) or Estimated (E)
1.1 How many stop smoking practitioners are directly employed by this service?		
1.2 How many of these practitioners are NCSCT Stage 1 certified?		
1.3 How many stop smoking practitioners are subcontracted through the service (e.g. in primary care)?		
1.4 How many of the total stop smoking practitioners is this their main role?		

D2 **Training and professional development**

2.1 **What is the minimum amount of training required (including online and/or face-to-face training and observation time) for staff to begin working as a stop smoking practitioner?** (Please indicate using either total hours or an equivalent number of total days. Please provide any further clarification (as required) within the notes section on page 6)

☐ 0   ☐ 7 hours or less   ☐ 8 hours   ☐ 16 hours   ☐ 24 hours   ☐ 32 hours   ☐ 40 hours   ☐ 40+ hours

☐ None   ☐ Less than 1 day   ☐ 1 day   ☐ 2 days   ☐ 3 days   ☐ 4 days   ☐ 5 days   ☐ more than 5 days

2.2 **Please indicate who provides your training** (tick all that apply)

☐ NCSCT   ☐ In-house   ☐ Maudsley   ☐ QUIT   ☐ Other (please specify)

2.3 **Are your practitioners required to attend update meetings or courses at least once a year?**	☐ Yes ☐ No

D3 **Resources**

3.1 **Do all of your stop smoking practitioners have full access to:**

i) an expired-air CO monitor that is regularly maintained and calibrated?	☐ Yes ☐ No
ii) an online database for recording of clinical data?	☐ Yes ☐ No
iii) clean, quiet, private premises to consult with clients?	☐ Yes ☐ No

4

NCSCT   Provider self-completion questionnaire

D4	**Data collection and governance**		
4.1	**Do your practitioners have to use a standard question for assessing 4-week smoking status along the lines of: 'Have you smoked any cigarettes at all in the past 2 weeks?'**	Yes	No
4.2	**Do your practitioners have to use a standard question for assessing 12-week smoking status along the lines of: 'Have you smoked any cigarettes at all in the past 10 weeks?'** (if applicable)	Yes	No
4.3	**Do your practitioners have to measure expired-air CO at the 4-week post-quit session?**	Yes	No
4.4	**Do your practitioners have to measure expired-air CO at the 12-week post-quit session?** (if applicable)	Yes	No
4.5	**Do you undertake an internal check of claimed 4-week CO-verified quitters to ensure that the smoker a. set a quit date with the service, and b. fulfilled the criteria for 4- and 12-week success:**		
	i) with all claimed successes	Yes	No
	ii) with a sample of claimed successes of at least 10%	Yes	No
4.6	**Please attach the client record form you use or alternatively a list of the data fields you collect.**		

If you have any comments or suggestions, or anything you wish to add please write in the box below.
Continue on the notes page if necessary.

I declare that all the information provided within this self-completion questionnaire is true to the best of my knowledge.

Centre manager signature	
Print name	**Date**

Thank you for completing this self-completion questionnaire.

Please return this questionnaire to:
NCSCT, CK International House, 1–6 Yarmouth Place, London W1J 7BU

Please also include as attachments:

1. Your treatment protocol(s) as applicable
2. Your client record form if you have one
3. Any written policies on any aspects of treatment provision that you think are relevant, including your CO monitor protocol

5

NCSCT   **Provider self-completion questionnaire**

Notes

6

NCSCT   **Provider self-completion questionnaire**

Appendix A: Definitions

Quit date

The date on which a smoker plans to stop smoking altogether with support from a stop smoking adviser as part of an NHS-assisted quit attempt.

CO verified four-week quitter

A treated smoker whose CO reading is assessed 28 days from their quit date (-3 or +14 days) and whose CO reading is less than 10ppm (parts per million).

The percentage of self-reported four-week quitters who have been CO verified should be calculated as shown below:

> **Number of treated smokers who self-report continuous abstinence from smoking from day 14 to the four-week follow-up point, and who have a CO reading of less than 10ppm**
>
> ———————————————————————————————————
>
> **All self-reported quitters**

Self-reported four-week quitter

A treated smoker whose quit status at four weeks from their quit date (or within 25 to 42 days of the quit date) has been assessed (either face to face, by telephone, text, email or postal questionnaire). The percentage of self-reported four-week quitters should be calculated as shown below:

> **Number of treated smokers who self-report continuous abstinence from smoking from day 14 post-quit date to the four-week follow-up point**
>
> ———————————————————————————————————
>
> **All treated smokers**

7

NCSCT   Provider self-completion questionnaire

Appendix B: The NCSCT Stop Smoking Service Client Record Form

NCSCT   Stop Smoking Service Client Record Form   `1`

Name of Stop Smoking Service	

Advisor name	
Advisor type PTP	☐ 1 Primarily SSP [1] ☐ 2 Primarily other duties [2]
NCSCT advisor no. NNO	
Service advisor no. SNO	

Service setting SET
☐ 1 Specialist clinic   ☐ 3 GP practice   ☐ 5 Prison
☐ 2 Pharmacy   ☐ 4 Hospital ward   ☐ 6 Other

Service type STP
☐ 1 Individual by appointment   ☐ 4 Open group (start at diff. times)   ☐ 7 Internet
☐ 2 Individual drop-in   ☐ 5 Telephone   ☐ 8 SMS
☐ 3 Closed group (all start together)   ☐ 6 Couple / family   ☐ 9 Other

Client family name	
Client given name	
Address	

Postcode	
NHS no.	
Tel	
Email	
Alternative tel	
Date of birth DOB	
Age AGE	
Gender	☐ 1 Male ☐ 2 Female
Pregnant PRE	☐ 1 No ☐ 2 Yes
Breastfeeding BRE	☐ 1 No ☐ 2 Yes
Exempt from prescription charge EXE	☐ 1 No ☐ 2 Yes

Occupation code OCC (see guide on page 4)
☐ 1 Full-time student
☐ 2 Never worked / long-term unemployed
☐ 3 Retired
☐ 4 Home carer
☐ 5 Sick / disabled and unable to work
☐ 6 Managerial / professional
☐ 7 Intermediate
☐ 8 Routine and manual
☐ 9 Prisoner
☐ 10 Unable to code

Ethnic group ETH

White
☐ 1 English / Welsh / Scottish / Northern Irish / British
☐ 2 Irish
☐ 3 Gypsy or Irish Traveller
☐ 4 Any other White background

Mixed / multiple ethnic groups
☐ 5 White and Black Caribbean
☐ 6 White and Black African
☐ 7 White and Asian
☐ 8 Any other Mixed background

Asian or Asian British
☐ 9 Indian
☐ 10 Pakistani
☐ 11 Bangladeshi
☐ 12 Chinese
☐ 13 Any other Asian background

Black / African / Caribbean / Black British
☐ 14 African
☐ 15 Caribbean
☐ 16 Any other Black / African / Caribbean background

Other ethnic groups
☐ 17 Arab
☐ 18 Any other ethnic group

Other
☐ 19 Not stated

8

NCSCT   Provider self-completion questionnaire

NCSCT   Stop Smoking Service Client Record Form   2

How client heard about the service HEA

- 1 GP
- 2 Friend / relative
- 3 Pharmacy
- 4 Other health professional
- 5 Advertising
- 6 Other

Agreed quit date QUI	
Date of last tobacco use DLT	
Date of 4-week follow up D4W	
Date of 12-week follow up D12W	

Type of pharmacological support chosen [3] MED1 MED2 MED3
(Please tick up to three boxes)

- 1 None
- 2 Zyban (bupropion)
- 3 NRT – Gum
- 4 NRT – Lozenge
- 5 NRT – Inhalator
- 6 NRT – Patch
- 7 NRT – Microtab
- 8 NRT – Nasal spray
- 9 NRT – Mouthspray
- 10 Champix (varenicline)
- 11 Electronic cigarette
- 12 Other

Time to first cigarette of the day FIR

- 0 over 60 min
- 1 31 to 60 min
- 2 6 to 30 min
- 3 within 5 min

Usual daily cigarette consumption CPD

Advisor signature

Client signature

(indicating consent to treatment, audit and follow-up (including by a third party) and communication of outcome data to a GP)

References

1. Primarily SSP = Stop Smoking Practitioner: employed solely or mainly for that role (also known as Stop Smoking Specialist)
2. Also known as Community Advisor or Level 2 advisor: where smoking cessation is one part of their job
3. Medications to be used concurrently at the start of treatment. This will be recorded as three different variables

9

NCSCT   Provider self-completion questionnaire

NCSCT   Stop Smoking Service Client Record Form   3

Further measures at first assessment visit

How much of the time is currently spent with urges to smoke? TUR
 1 None of the time   2 A little of the time   3 Some of the time   4 A lot of the time   5 Almost all of the time

How strong are the urges? SUR   1 No urges   2 Slight   3 Moderate   4 Strong   5 Extremely strong

Expired air CO (ppm) CO1

Weeks since most recent quit attempt TSQ

How long most recent quit attempt lasted QLA

Currently being treated for physical health problems CHP   1 No   2 Yes

Currently being treated for drug or alcohol problems CHD   1 No   2 Yes

Currently being treated for other mental health problems CHM   1 No   2 Yes

Commitment to succeeding at this attempt COM   1 Weak   2 Moderate   3 Strong   4 Very strong

Confidence in success at this attempt CON   1 Low   2 Moderate   3 High   4 Very high

Partner smoking status PAR   1 Does not smoke / not applicable   2 Smokes

Current cannabis use CAN   1 No   2 Yes

Alcohol consumption ALC   1 Up to 14 units per week   2 15 to 21 units per week   3 More than 21 units per week

Past experience of stop smoking medicines PAM
(Please tick all that apply)
 PAM1 NRT   PAM2 Zyban (bupropion)   PAM3 Champix (varenicline)   PAM4 Other

Outcome

4-week quit	Self-report of not a puff in past 2 weeks QU4	1 No	2 Yes	3 Not known
	CO reading CO4			
	CO-verified 4-week quitter QT4	1 No	2 Yes	

12-week quit	Self-report of not a puff in past 10 weeks QU12	1 No	2 Yes	3 Not known
	CO reading CO12			
	CO-verified 12-week quitter QT12	1 No	2 Yes	

Clinical notes (describe any concurrent medication, medication side effects, withdrawal symptoms, barriers to abstinence and other relevant information)

10

NCSCT   Provider self-completion questionnaire

NCSCT   Stop Smoking Service Client Record Form   4

How to code occupational group

Occupation Code	Note
Full-time student	
Home carer	Home carer – i.e. looking after children, family or home.
Retired	
Never worked / long-term unemployed	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.
Sick / disabled and unable to work	
Managerial / professional	Managerial and professional occupations 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, organizing, and co-ordinating work or finance; self-employed professionals (occupations listed as above) or self-employed and employing more than 25 people.
Intermediate	Intermediate occupations include: call centre agent, clerical worker, nursing auxiliary, nursery nurse, office clerk, secretary; non-professional self-employed individuals, or self-employed and employing less than 25 people.
Routine manual	Routine and manual occupations include: electrician, fitter, gardener, inspector, plumber, printer, train driver, tool maker, bar staff, caretaker, catering assistant, cleaner, farm worker, HGV driver, labourer, machine operative, mechanic, messenger, packer, porter, postal worker, receptionist, sales assistant, security guard, sewing machinist, van driver, waiter/waitress.
Prisoner	The 'prisoner' occupation category has been introduced for collections from 2009/10 onwards in an effort to reduce the number of clients recorded under 'unable to code'. With the exception of prison staff, clients treated in prisons should all be recorded as prisoners.
Unable to code	

Notes:

This form was designed by Robert West, Jennie Kenyon, Andy McEwen and Leonie Brose. It captures the data required for English Department of Health monitoring plus:

1. additional data needed to estimate the background quit rate in the absence of treatment; in other words the added value of treatment

2. essential data on the treatment provided

3. outcomes at 4 and 12 weeks

Each field includes a code which is the suggested variable name for an electronic database in which the data is recorded.
The values entered should be the numbers corresponding to the answers given.

NCSCT advisor number refers to the number given when registering with the NHS Centre for Smoking Cessation and Training (NCSCT): www.ncsct.co.uk.
This is unique to each advisor in the country. The service advisor number is the number the service provider uses to identify the advisor.

11

Appendix B:
Audit criteria

Provider self-completion questionnaire criteria

Section	Red	Amber	Green	Green +
A. Client base	N/A	N/A	N/A	N/A
B. Support provided				
B1 Support sessions				
1.1 (i – vi)	Less than 4	4 – 5	6	More than 6
1.2				
i)	Less than 15 minutes	15 – 29 minutes	30 minutes	30 – 60 minutes
ii)	Less than 45 minutes	45 – 59 minutes	60 minutes	60 – 90 minutes
iii)	Less than 45 minutes	45 – 59 minutes	60 minutes	60 – 90 minutes
iv)	Less than 10 minutes	10 – 19 minutes	20 minutes	30 minutes
v)	Less than 10 minutes	15 – 29 minutes	30 minutes	30 – 60 minutes
vi)	N/A (unless completed)	N/A (unless completed)	N/A (unless completed)	N/A (unless completed)
1.3				
i)	Less than 10 minutes	N/A	10 minutes	15 minutes
ii)	Less than 45 minutes	45 – 59 minutes	60 minutes	60 minutes
iii)	Less than 45 minutes	45 – 59 minutes	60 minutes	60 minutes
iv)	Less than 10 minutes	N/A	10 minutes	15 minutes
v)	Less than 10 minutes	N/A	10 minutes	15 minutes
vi)	N/A (unless completed)	N/A (unless completed)	N/A (unless completed)	N/A (unless completed)
1.4	Never	Sometimes	Always	Always
1.5	Never	Sometimes (not within 3 days either side of QD)	Within 3 days either side of QD	Y
1.6	N	N/A	Y	Y
1.7	N	N/A	Y	Y
B2 Behavioural support required				
2.1	N	N/A	Y	Y
2.2	N/A	N/A	N	Y
2.3	N	N/A	N	Y
2.4 (i – viii)			All Y	All Y
B3 Medication				
3.1				
i)	N	N/A	Y	Y
ii)	N	N/A	Y	Y
iii)	N	N/A	Y	Y
iv)	N/A	N/A	N/A	N/A
3.2	N/A	N	Y	Y

Section	Red	Amber	Green	Green +
C. Throughput and success rate				
1.1	N/A	N/A	N/A	N/A
1.2	Less than 70%	70 – 84%	85 – 90%	91 – 100%
1.3	Less than 35%	35 – 49%	50%	51 – 100%
1.4	More than 35%	24 – 35%	0 – 24%	0 – 15%
D. Infrastructure				
D1 Staffing				
1.1	N/A	N/A	N/A	N/A
1.2	Less than 75%	75 – 99%	100%	100%
1.3	N/A	N/A	N/A	N/A
1.4	N/A	N/A	N/A	N/A
D2 Training and personal development				
2.1	Less than a day (8 hours)	At least one day but less than 3 days (8 – 23 hours)	3 (24 hours) days	5 days or more (40+ hours)
2.2	N/A	N/A	N/A	N/A
2.3	N	N/A	Y	Y
D3 Resources				
3.1				
i)	N	N/A	Y	Y
ii)	N/A	N/A	N	Y
iii)	N	N/A	Y	Y
D4 Data collection and governance				
4.1	N	N/A	Y	Y
4.2	N/A	N/A	N/A	N/A
4.3	N	N/A	Y	Y
4.4	N/A	N/A	N/A	N/A
4.5				
i)	N/A	N/A	N	Y
ii)	N/A	N	Y	N/A
4.6	Less than mandatory (DH) data	N/A	At least (DH) data	N/A Equivalent to NCSCT monitoring

Patient data assessment criteria

Number of contacts verified	Rating
90 – 100%	Green / Green+
80 – 89%	Amber
Less than 80%	Red
Customer satisfaction	**Rating**
More than 90% very satisfied	Green +
More than 90% satisfied	Green
80 – 89% satisfied	Amber
Less than 80% satisfied	Red

Overall audit rating

Note: As stated, the original intention was for the audit result to follow a simple 'pass or fail' rating, however this was later revised as a result of testing the audit model and following provider feedback. Therefore the rules below have been developed to support a 'red /amber / green' (RAG) rating scale. As this is yet to be tested widely, it should be noted that this could require modification once more audits have been undertaken.

Rating	Requirements
Green+	In order to get an overall green+ rating the provider must as a minimum: ■ achieve a green rating in the client assessment and; ■ not receive more than 1 amber rating in the provider assessment and; ■ not receive any red ratings
Green	In order to get an overall green rating the provider must as a minimum: ■ achieve a green rating in the client assessment and; ■ not receive more than 3 amber ratings in the provider assessment and; ■ not receive any red ratings
Amber	In order to get an overall amber rating the provider must as a minimum: ■ achieve an amber rating in the client assessment and; ■ not receive more than 4 red ratings in the provider assessment
Red	In order to get an overall red rating the provider must as a minimum: ■ receive a red rating in the client assessment and /or ■ receive more than 4 red ratings in the provider assessment

Appendix C:
Telephone script

ACTION: Make call

Response options:

No answer	Schedule second/third attempt on different day and at different time of day. **[Each different time/date that attempts are made to contact the client should be recorded on our database]**
Answer phone	Do not leave a message. Schedule second/third attempt on different day and at a different time of day. **[Each different time/date that attempts are made to contact the client should be recorded on our database]**
Phone answered (not client)	*"Hello. I was wondering if I could speak with (NAME OF PERSON)."* If not the client and you are pressed for further details please state *"It's not important, but I will need to speak with them personally".* If named client is not in *"Are you able to advise as to when may be convenient for me to speak with NAME"* Thank the call recipient and end call.
Phone answered (client)	Proceed with script

SCRIPT: *"Hello. I am phoning on behalf of your stop smoking service […] It is possible that you may have seen a stop smoking advisor or attended one of the stop smoking services recently. If so, I just wanted to ask a few questions about the service you received from them, would that be OK? It would take just a couple of minutes and any information you provide will be treated as anonymous."*

Response options:

Not convenient to continue	Re-schedule call to suit client (agree a date and time for call back)
Call can continue	Proceed with audit

SCRIPT: *"As part of our routine process we normally record these calls. Are you happy for this call to be recorded?"*

Continue with call whatever the outcome but do not record call if client answers no.

1. *"Can I just check, around [quit date] did you see someone from the stop smoking service – it could have been a nurse, pharmacist or someone else – so that they could help you stop smoking? Or did you attend a stop smoking group perhaps?"*

    Response options: Yes   Go to question 4

                          No   Go to question 2

                          Cannot remember   Go to question 2

2. *"Around that time did you receive any advice from someone in the health service about your smoking, perhaps a pharmacist, doctor or nurse?"*

    Response options: Yes   Go to question 3

                          No   Go to call sign off

                          Cannot remember   Go to call sign off

3. *"Can you briefly describe what happened?"*

    Response options: Record client comments and then go to **CALL SIGN OFF**

    If you have got to this question, it means that the client did not receive the level of support reported so this client should not be verified.

4. *"Had you already stopped when you first saw the stop smoking advisor?"*

    Response options: Already stopped (for less than 48 hours)

                          Already stopped (more than 48 hours prior to first session)*

                          No

                          Cannot remember

    * If the client responds with this answer, please stop here and go to and use the additional questions on page 5

5. ***"How many times did you see them or attend a session?"***

    Response options: Once*

                                     Twice*

                                     Several times

                                     Cannot remember

    Additional Comments:

    * If client answers once or twice to this question, complete question 8.1 to allow for
      self-reported successes

6. ***"Did you set a quit date with the service?"***

    Response options: Yes

                                     No

                                     Cannot remember

    **[NOTE: If the term 'quit date' has to be explained to the client, for example *'did you
    set a date with your stop smoking adviser when you would quit smoking completely?'*
    please record the detail of this on the database]**

7. ***"Did you manage to stop smoking?"***

    Response options: Yes completely and I am still not smoking

                                     Yes for at least 4 weeks but I started smoking again after that

                                     Yes but I smoked at least a little bit within 4 weeks
                                     (if this response is chosen, go to 7a and 7b)

                                     No **(if no, ask if they are still smoking and if they are, ask if they
                                     would like to be referred back into the service – please record
                                     the outcome on the database and refer back into the service)**

                                     Cannot remember

7a. *"Can you remember whether you smoked at the beginning or the end of those 4 weeks?"*

  Response options: Beginning (1st 2 weeks)

          End (Last 2 weeks)

          Cannot remember

7b. *"Was your adviser aware that you had smoked?"*

  Response options: Yes

          No

          Cannot remember

---

8. *"Around 4 weeks after your quit date did you blow into a machine to measure the carbon monoxide in your breath?"*

  Response options: Yes

          No

          Cannot remember

  If 'no' above, answer 8.1:

  If yes:

8a. *"Do you remember if you passed or not?"*

  Response options: Yes I passed

          No I did not pass

          Cannot remember

8.1 **(if service database says outcome was self report, client reports 'no' to Q8, or if they answered 'once' to question 5):**

  "Around 4 weeks after your quit date did someone from the service make contact with you, perhaps by phone to ask whether you were smoking or not?"

  Response options: Yes

          No

          Cannot remember

9. *"Do you have any comments that might help us improve the service xx provide?"*

    Response options: Record client comments, referencing the question number

10. *"Would you recommend this service to someone who was trying to stop smoking?"*

    Response options: Yes

    No (if not, why not)

    Unsure

    Record any additional client comments, referencing the question number

11. *"Overall, how satisfied were you with the support you received?"*

    Response options: Very satisfied

    Satisfied

    Unsure

    Unsatisfied

    Very unsatisfied

    Record any additional client comments, referencing the question number

CALL SIGN OFF: *"That is very helpful. Thank you very much indeed for your time."*

Question 4

Additional questions to ask if the client answers that they had already stopped smoking more than 48 hours prior to their first session.

4.1 **How long before your first session did you stop smoking?**

4.2 **Are you still not smoking?**

4.3 **What support did you receive from the service?**

4.4 **Did you at any point blow into a machine to measure the carbon monoxide in your breath?**

4.5 **Would you recommend this service to someone who was trying to stop smoking?**

4.6 **Overall, how satisfied were you with the support you received?**

Appendix D:
Pilot provider audit reports

NCSCT

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NCSCT Provider Audit

XXXXXXXXXXXXXXXXXXX

September – November 2011

(**Note:** This is a pilot and as such not classed as an actual audit but an example of what such an audit might appear like. We are extremely grateful to XXXXX for inviting us to pilot the audit procedures with their service. The issues raised in this pilot audit will be discussed with XXXXX and kept confidential. The findings need to be discussed with the provider and the company will be able to be re-audited after necessary changes have been made).

NCSCT Provider Audit: September – November 2011

Contents

44

NCSCT Provider Audit: September – November 2011

1. Executive Summary

Overall rating: *Amber*

Rating summary:

Provider self-assessment	Area	Rating
	Support sessions	
	Behavioural support provided	
	Medication	
	Throughput and success rates	
	Training and development	
	Resources	
	Data collection and governance	
Patient data assessment	**Area**	**Rating**
	Verified contacts 80% (n=55)	
	Client satisfaction	

Accreditation awarded: **Not currently**

In order to achieve accreditation the provider needs to:

1. ensure more accurate monitoring and recording of CO-validated four-week quit rates

2. achieve an 85% CO-validation rate

3

2. Introduction

Demonstration of quality is growing ever more important, especially in the current changing landscape, where there is an increasing need to show value for money and quality of service. Monitoring of service provider delivery and performance is therefore essential to understand how services are working, to identify and reward good practice and to suggest where improvements can be made.

The NCSCT has developed and is piloting a system of national accreditation. XXXXX approached the NCSCT volunteering for the initial pilot. The pilot period ran from 8 September to 10 November 2011.

3. Background

The aim of the NCSCT Provider Audit is to independently establish whether service providers meet minimum standards of care and data integrity. The audit model includes a patient data assessment and a provider data assessment:

Provider data assessment: The provider data assessment consists of a self-assessment questionnaire that focuses on the core elements of service provision. This is completed by a representative of the service provider and signed off at service manager level.

Patient data assessment: The independent patient data audit verifies a random selection of claimed four-week CO-validated and self-reported quitters via a client telephone interview carried out by the NCSCT.

The audit aims to provide:

- stop smoking service (SSS) providers with an assurance of quality

- SSS providers with an indication of how they may improve their provision

- SSS commissioners with a quality benchmark to use when commissioning SSS providers

- assurances that claimed success rates are accurate and;

- a measure of customer satisfaction.

If the service fulfils the required criteria in both the provider and patient data assessments, NCSCT accreditation is awarded.

4

4. Provider Data Assessment

4.1 Method

The questionnaire was designed to assess all areas of service provision including:

- the nature of the client base
- the support provided
- claimed throughput and success rates and;
- the infrastructure.

4.2 Results

- All but one of the responses measured against the criteria exceeded the minimum level required (see table 1).

- The response provided to one of the questions indicated that one of the NCSCT standards of care was not achieved to the necessary levels to gain accreditation:

    – within the throughput and success rate section (Section C), the number stated as CO-validated four-week quitters was 516, which equates to a CO-validation rate of 83%. Based on the DH's *Stop smoking service delivery and monitoring guidance 2011/12* and the NCSCT criteria developed for this section of the audit, the percentage required for this question is 85%. This is also a requirement set out in the XXXXX treatment plan.

(XXXXX reported that they would have preferred to have an electronic questionnaire made available for ease of completion. This will be considered as the audit model and process are developed post pilot phase.)

Table 1: Summary table of provider assessment outcomes against the criteria

Section	Outcome against criteria
A. Client base	N/A
B. Support provided	All responses exceed the minimum level required.
C. Throughput and success rates	All responses exceed the minimum level required apart from question C 1.2.
D. Infrastructure	All responses met the minimum level required.

5

5. Patient Data Assessment

5.1 Method

The NCSCT randomly contacted reported quitters who had used the provider during the previous quarter. Where more than 10% of the original sample were not verified a further sample was randomly selected.

The total number of clients recorded by XXXXX to have accessed the service in Quarter 1 of 2011/12 (April – June 2011) for this period was 148.

5.1.1 Verified contact

A contact is regarded as verified if the client confirmed:

- they recalled visiting the service

- they were smoking when they first saw a stop smoking advisor (or if they had already stopped, it was in the 48 hours prior to them accessing the service)

- they set a quit date with the service

- they were completely abstinent between days 15 and 28 of their quit attempt (as a minimum) and;

- they passed CO-validation (CO reading of <10ppm) if they were claimed as CO-validated.

5.1.2 Non–verified contact

A contact is regarded as not verified if the client:

- could not recall accessing the service

- had already stopped smoking when they accessed the service (for longer than 48 hours)

- had only visited the service once and had not received any follow-up from the service

- had smoked in days 15 to 28 of their quit attempt, before the provider's four-week follow-up.

Clients who are recorded as CO-validated quitters but cannot recall having their CO measured (n=8) are not classed as non-verified but the frequency of this is reported separately in the results.

NCSCT Provider Audit: September – November 2011

5.1.3 Excluded clients

Clients were excluded from the audit if:

- no response gained after three attempts (made on varying days and times including evenings and weekends)

- the client did not want to respond to the questions

- no contact number was provided

- the contact number provided was unobtainable or incorrect and;

- client responses could not be matched against the audit criteria.

5.1.4 Client re-referral

Clients who were identified as having relapsed were asked if they would like to be referred back into the service.

5.2 Results

Of the initial sample taken, 18% (n=9) were not verified and an additional sample was taken from the database. In this case, due to the high number of exclusions, attempts were made to contact all 148 clients on the database.

Of the total sample:

- 37.2% (n=55) were contacted and verified (79.7% of the total number contacted)

- 9.4% (n=14) were contacted and not verified (20.3% of the total number contacted)

- 53.4% (n=79) were excluded

5.2.1 Reasons for non-verification

Of the 14 not verified, nine had stopped smoking before attending the service, one visited the service once and did not quit, and four had smoked between days 15 and 28 of their quit attempt.

7

5.2.2 Reasons for exclusion

Table 2 shows the reasons for exclusion.

Table 2: Reasons for exclusion

Reason	Percentage
No response after three attempts	40.5% (n = 32)
Client did not want to talk	5.1% (n = 4)
No contact number was provided	6.3% (n = 5)
Contact number provided unobtainable	21.5% (n = 17)
Contact number was incorrect	3.8% (n = 3)
Other (including responses too vague)	22.8% (n = 18)

5.2.3 Understanding of key terminology

It was found that some clients appeared to have had a lack of understanding around key terms such as 'quit date'. Five clients when asked whether they set a quit date, said they did not. In line with the audit criteria this would have meant they were not verified, however the clients proceeded to suggest through their answers to further questions that they had quit smoking for a significant period after visiting the service and received support from them. This indicates that those particular clients had quit with the service, and therefore were classed as verified treated smokers. It is acknowledged that, recording them as audit passes was giving the client and the service the benefit of the doubt and the fact that the clients did not recognise the term 'quit date' indicates that there may need to be more explicit messaging provided around this and other key terms by the service.

There is however clear guidance provided in the XXXXX treatment plan around explaining and setting quit dates, so this lack of understanding could also be down to limited client recall.

5.2.4 Language barriers

Initial findings also showed that there were some difficulties caused by language barriers, leading to a small number of the client interviews having to be done through an interpreter. The results of this meant that in some cases the interview could not be completed in full. However enough information was obtained in each case to make an informed decision as to the outcome (all were verified as treated smokers).

50

NCSCT Provider Audit: September – November 2011

5.2.5 Method of client follow-up

In total there were three cases where clients reported having only attended the service once and, due to an omission in the interview script, were not asked if they had been followed up by the service by an alternative method such as telephone or letter. As a result these clients were excluded.

It is worth noting however that these three clients were recorded as CO-validated quitters which would appear to be incorrect. A further five cases were also recorded as CO-validated, who reported during the client interviews that they had not undertaken a CO test.

5.2.6 Referrals

In total 18 people asked to be referred back to the service during the telephone interview which is a very positive result. Sixteen of those who asked to be referred back had stopped smoking with the service for the required four weeks but had since relapsed.

5.2.7 Client satisfaction

Client satisfaction was high – 86.9% (n=53) of those asked whether they were happy with the service they received said they were very satisfied (see Table 3) and 93.4% (n=57) who were asked said they would recommend the service to a smoker (see Table 4).

Some examples of client comments received:

Text very useful, very good service

I received exactly what I needed when I needed it. The service was excellent. I couldn t have done it without them

Very pleased with service, all family has stopped through service so very pleased!

Better access for disabled in bus

9

NCSCT Provider Audit: September – November 2011

Table 3: How satisfied were you with the service?

Very satisfied	86.9% (n = 53)
Satisfied	8.2% (n = 5)
Unsure	3.3% (n = 2)
Unsatisfied	1.6% (n = 1)

This indicates that a personable, friendly and effective service is being offered, which the clients praised highly.

Table 4: Would you recommend the service to another smoker?

Yes	93.4% (n = 57)
No	1.6% (n = 1)
Unsure	4.9% (n = 3)

NCSCT Provider Audit: September – November 2011

6. Conclusion

The service performed strongly in many areas of the pilot audit. However, if this was an actual audit NCSCT accreditation would not be awarded because:

- Patient data assessment - the number of clients not verified was larger than the 10% margin (20.3%). However, it should be noted that there were many clients who were verified and the majority asked were very satisfied with the service provided.

- Provider data assessment – currently the annual CO-validation rate falls just short of the 85% requirement. However it is acknowledged that the current rate of 83% is high in comparison to the national average (69%).

7. Recommendations

Based upon the findings of the audit the following recommendations are given to assist in fulfilling the audit criteria and achieving accreditation.

1. It is important that there is a clear understanding of who can and who cannot be classed as a treated smoker to ensure accurate data is being submitted. The key definitions are outlined within the DH's *Stop smoking service delivery and monitoring guidance 2011/12* [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125389] and should be made available to all staff to support accurate reporting.

2. The notion of setting a quit date needs to be clearly introduced to clients by stop smoking practitioners during their initial session.

3. Ensure the clients who do not attend their four week follow-up appointment are routinely followed up via another method, such as the telephone, to ensure that their smoking status is recorded accurately.

4. Ensure that all clients who are biochemically validated as quitters are recorded as CO-validated. Those who are not CO-validated such as those followed-up over the phone should only be recorded as self-reported quitters.

5. Ensure that client telephone numbers, which can be used for follow-up, are recorded correctly.

6. Ensure all clients are asked to provide consent to independent third party follow-up.

NCSCT

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NCSCT Provider Audit

XXXXXXXXXXXXXXXXXX

March – April 2012

(**Note:** This is a pilot and as such not classed as an actual audit but an example of what such an audit might appear like. We are extremely grateful to XXXXX for inviting us to pilot the audit model with them. The issues raised in this pilot audit will be kept confidential).

Contents

NCSCT Provider Audit: March – April 2012

1. Executive Summary

Overall rating: Amber

Rating summary:

Provider self-assessment	Area	Rating
	Support sessions	
	Behavioural support provided	
	Medication	
	Throughput and success rates	
	Training and development	
	Resources	
	Data collection and governance	
Patient data assessment	**Area**	**Rating**
	Verified contacts 80% (n=55)	
	Client satisfaction	

Accreditation awarded: Not currently

In order to achieve accreditation the provider needs to:

1. Ensure clients are told about the pharmacotherapy that provides the best success rates (either Champix or combination NRT)

2. Achieve a lower lost to follow-up rate (24% or less) and;

3. Ensure that staff are given at least the equivalent of three days training before they begin working as a stop smoking practitioner.

3

2. Introduction

Demonstration of quality is growing ever more important, especially in the current changing landscape, where there is an increasing need to show value for money and quality of service. Monitoring of service provider delivery and performance is therefore essential to understand how services are working, to identify and reward good practice and to suggest where improvements can be made.

The NCSCT has developed and is piloting a system of national accreditation. XXXXX provided an expression of interest in piloting the model. The pilot period ran from 5 March 2012 to 2 April 2012.

3. Background

The aim of the NCSCT Provider Audit is to independently establish whether service providers meet minimum standards of care and data integrity. The audit model includes a patient data assessment and a provider self-assessment:

Provider self-assessment: The provider self-assessment consists of a self-assessment questionnaire that focuses on the core elements of service provision. This is completed by a representative of the service provider and signed off at service manager level.

Patient data assessment: The independent patient data assessment verifies a random selection of claimed four week CO-validated and self-reported quitters via a client telephone interview carried out by the NCSCT.

The audit aims to provide:

■ stop smoking service (SSS) providers with an assurance of quality

■ SSS providers with an indication of how they may improve their provision

■ SSS commissioners with a quality benchmark to use when commissioning SSS providers

■ assurances that claimed success rates are accurate and;

■ a measure of customer satisfaction.

If the service fulfils the required criteria in both the provider and patient data assessments, NCSCT accreditation is awarded.

4

4. Provider Self-Assessment

4.1 Method

The questionnaire has been designed to assess all areas of service provision including:

- the nature of the client base
- the support provided
- claimed throughput and success rates and;
- the infrastructure.

4.2 Results

Table 1: Summary table of provider assessment outcomes against the criteria

Section	Outcome against criteria
A. Client base	N/A
B. Support provided	All responses exceeded the minimum level required apart from B3 3.2
C. Throughput and success rates	All responses met the minimum level required apart from 1.4
D. Infrastructure	All responses exceeded the minimum required apart from D2 2.1

5

B1 – Support sessions

It was highlighted in the completed self-assessment questionnaire that it is not essential for practitioners to arrange an appointment with clients on their quit date. Based on the original criteria used to assess this element of the audit, this would not have met the required standard. However, this has now been revised, as although evidence shows that setting an appointment on a client's quit date is best evidence-based practice, we acknowledge that this is may not always be practical. We would suggest however that an appointment is scheduled as near as possible to the quit date (if not possible on the actual quit date) and have revised this element of the assessment to allow a period of three days either side for the quit date session.

B3 – Medication

Question B3 3.2 was left unanswered on the self-assessment questionnaire. This may have been an accidental omission whilst it was being completed as there is detailed information and guidelines within the XXXXX Nicotine Replacement Therapy (NRT) clinical protocol regarding the medication available. However if clients are not explicitly provided with information about the medications associated with the best success rates, it would be advisable to do so.

C – Throughput and success rates

The lost to follow-up figure stated on the completed self-assessment questionnaire was 1,538, which equates to 34%. This is above the required figure set out in the criteria for this question (a maximum of 24%, which is based on the national average).

D2 – Training and Personal Development

In the completed self-assessment questionnaire it was reported that practitioners need a minimum of two days training with the trust before they can begin working as stop smoking practitioners. Thorough training guidelines are provided within the XXXXX clinical protocol, including competences and performance requirements. It would however be advised that practitioners should undertake the equivalent of three days training prior to beginning to work as a stop smoking practitioner to ensure they have the skills and understanding needed to support smokers looking to quit.

This, for example, could be achieved if advisers were expected to complete the NCSCT training programme including both the Stage 1 and Stage 2 assessments, equating to approximately 10 hours, complemented by the current local training programme.

6

NCSCT Provider Audit: March – April 2012

5. Patient Data Assessment

5.1 Method

The NCSCT randomly contacted reported quitters that had used the provider during the previous quarter (Q3 2011/12). Where more than 10% of the original sample (n=50) were not verified a further sample was randomly selected.

5.1.1 Verified contact

A contact is regarded as verified if the client confirmed:

- they recalled visiting the service

- they were smoking when they first saw a stop smoking advisor (or if they had already stopped, it was in the 48 hours prior to them accessing the service)

- they set a quit date with the service

- they were completely abstinent between days 15 and 28 of their quit attempt (as a minimum) and;

- they passed CO-validation (CO reading of <10ppm) if they were claimed as CO-validated.

5.1.2 Non–verified contact

A contact is regarded as not verified if the client:

- could not recall accessing the service

- had already stopped smoking when they accessed the service (for longer than 48 hours)

- had only visited the service once and had not received any follow up from the service and;

- had smoked in days 15 to 28 of their quit attempt, before the provider's four-week follow-up.

5.1.3 Excluded clients

Clients were excluded from the audit if:

- there was no response after three attempts (made on varying days and times including evenings and weekends)

- the client did not want to respond to the questions

- no contact number was provided

- the contact number provided was unobtainable or incorrect and;

- client responses could not be matched against the audit criteria.

5.1.4 Client re-referral

Clients who were identified as having relapsed were asked if they would like to be referred back into the service.

7

5.2 Results

Of the initial sample taken, 16% (n=8) were not verified and so an additional sample was taken from the database. Of the total sample:

- 48% (n=86) were contacted and verified (86% of the total number contacted)

- 7.8% (n=14) were contacted and not verified (14% of the total number contacted)

- 44.1% (n=79) were excluded

5.2.1 Reasons for non-verification

Of the 14 not verified, three had already stopped smoking prior to seeing an advisor and eleven did not quit for the required four week period.

5.2.2 Definition of a treated smoker

Of those who could not be verified, 78.6% (n=11) were not because they had not quit for more than a few days, as opposed to the minimum requirement for them to have quit for four weeks, remaining continuously abstinent between at least days 15 and 28 of their quit attempt. Accurate recording of clients' quit attempts is crucial in order for valid data to be submitted and all staff should be fully aware of who should and who should not be classed, and therefore reported as, a treated smoker.

5.2.3 Reasons for exclusion

Table 2: Reasons for exclusion

Reason	Percentage
No response after three attempts	44.3% (n=35)
Contact number provided unobtainable or incorrect	34.2% (n=27)
Other (including communication problems)	21.5% (n=17)

NCSCT Provider Audit: March – April 2012

5.2.4 Understanding key terminology

Whilst undertaking the calls it was identified that some clients did not fully understand what the term 'quit date' meant. Eight clients, when asked whether they had set a quit date, responded 'no'. When more information was provided by the client about their experience however, all but one described themselves as going on to make a successful quit attempt. Those particular clients were therefore deemed to have quit with the service and were verified, although this may suggest that more explicit messaging may need to be provided by advisers to clients to encourage better understanding.

It should also be noted however that there is a reference to setting a quit date on the client consent form outlined in XXXXX clinical protocol, which indicates that the lack of understanding could be due to limited client recall.

5.2.5 Current smoking rates

Of those who were verified during the pilot audit and asked about their current smoking status (n=85), 68.2% (n=58) reported that they had quit and were still not smoking, 25.9% (n=22) said they had quit for the required four weeks but had since gone back to smoking and 5.9% (n=5) said they had stopped but had smoked a small amount within the four weeks.

5.2.6 Referrals

Clients who stated that they had relapsed were asked whether they would like to be referred back to the service; ten people agreed to have their details passed back to the core service.

5.2.7 Client satisfaction

Client satisfaction was very high: 93.5% (n=87) of those asked if they were satisfied with the service they received said they were 'very satisfied' (see Table 4), and all those who were asked (100%, n=93) if they would recommend the service they received their support from said that they would.

Table 4: How satisfied were you with the service?

Very satisfied	93.5% (n=87)
Satisfied	4.3% (n=4)
Unsure	1.1% (n=1)
Unsatisfied	1.1% (n=1)

Examples of client comments received:

fantastic service, couldn t be improved

it was brilliant

everyone was very helpful

9

6. Conclusion

XXXXX performed strongly in many areas of the pilot audit. However, if this was an actual audit NCSCT accreditation would not have been awarded because:

■ Patient data assessment: the number of clients not verified was larger than the 10% margin (14%, n=14). However, it should be noted that there were many clients who were verified and the majority of clients reported as being very satisfied with the service they received.

■ Provider self-assessment:

  – Clients should be told about which pharmacotherapy offer them the best success rates (either Champix or combination NRT).

  – The lost to follow-up rate is higher than the maximum figure of 24%.

  – A minimum of three days staff training is required to begin working as a stop smoking practitioner, rather than the two days indicated on the completed self-assessment questionnaire.

NCSCT Provider Audit: March – April 2012

7. Recommendations

Based upon the findings of the pilot audit the following recommendations are given to assist in fulfilling the audit criteria and achieving accreditation.

1. It is important that there is a clear understanding of who can and who cannot be classed as a treated smoker to ensure accurate data is being submitted. They key definitions are outlined with the DH's *Stop smoking delivery and monitoring guidance 2011/12* [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_125389] and should be made available to all staff to support accurate reporting.

2. Ensure that client telephone numbers, which can be used for follow-up, are recorded correctly and that clients are followed-up wherever possible; this will help reduce lost to follow up rates.

3. Schedule a client appointment as close to their agreed quit date as possible (a maximum of three days before or after their quit date).

4. Ensure that all staff are provided with a minimum of three days training before they are able to commence working as a stop smoking practitioner.

5. The notion of setting a quit date needs to be clearly introduced to the clients by stop smoking practitioners during their initial meeting.

6. Ensure that there is regular internal auditing to check that smokers are setting a quit date with the service, and that the treatment outcome fulfilled the criteria for four and twelve week success.

7. To ensure transparency, it may be helpful to produce a short treatment protocol to be referred to by practitioners, which clearly sets out the key steps and components involved in successful face-to-face smoking cessation interventions. An example of this is the NCSCT's *Standard Treatment Programme* [www.ncsct.co.uk/Content/FileManager/documents/training/ncsct-standard-treatment-programme.pdf]

8. Ensure all clients are asked to provide consent to independent third party follow-up.

11