



The Minimum Dataset for Scottish Smoking Cessation Services

Guidelines for Using the MDS

May 2009

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Notes on the 2009 Guidelines Update

This document is intended to support Scottish NHS Board (Health Board) Smoking Cessation Services in understanding and utilising the revised national Minimum Dataset (*MDS*) following changes made during the review process carried out by the Expert Review Group, and to be implemented for all quit dates set for **January 1st 2009** and thereafter.

What the Minimum Dataset is for

The Minimum Dataset is for recording the core data required for anonymous national reporting of **clients who access Scottish NHS Board specialist smoking cessation services, take part in a smoking cessation intervention, and who set a quit date with the service during the course of the intervention.** It is acknowledged that this covers only one part of services' work, and services frequently act in other ways to support smokers who may fall outside the criteria for inclusion into the MDS. For a more detailed discussion around the background and rationale behind the MDS, please see the supporting documentation available on the MDS section of the ASH Scotland Website: (<http://www.ashscotland.org.uk/ash/4241.html>).

The Minimum Dataset Review, and the Expert Review Group

The Expert Review Group's aim is to monitor, analyse, and suggest directions for development for the dataset that aim to balance the Scottish Government's requirements for statistically robust national level data with the need to integrate with diverse local cessation service delivery as much as possible. The purpose for the group is to help ensure that the MDS:

- *reflects service developments across Scotland;*
- *has a strong basis of monitoring and evaluation at both a local and national level;*
- *shows meaningful comparisons between NHS Boards across Scotland;*
- *supports local service delivery;*
- *documentation reflects any changes made and enhances understanding of the rationale behind the dataset.*

This document and the revised version of the MDS contained within reflects the work of the multi-disciplinary Expert Review Group, and the input of many smoking cessation professionals who have contributed in the consultation over the revisions.

The Expert Review Group's recommendations are detailed in their Report (which will be available on the MDS section of the ASH Scotland Website above), with further information and rationale behind the changes to be found there. Particular queries regarding the MDS should be directed to PATH's Research and Evaluation officer at the contact details overleaf.

The Revised Minimum Dataset

The amendments to the MDS reflect the conclusions of the Expert Review Group, and the contribution of many services and individuals who attended or responded to consultations over the MDS. The Expert Review Group takes this opportunity to thank once again all those who contributed.

The discussions on the revisions were challenging, as the diverse development and needs of services are difficult to incorporate in one standardised national dataset; however, the Expert

Review Group feels that consensus has been achieved, and the input of services has been invaluable in informing this process.

The MDS will always be a compromise between the national demands for a robust standardised system of monitoring, and local needs to gather data which reflects the delivery using terms and criteria that 'make good sense' to services.

As with most compromises, the balance achieved is not a perfect one, but it is hoped that the revision of the dataset takes it a further step towards being useful as both a local and national tool.

The Revised Guidelines

Those familiar with previous versions of the MDS guidelines will note that the revised version of this document is missing some sections found in its predecessors. Sections in previous versions dealing with the background of the dataset's development, and describing 'why a minimum dataset is needed' have been removed from their place here, and are being compiled into a summary document entitled **Minimum Dataset: Background and Rationale**, which will be available on the MDS section of the ASH Scotland website when complete.

The reasoning behind this editing is the feeling that these Guidelines should deal with operational issues in the use of the dataset, explanations of the items included, and criteria used. Whilst it is useful to know the background behind the MDS's development, this does not impact directly on one's ability to use it, or to use the accompanying national smoking cessation database provided and supported by ISD Scotland - the reasons most will be referring to this document.

Further grounds to pare down this document to essential information regarding the use of the 31 MDS items is that, having been running for nearly 3 years at time of writing, most services are familiar with the MDS and electronic national smoking cessation database. When previous versions of this guidance document were originally released, services were less familiar with the principles behind the MDS, and hence more information on its background was justified.

If you have any queries regarding the 31 MDS items that are not answered by this document, or any of the linked references provided, please get in touch with the PATH Research and Evaluation Officer at the details below.

PATH Research and Evaluation Officer

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mds on the web. <http://www.ashscotland.org.uk/ash/4241.html>

The Minimum Dataset for Scottish Smoking Cessation Services January 2009

For Office Use Only						
1. Client ID:						
2. Health Board area:		3. Clinic area/type:				
Client Information						
4. Date of birth: __/__/__	5. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	6. If female, pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown				
<p>7. What is the client's ethnic group? (Choose one section from A to E, then tick one box which best describes the client's ethnic group or background):</p> <table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top; width: 25%;"> <p><i>A. White</i></p> <input type="checkbox"/> Scottish <input type="checkbox"/> English <input type="checkbox"/> Welsh <input type="checkbox"/> Northern Irish <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Gypsy/Traveller <input type="checkbox"/> Polish <input type="checkbox"/> Any other white ethnic group, please specify _____ </td> <td style="vertical-align: top; width: 25%;"> <p><i>B. Mixed or multiple ethnic groups</i></p> <input type="checkbox"/> Any mixed or multiple ethnic groups, please specify _____ </td> <td style="vertical-align: top; width: 25%;"> <p><i>C. Asian, Asian Scottish or Asian British</i></p> <input type="checkbox"/> Pakistani, Pakistani Scottish or Pakistani British <input type="checkbox"/> Indian, Indian Scottish or Indian British <input type="checkbox"/> Bangladeshi, Bangladeshi Scottish or Bangladeshi British <input type="checkbox"/> Chinese, Chinese Scottish or Chinese British <input type="checkbox"/> Other, please specify _____ </td> <td style="vertical-align: top; width: 25%;"> <p><i>D. African, Caribbean or Black</i></p> <input type="checkbox"/> African, African Scottish or African British <input type="checkbox"/> Caribbean, Caribbean Scottish or Caribbean British <input type="checkbox"/> Black, Black Scottish or Black British <input type="checkbox"/> Other, please specify _____ </td> </tr> </table> <p><i>E. Other ethnic group</i></p> <input type="checkbox"/> Arab <input type="checkbox"/> Other, please specify _____			<p><i>A. White</i></p> <input type="checkbox"/> Scottish <input type="checkbox"/> English <input type="checkbox"/> Welsh <input type="checkbox"/> Northern Irish <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Gypsy/Traveller <input type="checkbox"/> Polish <input type="checkbox"/> Any other white ethnic group, please specify _____	<p><i>B. Mixed or multiple ethnic groups</i></p> <input type="checkbox"/> Any mixed or multiple ethnic groups, please specify _____	<p><i>C. Asian, Asian Scottish or Asian British</i></p> <input type="checkbox"/> Pakistani, Pakistani Scottish or Pakistani British <input type="checkbox"/> Indian, Indian Scottish or Indian British <input type="checkbox"/> Bangladeshi, Bangladeshi Scottish or Bangladeshi British <input type="checkbox"/> Chinese, Chinese Scottish or Chinese British <input type="checkbox"/> Other, please specify _____	<p><i>D. African, Caribbean or Black</i></p> <input type="checkbox"/> African, African Scottish or African British <input type="checkbox"/> Caribbean, Caribbean Scottish or Caribbean British <input type="checkbox"/> Black, Black Scottish or Black British <input type="checkbox"/> Other, please specify _____
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<input type="checkbox"/> Not Disclosed						
8. Does the client receive free prescriptions?						
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown						
9. Employment status (please tick one box)						
<input type="checkbox"/> In paid employment <input type="checkbox"/> Full-time student <input type="checkbox"/> Homemaker/full-time parent or carer <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Permanently sick or disabled <input type="checkbox"/> Not known/missing <input type="checkbox"/> Other (please specify) _____						
10. Full postcode:						

Tobacco Use and Quit Attempts					
<p>11. On average, how many cigarettes does the client usually smoke per day?</p> <p><input type="checkbox"/> 10 or less <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-30 <input type="checkbox"/> More than 30 <input type="checkbox"/> Unknown</p>	<p>12. How soon after waking does the client usually smoke their first cigarette?</p> <p><input type="checkbox"/> Within 5 minutes <input type="checkbox"/> 6-30 minutes <input type="checkbox"/> 31-60 minutes <input type="checkbox"/> After 60 minutes <input type="checkbox"/> Unknown</p>	<p>13. How many times has the client tried to quit smoking in the past year?</p> <p><input type="checkbox"/> No quit attempts <input type="checkbox"/> Once <input type="checkbox"/> 2 or 3 times <input type="checkbox"/> 4 or more times <input type="checkbox"/> Unknown</p>			
Intervention Details					
<p>14. Date referred to service: __/__/__</p>	<p>15. Quit date: __/__/__</p>	<p>16. Date of initial appointment: __/__/__</p>			
<p>17. Does the client consent to follow-up?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p>18. Pharmaceutical usage</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> NRT only (single product) <input type="checkbox"/> Varenicline only <input type="checkbox"/> NRT and Varenicline (change in product) <input type="checkbox"/> None <input type="checkbox"/> Unknown </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> NRT only (more than one product) <input type="checkbox"/> Bupropion only <input type="checkbox"/> NRT and Bupropion (change in product) </td> </tr> </table> <p>Total number of weeks used _____</p>			<input type="checkbox"/> NRT only (single product) <input type="checkbox"/> Varenicline only <input type="checkbox"/> NRT and Varenicline (change in product) <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> NRT only (more than one product) <input type="checkbox"/> Bupropion only <input type="checkbox"/> NRT and Bupropion (change in product)	
<input type="checkbox"/> NRT only (single product) <input type="checkbox"/> Varenicline only <input type="checkbox"/> NRT and Varenicline (change in product) <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> NRT only (more than one product) <input type="checkbox"/> Bupropion only <input type="checkbox"/> NRT and Bupropion (change in product)				
<p>19. Intervention(s) used in this quit attempt</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> One to one sessions <input type="checkbox"/> Telephone support <input type="checkbox"/> Couple/family based support <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> Unknown </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Group support (closed groups) <input type="checkbox"/> Group support (open/rolling groups) </td> </tr> </table>			<input type="checkbox"/> One to one sessions <input type="checkbox"/> Telephone support <input type="checkbox"/> Couple/family based support <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Group support (closed groups) <input type="checkbox"/> Group support (open/rolling groups)	
<input type="checkbox"/> One to one sessions <input type="checkbox"/> Telephone support <input type="checkbox"/> Couple/family based support <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Group support (closed groups) <input type="checkbox"/> Group support (open/rolling groups)				
<p>20. Intervention setting(s)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Primary Care <input type="checkbox"/> Pharmacy <input type="checkbox"/> Educational establishment <input type="checkbox"/> Other (please specify) _____ </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Hospital - Inpatient <input type="checkbox"/> Prison <input type="checkbox"/> Non-NHS community venue </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Hospital - Outpatient <input type="checkbox"/> Workplace <input type="checkbox"/> Home </td> </tr> </table>			<input type="checkbox"/> Primary Care <input type="checkbox"/> Pharmacy <input type="checkbox"/> Educational establishment <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Hospital - Inpatient <input type="checkbox"/> Prison <input type="checkbox"/> Non-NHS community venue	<input type="checkbox"/> Hospital - Outpatient <input type="checkbox"/> Workplace <input type="checkbox"/> Home
<input type="checkbox"/> Primary Care <input type="checkbox"/> Pharmacy <input type="checkbox"/> Educational establishment <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Hospital - Inpatient <input type="checkbox"/> Prison <input type="checkbox"/> Non-NHS community venue	<input type="checkbox"/> Hospital - Outpatient <input type="checkbox"/> Workplace <input type="checkbox"/> Home			
1-Month Follow-Up					
<p>21. Was the client successfully contacted for 1-month follow-up?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (Client lost to follow up) <input type="checkbox"/> No (Client did not consent to follow up) <input type="checkbox"/> No (Client died) <input type="checkbox"/> Unknown</p>					

Guidelines for Using the Minimum Dataset - Overview

The Minimum Dataset (*MDS*) consists of the core information that is to be collected for each client *who sets a quit date with a specialist smoking cessation service*¹, for the purposes of local and national monitoring and evaluation of smoking cessation services. It is important that all smoking cessation services use standard definitions of key terms and procedures to ensure consistency and validity of data collected.

Full, accurate, and timely completion of the minimum dataset is crucial. Those involved in the monitoring and evaluation of services should read and understand the following guidance before using the minimum dataset.

Data Collection Forms

Smoking Cessation Services in Scotland have developed in divergent ways to best meet the needs of their local population. This divergence manifests itself in the ways services collect MDS information in various ways and at various stages of contact.

Services should ensure that their own local data collection forms are amended to include **all** of the information outlined in this document. The MDS, as given in this document, is designed as an at-a-glance reference to show the essential questions and responses for the MDS. It is not intended to be used by services in its present form, although it may certainly be used as a template if services wish. Services should adapt their local data collection procedures in order to collect the minimum dataset and any additional information in the most appropriate way for them.

Of course, services can (as many do) collect additional information above and beyond that included in the MDS.

Data Protection and Confidentiality

It is vital that all data is gathered and used in accordance with data protection and patient confidentiality guidelines. Clients should be given clear information on why information is being collected and what it may be used for. They should be informed that anonymised data will be used for monitoring purposes and asked for their consent to be contacted at a later date in connection with their smoking (i.e. at the 1-, 3- and 12-month follow-ups). Should a client refuse follow-up at any stage, records should be clearly noted to this effect. Clients have the right to refuse and this should not affect their right to receive treatment. If you intend to share client data with anyone, then the client's permission should be obtained beforehand. Data should only be used for the purposes for which permission was given.

For more information on issues surrounding data protection and client confidentiality refer to PATH's guidance on *Using Client Data: Data Protection, Client Confidentiality and Access to Information*, available online at:

<http://www.ashscotland.org.uk/ash/4241.html>

¹ The definition of a specialist service is available to download from <http://www.ashscotland.org.uk/ash/4240.6.662.html>

Guidance for Items 1-3: Client/Clinic Identity

1. Client ID

A system for allocating clients with unique identifying codes is required as a way of linking anonymised data and to enable resolution of any queries arising after submission of anonymised data. Services should devise their own system for allocating local identifying codes, avoiding duplication and ensuring consistency locally.

Please note that the national smoking cessation database also automatically generates a unique system ID/record number for each quit attempt record entered.

2. Health Board area

This question is asked so that service uptake across Scotland can be monitored at regional level. There are 14 possible options for Health Board area, the web links below lead to the region's section on the NHS Scotland website:

- [Ayrshire & Arran](#)
- [Borders](#)
- [Dumfries & Galloway](#)
- [Fife](#)
- [Forth Valley](#)
- [Grampian](#)
- [Greater Glasgow & Clyde](#)
- [Highland](#)
- [Lothian](#)
- [Lanarkshire](#)
- [Orkney](#)
- [Shetland](#)
- [Tayside](#)
- [Western Isles](#)

Please note that the information regarding a service's NHS Board area is automatically generated by ISD's electronic national smoking cessation database system (based on the NHS Board area of the system user) and does not have to be entered manually.

Note: The State Hospital, Carstairs, has a separate code in line with its special NHS Board area status.

3. Clinic area/type

Services should record the clinic area or type. This field is locally defined and could be geographical clinic areas or clinic types depending on a particular service or reporting needs. Your local service manager/smoking cessation coordinator at NHS Board level will have defined the options in this field after liaising with Information Services Division (ISD) Scotland's database manager.

Guidance for Items 4-10: Client Information

4. Date of birth

A client's date of birth is a key piece of demographic data, which is routinely collected in clinical settings. This item is required to measure uptake by different age groups.

For information about the Scottish Government's targets for particular demographic groups (including age), please refer to the **Minimum Dataset Background and Rationale** document, described in the notes at the start of this guidance.

5. Gender

This item is collected to measure uptake of services by men and women. Two options, male and female, are offered in the MDS. While it is recognised that there may be clients who have changed their gender from their sex at birth, or who consider their gender and biological sex as distinct, for the purposes of this dataset self-reported 'current gender' is adequate.

6. If female, pregnant?

Services should ask **all** female clients if they are known to be pregnant. This is to measure uptake by pregnant women – an identified priority group.

7. What is the client's ethnic group?

This question is included in the MDS to find out about uptake and cessation by individuals from different ethnic groups. Recent government initiatives, including the Scottish Executive's 2000 *Fair for All* agenda², encourage health services to provide culturally appropriate services for diverse ethnic groups. Differences in cessation outcome success have been seen across ethnic groups in other countries, and it is important to gather similar data for Scotland.

The categories to be used for ethnicity in the MDS are those recently devised for the forthcoming 2011 Scottish National Census³. All official data-gathering organisations are advised to move to these new categories, having gone through a rigorous testing and development process, detailed in the report document here: <http://www.scotland.gov.uk/Publications/2008/07/29095058/0>

² For more information on Fair for All please visit: <http://www.scotland.gov.uk/library3/society/ffar-00.asp>

³ Further information on the 2011 Scottish Census is available from the following website:
Census Homepage: <http://www.gro-scotland.gov.uk/census/censushm2011/index.html>

As with any system of categorising a fluid and culturally variable concept such as ethnicity, these categories may not be entirely unproblematic; however, this is the preferred structure for collecting ethnicity data in Scotland at the present time.

Clients should be asked to ‘... choose **one** section from A to E, then tick **one** box which **best describes** your ethnic group or background’. If they select any of the ‘other’ options they should specify what they designate as their ethnic group or background in the space provided.

The options presented in the list are taken directly from the 2011 National Census categories, the linked report above provides extensive detail of the methods gone through to arrive at the current list.

Clients may want to go between choices or may need help to find the appropriate category (though the options have been designed to minimise this as much as possible).

If the client is uncomfortable about answering this question they may select the ‘not disclosed’ option.

8. Does the client receive free prescriptions?

The question ‘does the client receive free prescriptions?’ is useful for two reasons. First of all, from a cost perspective, it is important to find out how many clients using smoking cessation services are entitled to free prescriptions for NRT, Varenicline and Bupropion. Secondly, entitlement to free prescriptions can be used as a proxy-measure for socio-economic status, along with two further proxy measures: item 9 - *employment status*, and item 10 - *postcode*. Together these are useful for the analysis of service uptake and outcomes by people on lower incomes (a priority group – see question 10 on postcode for more information).

Considering each of these proxy-measures of socio-economic status in isolation is likely to result in significant error (e.g. many people who qualify for free prescriptions are not necessarily on low incomes), but by using multiple measures, greater accuracy is obtained.

If clients are unsure if they are entitled to free prescriptions they can be referred to a free prescriptions checklist, available on the Scottish Government site (<http://www.scotland.gov.uk/Resource/Doc/219921/0059079.pdf>). Proof of entitlement may be required from individuals seeking to claim free prescriptions.

Exemptions from prescription charges, as given in the document above, are if you:

- *are under 16 years old;*
- *are 16, 17 or 18 and in qualifying full-time education;*
- *are 60 years of age and over;*
- *have a specific listed medical condition which confers exemption;*

- *have a valid Maternity Exemption Certificate (EC92);*
- *have a valid War Pension Exemption Certificate;*
- *have a valid Prescription Pre-payment Certificate;*
- *receive, or has a partner who receive Pension Credit Guarantee Credit;*
- *receive, or has a partner who receives Income-Based Jobseeker's Allowance;*
- *hold or are named on a valid NHS Tax Credit Exemption Certificate;*
- *are named on a current NHS Low Income Scheme certificate HC2 'Help with health costs.'*

Clients should always be asked if they receive free prescriptions *at the present time*.

Further information, and support on these categories, are available on the Scottish Government Website

<http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/Health-Costs>

As the Scottish Government are currently engaged in phasing-out prescription charges, this item will no longer be relevant when the charges are abolished in 2011, and the MDS will have to rely on the other proxy measures of socio-economic status.

9. Employment status

Employment status is asked in the MDS as an additional measure of socio-economic status in order to determine uptake of services by people on lower incomes.

This question is also useful at service level because it gives information that is potentially useful in relation to the context of an individual's tobacco use and quit attempt – for example, in their ability to attend a service, or possible levels of stress or isolation.

Clients should be asked to select one of the following options:

<i>In paid employment</i>	<i>Full-time student</i>
<i>Homemaker/full-time parent or carer</i>	<i>Unemployed</i>
<i>Retired</i>	<i>Permanently sick or disabled</i>
<i>Other (please specify)</i>	<i>Not known/missing</i>

It is recognised that there are limitations with the use of employment status as a proxy for socio-economic status. For example, it does not distinguish between short and long-term unemployment and does not give an indication of income. As mentioned above under item 8 (*does the client receive free prescriptions?*), this is why it is considered along with data provided in items 8 and 10 before making judgements on a client's socio-economic status.

It is possible that some clients may not fit neatly into one category (e.g. persons who have taken early retirement, but continue to work part-time). In these circumstances they should be encouraged to select one option that they feel best fits their situation. If neither option fits then 'other' can be selected and details given in the space provided.

10. Full postcode

Full postcode (e.g. *EH2 2HB*, *IV1 1TR*) is recorded as a further proxy measurement for socio-economic status. This is important for analysing the uptake of services and cessation rates by adults on lower incomes, or from disadvantaged groups, who have been designated as a priority group within smoking cessation.

Postcodes can be mapped onto local information to provide a deprivation category score. Until recently, in Scotland the standard deprivation measure – The Carstairs Index of Deprivation - was based on postcode *sector* (e.g. EH2 2, IV1 1), so it was not necessary to use the full postcode. However, since the 2001 Census there is a move towards a new measure, the Scottish Index of Multiple Deprivation (SIMD), which is an electoral ward based measure and **requires full postcode**.

The SIMD is based on 37 indicators across 7 domains: current income, employment, health, education, skills and training, housing, geographic access and crime. For more information on the SIMD, see the following website: <http://www.scotland.gov.uk/Topics/Statistics/SIMD/>

Although full postcode is an item on the dataset that could potentially identify a client (particularly in more rural areas), users of the national smoking cessation database should be aware that postcode is converted to 'data zone' area in the dataset that ISD has access to for central monitoring purposes.

Guidance for Items 11-13: Tobacco Use and Quit Attempts

The following three items are asked in order to provide a measure of tobacco dependence and motivation to quit. At service level these are useful to help services provide appropriate treatment. They are also useful from a monitoring and evaluation point of view, to find out about uptake of services and effectiveness of different interventions in relation to clients' nicotine dependence. There is no perfect system for calculating dependence; the following three items simply offer a short and standardised way of measuring dependence across Scotland.

Note that responses to items 11 & 12 can be combined to give a score on the Heavy Smoking Index⁴, which is a robust measure of nicotine dependence.

11. On average, how many cigarettes does the client usually smoke per day?

This question is asked to gauge client's tobacco use and level of addiction, and to provide further context to the quit attempt and outcomes.

Clients may provide an answer which does not neatly fit within these categories (e.g. 'usually I smoke 20 a day, but sometimes it's more if I'm stressed' or 'I smoke more at the weekends than I do during the week') and may ask for clarification as to how to answer this question. In this situation it should be emphasised that you are looking for the *average* number of cigarettes and clients should be encouraged to select the option that best fits with their tobacco use.

If a client has recently stopped smoking prior to attending the service, please record here the average number of cigarettes they were smoking before they stopped.

For clients who use a form of tobacco other than cigarettes, many services use a 'tobacco conversion chart' to convert the amount of rolled tobacco or pipe tobacco smoked into an equivalent value in cigarettes. The national smoking cessation database also contains a conversion formula that can be referred to when entering MDS data onto the system.

12. How soon after waking does the client usually smoke their first cigarette?

The question 'How soon after waking does the client usually smoke their first cigarette?' is used in combination with the items immediately above and below to gauge client's level of dependence on cigarettes, and to provide context to the quit attempt and outcomes.

Clients may initially offer a response that does not neatly fit within these categories (e.g. 'sometimes I smoke straight away, but sometimes I don't smoke for hours'). In these circumstances clients should be encouraged to select the option that best fits with what happens on most days.

⁴ Heatherton, T, Kozlowski, L et al (1989) Measuring the heaviness of smoking: using self-reported time to first cigarette of the day and number of cigarettes per day. *British Journal of Addiction*, 84, 791-800.

13. How many times has the client tried to quit smoking in the past year?

The question ‘How many times has the client tried to quit smoking in the past year?’ is asked to measure the number of recent unsuccessful quit attempts and to provide further context to the current quit attempt and outcomes.

This question is, by nature, subjective and there are many possible interpretations as to what constitutes a ‘quit attempt’ (for example, some people might claim that they try to stop smoking every Monday morning, others may wonder if it means trying to quit using support from the smoking cessation service).

Clients may ask for clarification as to what exactly is meant by this question or what period of time without smoking qualifies as a quit attempt. If a client asks for guidance, encourage them to think back to how many times they have *seriously* tried to stop smoking (e.g. have managed to stop smoking for more than 24 hours) and to pick the option that best fits with their situation.

This question can be seen as a measure of a client’s motivation to stop smoking (the more quit attempts, the more motivated). However, there are conflicting opinions as to whether previous quit attempts are positively or negatively associated with cessation. The inclusion of this question will provide useful information about the impact of previous quit attempts on the current attempt to stop smoking.

Guidance for Items 14-20: Intervention Details

14. *Date referred to service*

Items 14, 15, and 16 all track key dates for clients entering and using the service. *Date referred to service* should be completed to reflect either the date a client's details are referred to the smoking cessation service from an external source (e.g. from a GP or secondary care), or, if a client is effectively self-referring (they attend the service directly without having to see another healthcare practitioner), the date that they first attend the service (this may be the same as item 16 – *Date of initial appointment*).

This item, in combination with 15 and 16 will allow more detailed local and national analysis of a client's path through services, how long clients may take to set a quit date from their initial contact and give some indication as to waiting and referral times when the client is referred to the service from external sources.

15. *Quit date*

The QUIT DATE may not be the 'actual' quit date of a client, but the 'proposed or planned' quit date which clients aim to achieve. All clients, and only clients, who actually set a 'proposed or planned' quit date, will be included in the MDS for national monitoring and annual statistical reports.

It is recognised that this is only *one part* of the work smoking cessation services carry out. Many services expend resources and expertise supporting those who never set a quit date. This is recognised in the way the national reporting is presented. However, for the purposes of outcomes measurement, the criteria must be something that is measurable, and standardised.

A client cannot set a quit date before they enter a Smoking Cessation Service. Their quit date cannot be earlier than their first point of contact with a service. The smoking cessation services aim to help smokers to stop and stayed stopped, rather than being a relapse prevention service. A main aim of the MDS is to measure the effect of SCS as a form of intervention – this will not be possible if clients are able to set a quit date, or begin their quit attempt, prior to entering a service.

The quit date gives a definite point from which to measure follow-ups, in particular for the purposes of monitoring against national and local targets. It also indicates that a client is serious about trying to give up smoking. Measuring follow-ups from the time of the quit date provides a standardised method that can easily be adapted by most services. The quit date model fits with guidance for the use of Nicotine Replacement Therapy, Bupropion and Varenicline, and with the practices of many smoking cessation services in

Scotland⁵. It also brings Scotland in line with standards already implemented in the rest of the UK.

Services who do not currently ask clients to set a quit date are strongly urged to do so. This is important as it is the baseline for measuring follow-ups.

During the development of the MDS, other end points were considered, such as the start or end of the intervention. The first was not chosen as this could include many people who contacted the service but did not continue with a quit attempt. The latter was deemed to be too vague and difficult to define, particularly as some clients may still receive counselling long after they have actually quit.

As noted above, clients who access smoking cessation services but do not go on to set a quit date are, at present, beyond the scope of national monitoring. Nonetheless, it is appreciated that significant effort, time and resources are spent on clients who do not set a quit date. Services are *strongly encouraged* to collect additional information on such clients for the purposes of local monitoring, evaluation and service planning.

Staff should explain to clients the concept of a 'quit date'. They should also judge when is the right time to get a client to set a quit date. At initial contact with a service, for example, may be too early for this.

To ensure that follow-ups are conducted at the appropriate time, staff are encouraged to make note of when follow-ups are due, based on the quit date (see the following sections for more information on follow-up times). Note: ISD's national smoking cessation database is able to calculate when clients are due to be followed up, based on their quit date.

On the national smoking cessation database, once a client has had their 1-month follow-up data entered it is not possible to then go back and amend their quit date. If a client sets a new quit date, then this should be recorded as a new quit attempt.

16. Date of initial appointment

This should be entered as the date of the client's *first actual session* in the course of cessation support that they are engaging in (not the first time they make contact with the service, e.g. by telephone, to enquire about the service provided).

Gathering data on this will, in combination with information on quit date and referral date, provide more detailed information on the various pathways and timescales as a client goes through the service. Local and national analysis of time from referral to first appointment will also be possible.

⁵ For example, many smoking cessation programmes use a group-based approach to smoking cessation of 6-7 weeks' duration. Clients are encouraged to set a quit date for the week 2-3 of the course, meaning that the end of the course is 1-month post quit date.

17. Does the client consent to follow-up?

This item is to verify consent to follow-up in the MDS. Consultation and discussion with services lead us to believe that consent to follow up is generally high, and it is recognised that most services already use a locally devised template to ensure that clients consent to the follow-up procedure entailed by the MDS.

For the few cases where follow-up by the services is considered to be unwanted or intrusive however, it was thought important to incorporate this item as a 'final check' to record that consent has been sought. This is particularly important in the case of some services where the follow-up is carried out by a different organisation - or in a different location - to the one that carries out the intervention (which is not uncommon across Scotland).

If a client states they do not wish to be followed-up, then their views should be noted and respected.

Having this as an explicit check ensures that there will be few incidents where follow-up is carried out on a client who has stated they do not wish to be followed-up, for whatever reason.

18. Pharmaceutical usage

This item is included to get an indication of what form of Nicotine Replacement Therapy, Bupropion, or Varenicline was used - if at all - and the length of time that these pharmaceutical products were used for.

The options provided allow for specifying if more than one type of NRT was used (for example, using both gum and an inhalator), and whether the client started on one product, then moved to another (for example, starting on Varenicline, then switching to NRT). The option for simultaneous use of both NRT and Varenicline/Bupropion is not catered for, as currently this is not recommended in clinical prescribing guidance.

It will be useful to find out if cessation rates are affected by the duration of use of NRT or Bupropion (Zyban). For example, staying with a product for the whole course of treatment could be a predictor of a successful quit attempt.

The MDS collects information on pharmaceutical treatment (smoking cessation pharmacotherapies) used in the *current* quit attempt only and does not ask about anything used in the past.

If, in the course of the client's quit attempt, there is a change in pharmaceutical usage, this information should be updated (note: for users of the national smoking cessation database, please update details on the 'current service use' screen). Note that, because at the one month follow-up the total duration of pharmaceutical (pharmacotherapy) use may not be known (that is, the client may still be on a course of treatment) - *this question should be revisited at the 3-month follow-up to ensure its accurate completion (with both product(s) used and 'weeks used' updated on the 'current service use' screen of the national smoking cessation database, as necessary).*

19. Intervention(s) used in this quit attempt

The MDS gathers information on intervention types in order to see the range of approaches used and to compare outcomes. As the question phrasing implies, all approaches that were used by the client during this quit attempt should be selected.

The MDS collects information on interventions used in the *current* quit attempt only and does not ask about anything used in the past. The MDS does not collect further details about the length, frequency or duration of sessions. As always, services may wish to ask for this sort of information in addition to the minimum dataset.

The options given are a result of the combination between standardised, evidence-based interventions (such as one-to-one sessions) which will be familiar to most, and additional items that are included in order to accurately categorise what is going on in Scotland's diverse services and capture newer developments that are less well-understood or have a less firm evidence-base. Below are items that may benefit from further explanation.

- *Group support (open/rolling groups)*: This option is included to reflect development in services who offer this option to clients instead of, or in addition to, fixed membership or 'closed' groups. Inclusion in the MDS does not mean that the intervention type is 'endorsed' by PATH or the Scottish Smoking Cessation Guidelines; to ascertain this, services should consult the relevant documentation. Inclusion into the MDS is at the request of services in order to record their interventions accurately.
- *Telephone support*: This is used in some parts of Scotland, particularly rural areas, for clients who are unable to get to a clinic. Advice and support is given over the phone, rather than face-to-face. This option might also be appropriate for clients who have referred to national smoking helplines for information or support.
- *Couple or family based support*: This is a popular approach in some areas, where clients receive support in pairs or in small groups, along with partners or other family members. This kind of approach does not fit in neatly with either one to one or group work and should not be counted as such.

Any type of intervention that does not clearly fall into any of the categories presented in the MDS should be recorded in the 'other' category, and described appropriately.

20. Intervention setting(s)

The MDS includes this item in order to gather standardised information on the location of the intervention – where it is delivered. It is recognised that some services already gather this type data under *item 3 – clinic area/type*,

however, this is not standardised, as different areas have arranged to use this field in different ways. This item offers some standardisation so, for example, we can see how many interventions took place in a pharmacy setting across the country as a whole.

Services should record here the setting(s) in which a *substantial part of the intervention is delivered through or takes place within*. If the intervention is split between two settings (for example, the client receives initial sessions of a one to one intervention in a secondary care setting, but is then referred to a primary care setting) then both should be recorded in the MDS.

The options that are listed under this item on the MDS are below.

- *Primary Care*: This option should be selected if a substantial part of the intervention is delivered through any of NHS Scotland's Primary Care services (*excluding Pharmacies, see below*); for example GPs, Dentists, NHS walk-in centres and other non-hospital venues.
- *Hospital – Inpatient*: Should be selected when the intervention is provided in an NHS secondary care setting, where the client has been admitted to the hospital as an inpatient and is resident at the hospital overnight, or for an indeterminate amount of time.
- *Hospital – Outpatient*: Should be selected when the intervention is provided in an NHS secondary care setting, and the client is not admitted to the hospital, or hospitalised overnight, but instead visits a secondary care site for treatment or diagnosis.
- *Pharmacy*: Any clients who receive a substantial part of their intervention through a Pharmacy should be recorded here.
- *Prison*: Any specialist smoking cessation intervention that takes place within the Scottish Prison Service should be recorded as such here.
- *Workplace*: Where the intervention takes place as part of a structured, workplace-based programme of intervention.
- *Educational Establishment*: Where the intervention is set in any primary, secondary or tertiary-level educational establishment.
- *Non-NHS community venue*: This option is to record any interventions that take place in what might be described as a 'community venue.' This would include leisure centres, community centres, town halls, and similar.
- *Home*: This should be selected when one of the main settings for the intervention is in a privately owned home or residence.
- *Other (please specify)*: Any setting which is not covered by the options above should be recorded here.

Guidance for Items 21-31: 1,3, and 12-Month Follow-Up

Notes on Outcome Data

The most obvious outcome measure for smoking cessation services is quit rates/quit numbers. However, there are conflicting opinions amongst both researchers and practitioners of the best ways to measure and verify a quit.

While it is acknowledged that different criteria and guidelines exist, it is extremely important for data gathered through the MDS to follow as consistent a standard as possible in order to make comparisons within and between services nationally. Currently, we share our standards with England (The Russell Standard)⁶, and while there are certainly times where this model will be felt to be a less-than-perfect fit for every client that attends a service, it is still the most consistent and stable model available.

The minimum dataset records information on both short-term and longer-term quits. Clients setting a quit date should be followed-up at three points: 1 month, 3 months and 12 months post quit date.

Self-reported quits are used at all follow-up points, with additional carbon monoxide (CO) monitor validation requested at the 1-month follow-up point. A flow chart summarising the follow-up process is attached on pages 30-31.

⁶ West, R., et al. (2005) Outcome criteria in smoking cessation trials: proposal for the common standard. *Addiction*, 100, 299-303.

1-Month Follow-Up

The 1-month follow-up is the core measure of short-term cessation success (which is to some extent predictive of longer-term success) in the MDS.

Who to include in the 1-month follow-up

Services should attempt to follow-up *all clients setting a quit date*.

When to conduct the 1-month follow-up

The 1-month follow-up should be carried out immediately upon, or very shortly after, the 1 month date (exactly one month after the quit date). The first time at which a client should be contacted is 1-month after their quit date.

If they cannot be contacted at this time, further attempts (3 attempts are recommended) should be made within the subsequent 2 weeks of their follow up date. **Therefore, follow-ups should be completed within 6 weeks of the original quit date** (the one-month follow-up plus the two week window).

If it has not been possible to contact a client within this time, the individual should be counted as '*lost to follow-up*'. Services are encouraged to make note of when follow-ups are due when the quit date is set; the national smoking cessation database can assist in planning this by notifying services when follow-up is due.

This cut-off point helps to promote meaningful and consistent data, and puts Scotland in line with procedures in England.

How to conduct the 1-month follow-up

It is preferable for the professional who provided the intervention to see the client *in person* for the 1-month follow-up. The smoking cessation adviser and client will have established a relationship in the preceding weeks which should encourage honesty from the client regarding their quit attempt. Seeing the client in person also fits in with the structure of many smoking cessation programmes, where the client attends a course of 6-7 weeks' duration and is encouraged to set a quit date for week 2-3 of the course, meaning that the end of the course often coincides with 1-month post-quit date.

Additionally, seeing the client in person enables a carbon monoxide monitor reading to be taken to validate the self-reported smoking status (see overleaf). If, in exceptional circumstances, clients cannot be seen in person, they should be contacted by another means (e.g. telephone or post) for follow-up.

21. Was the client successfully contacted for 1-month follow-up?

The first item in relation to the 1-month follow up is if the client was able to be contacted for the 1-month follow-up or not. The options presented and how to proceed depending on response given are below.

Yes

Please now complete questions 22-25

No (Client lost to follow-up)

No (Client did not consent to follow-up)

No (Client died)

Unknown

Please now complete question 23

If the client was successfully contacted for follow-up then the date when follow-up took place should be noted in the following question. This is necessary to check what time period has elapsed since the quit date and follow-up, and to check it falls within the 'valid' 6 week time period since the initial quit date was set. If a client has been contacted for follow-up, then the remaining 1-month follow-up questions (22 - 25) should then be completed.

If the client was *not* contacted for follow-up, then the reason should be noted by ticking the appropriate box - either because they were lost to follow-up, or because follow-up was not carried out for another reason (the client did not consent to follow-up or if the client has died).

If the client has not been able to be contacted for follow-up then **only question 23** (*client withdrawn from service at time of follow-up*) needs to be completed. Those completing the MDS information for clients do not need to record any other information and this should ensure that time is not spent completing questions which are not relevant.

The 3-month and 12-month follow-ups need not be collected if the client is lost to follow-up at the 1-month stage.

22. Date follow-up carried out?

The above question should be completed for all clients who were successfully followed up at the 1-month stage. This question allows services to check whether the follow up was carried out within the valid timescales set to ensure consistency across services within Scotland.

23. Client withdrawn from service at time of follow-up?

This item should be completed for **all clients** who set a quit date (even those who have not been able to be contacted for 1-month follow-up). The box is to be checked only if it is known that the client has *withdrawn from/is no longer in* the service at time of 1-month follow-up.

Being '*withdrawn from service*' means that the client has started an intervention and set a quit date, but has subsequently dropped out of the service at or before the 1-month follow-up (i.e. they have stopped attending sessions and receiving support for whatever reason). Clients who fall into this category should still have follow-up attempted, and the follow-up outcome noted, but their effective 'withdrawal from service' should also be noted by checking this box.

If the client is still in service/still receiving support at the time of the 1-month follow-up, or the programme of the intervention has finished with the client having successfully maintained contact with the service for its duration, then this box need not be ticked.

This box should not be automatically checked if the client cannot be contacted for follow-up in item 21; their withdrawal from the service should be treated as independent from their ability to be contacted. (Though there will obviously be cases where a client who 'withdraws from the service' will also be 'not contactable' for follow up, they should be treated separately for analysis purposes.)

The purpose of asking this question is to be able to analyse one possible cause of the high number of clients reported as 'lost to follow-up' in analyses of the Scottish MDS data to date.

24. Has the client smoked at all (even a puff) in the last 2 weeks?

The above question should be asked of all clients who set a quit date and were successfully contacted at the 1-month follow-up. To ensure consistency the question should be asked exactly as above (inserting 'you' instead of 'the client' if speaking directly to them) – using the 'even a puff' phrasing.

As mentioned previously, the criteria used to determine quit success is one which attracts debate, with different organisations proposing different standards. While the criteria used here is not perfect, it is seen as the 'best fit' solution, based on what we know of cessation in the U.K. at present.

The source for this criteria is the West et al. clinical guidance – The Russell Standard - referred to previously⁷.

The creators of this criteria explain that a period of 2 weeks was chosen because this was deemed a significant period of time for a former smoker to be classified as not having smoked.

⁷ West, R., et al. (2005) Outcome criteria in smoking cessation trials: proposal for the common standard. *Addiction*, 100, 299-303.

The item design also allows a grace period in recognition of the fact that some smokers initially struggle and may lapse early on in the quit attempt (e.g. in the first couple of weeks), but then manage to stop effectively. It is important to remember that while some clients may not be classified correctly by this criteria (they may have lapsed within the 'last two weeks', but then go on to subsequent success), the best evidence we have suggests that most clients will be assessed effectively by this criteria.

This 2-week period also brings Scotland broadly in line with procedures used in the rest of the UK for measuring 1-month quit rates⁸.

If the client answers 'no' to this question, indicating that they have successfully quit, then a carbon monoxide validation should be taken and subsequent follow-ups should be attempted (3 and 12 months). If the client answers 'yes' to this question, indicating that they have smoked within the last 2 weeks, then they do not need to be followed up again. If, in exceptional circumstances, the smoking status of the client is 'not know' despite being contacted, there is also no need for continued follow-up at 3- and 12-months.

25. CO reading confirms quit?

Services should take carbon monoxide (CO) readings from all clients who self-report to having quit at the 1-month follow-up.

If a client answers that they have smoked in the last two weeks to the previous question, it is not necessary to take a CO reading. If, under exceptional circumstances, the follow-up was not conducted in person, then CO readings need not be taken. It is appreciated that CO monitoring may not be possible under certain circumstances, for example in rural or island boards where support sessions and/or follow-ups may have to be conducted by telephone or letter rather than face-to-face. For the purposes of the minimum dataset, CO validation is not required at any other follow-up other than the 1-month point (although services may wish to record CO monitor results at other times if they wish).

CO monitors are an important motivational tool for clients undergoing cessation treatment. Many services routinely use these as way of showing clients how they are improving their health by quitting. CO monitors are also a relatively cheap and easy way of validating that a person is a non-smoker and provide an additional, reliable measurement of short-term cessation rates. Indeed, there can be quite a difference between self-reported and carbon monoxide validated quit rates.

However, the rationale for taking CO readings is not because it is expected that clients are lying about their smoking status, but because it is useful and

⁸ In England services ask if the client has not smoked at all since two weeks after their quit date, (allowing a 2-week grace period as advocated by the Society for Research on Nicotine and Tobacco). In England if a client is followed up at exactly 4 weeks post quit and is permitted a 2-week grace period, this is effectively the same as asking them if they have smoked in the last two weeks – the question asked in Scotland. Of course, the Scottish question is not exactly comparable, particularly if the follow-up is carried out at 6 weeks, at the end of the permissible period. It was decided that the English question could be confusing for clients and staff, therefore another measure was chosen for Scotland.

considered more robust to have information about validated smoking rates in line with those recommended in the Russell Standard.⁹

Service providers may use whichever brand of CO monitor they prefer, and have access to. They should ensure regular calibration and maintenance of their monitors, in accordance with manufacturer's instructions, to provide accurate and consistent readings.

For the purposes of the minimum dataset, **a reading of less than 10ppm verifies the client as a non-smoker.**

Whilst CO monitor manufacturers' guidance may provide other values for the threshold reading between a smoker and non-smoker, the figure of 10 ppm is one that is (while erring on the side of leniency) extremely unlikely for a non-smoker to exceed, and is supported by current clinical guidance. It is emphasised that services may collect the actual figure from the CO reading, and use it to inform their intervention. However, for the completion of MDS data, any reading of **less than 10 ppm is considered to verify the client as a non-smoker.**

⁹ West, R., et al. (2005) Outcome criteria in smoking cessation trials: proposal for the common standard. *Addiction*, 100, 299-303.

3-Month Follow-Up

A 3-month follow-up is included in the minimum dataset to provide information on medium-term cessation. A high proportion of smokers are known to relapse in the first year of their quit attempt, particularly in the first 6 months. A further advantage of contacting clients at this stage is that it could facilitate further intervention if relapse has occurred.

Who to include in the 3-month follow-up

Services should attempt to follow-up *all clients setting a quit date who had successfully quit at the 1-month follow-up, based on self-report*. If CO validation did not confirm a client's self-reported quit then they should still be followed-up at 3 months. If a client explicitly does not consent to being followed up then they should not be contacted.

When to conduct the 3-month follow-up

The first time at which a client should be contacted is 3 months after their quit date. If they cannot be contacted at this time, a reasonable number of further attempts (e.g. 3 attempts, perhaps on different days, at different times, by different methods) should be made within the next 4 weeks. The 3-month follow-up should be completed roughly within 16 weeks of the quit date (depending upon the calendar months). If it has not been possible to contact a client within this time, the individual should be counted as '*lost to follow-up*' for that particular point of contact. This cut-off point helps to promote meaningful and consistent data. This system does not assume that service users who cannot be contacted have relapsed, and reporting reflects this. Services are encouraged to make note of when follow-ups are due when the quit date is set (as with the 1-month follow-up, the national smoking cessation database can assist in this task by flagging up follow-ups due to be carried out).

How to conduct the 3-month follow-up

It should be ensured that the follow-up questions are asked as described in the following pages. Follow-ups may be conducted in person, by phone, by post or by electronic methods (e.g. by email or text message), depending on the preferences of the service. It is suggested that services try to contact clients by telephone first and if after three attempts (preferably on different days/at different times) the client has not been reached, then a letter should be sent out requesting the follow-up information. Any client who could not be contacted by phone after multiple attempts and who does not reply to a letter should be counted as '*lost to follow-up*'.

26. Was client successfully contacted for 3-month follow-up?

The first item in relation to the 3-month follow-up is if the client was able to be contacted for the 3-month follow-up or not. The options presented are as below:

Yes

Please now complete questions 26-28, and verify Pharmaceutical Usage (item 18) is correct

No (Client lost to follow-up)

No (Client did not consent to follow-up)

No (Client died)

Unknown

Please now verify Pharmaceutical Usage (item 18) is correct

If the client was successfully contacted for follow-up then the date when follow-up took place should be noted in the following question. This is useful to check what time period has elapsed since the quit date and follow-up, and to check it falls within the time period allocated. If a client has been contacted for follow-up, then the remaining two 3-month follow-up questions (27 & 28) should then be completed. **The client's usage of pharmaceuticals (pharmacotherapies), as taken in *item 18* should be verified here to ensure that the information given on this client is still correct. Item 18 should be updated if the usage has changed (e.g. pharmacotherapies were used for longer than initially stated).**

If the client was *not* contacted for follow-up then the reason should be noted by ticking the appropriate box. If the client has not been contacted for follow-up, then their previously given usage of pharmaceuticals (pharmacotherapies) given in *item 18* should be verified from service records if possible, and amended if necessary.

Note: Attempts should still be made to follow-up clients at the 12-month stage, even if they could not be contacted at the 3-month stage; the electronic national smoking cessation database will assist in planning this work, as it will flag up for 12-month follow-up those who were not contactable at 3.

27. Date follow up carried out:

The above question should be completed for all clients who were followed up at the 3-month stage. This question allows services to check whether the follow up was carried out within the timescales set to ensure consistency across services within Scotland. If the follow-up was undertaken by letter, this should be the date correspondence was returned.

25. Has the client smoked at all since the 1-month follow-up?

The above question should be asked of all clients who set a quit date and have successfully quit (as measured by self-reported smoking status) at the 1-month follow-up. It should be asked exactly as it is written above (inserting 'have you' instead of 'has the client' if speaking directly to them) and the following options offered:

- No
- Yes, between 1 and 5 cigarettes in total
- Yes, more than 5 cigarettes
- Unknown

Not smoking at all, or smoking between 1 and 5 cigarettes since the 1-month follow-up is the criteria by which a client is considered as abstinent at the 3-month follow-up.¹⁰

This item offers a useful indication of the number of clients who have essentially been abstinent for a prolonged period, but might have had minor lapses at some point. Prior to the introduction of this standard, services may have used different criteria to confirm abstinence at 3-months. The above classification offers some standardisation – either of the first two options above would classify the client as abstinent.

If the client answers '*no*' or '*between 1 and 5 cigarettes in total*' then attempts should be made to follow them up at 12 months. Attempts should also be made to follow-up clients at 12 months who could not be contacted for follow-up at the 3-month stage. If the client reports to smoking more than 5 cigarettes then they do not need to be followed up at 12 months.

¹⁰ West, R., et al. (2005) Outcome criteria in smoking cessation trials: proposal for the common standard. *Addiction*, 100, 299-303.

12-month Follow-Up

Although 1-month and 3-month self-reported quits provide a useful indicator of short- and medium-term success, they are not sufficient to predict longer-term cessation, particularly as substantial relapse occurs in the first year after the quit date.

For this reason a 12-month follow-up is included in the minimum dataset to provide information on longer-term cessation. The format and process of the 12-month follow-up is very similar to that performed at 3 months.

Who to include in the 12-month follow-up

Services should attempt to follow-up *all clients who had successfully quit at the 1-month follow-up, based on self-reported data, unless they reported having smoked more than 5 cigarettes at the 3-month follow-up.*

If CO validation did not confirm a client's self-reported quit at 1 month then they should still be followed-up at 3 and 12 months. If a client explicitly does not consent to being followed up then they should not be contacted. Attempts should be made to follow-up clients at this point even if they could not be contacted at the 3-month follow-up. The national smoking cessation database automatically flags such clients for follow-up.

When to conduct the 12-month follow-up

The first time at which a client should be contacted is 12 months after their quit date. If they cannot be contacted at this time, a reasonable number of further attempts (e.g. three attempts, perhaps on different days and at different times, or by using different methods) should be made within the subsequent 4 weeks. Follow-ups should be completed within 56 weeks of the original quit date to be considered 'valid'. If it has not been possible to contact a client within 56 weeks from their quit date, the individual should be counted as '*lost to follow-up*'. This cut-off point helps to promote meaningful and consistent data. This system does not assume that service users who cannot be contacted have relapsed, and reporting reflects this. Services are encouraged to make note of when follow-ups are due when the quit date is set (as with the 1-month, and 3-month follow-ups, the electronic national smoking cessation database will assist in this task by flagging follow-ups due to be carried out).

How to conduct the 12-month follow-up

Please refer to 3-month guidance on page 25 – the procedures for 12-month follow-up are exactly the same.

29. Was the client successfully contacted for 12-month follow-up?

The first item in relation to the 12-month follow up is if the client was able to be contacted for the 12-month follow-up or not. The options presented are as below:

Yes

Please now complete questions 30-31

No (Client lost to follow-up)

No (Client did not consent to follow-up)

No (Client died)

Unknown

Do not complete any further questions

The format for response here is the same as with the 3-month follow-up, with the exception that verification of pharmaceuticals (pharmacotherapy) use is not necessary (it is assumed that the use of pharmacotherapies will have ended before 12 months).

30. Date follow up was carried out:

If the client was successfully contacted for follow-up then the date when follow-up took place should be noted here. If the follow-up was undertaken by letter, this should be the date correspondence was returned. This is useful to check what time period has elapsed since the quit date and follow-up, and to check it falls within the valid time period for 12-month follow-up.

31. Has the client smoked at all since the 1-month follow-up?

The above question should be asked of all clients who set a quit date and had successfully quit (self reported) at the 3-month follow-up, or if they were not able to be contacted at the 3-month follow-up. It should be asked exactly as it is written above (inserting 'have you' instead of 'has the client' if speaking directly to them) and the following options offered:

No

Yes, between 1 and 5 cigarettes in total

Yes, more than 5 cigarettes

Unknown

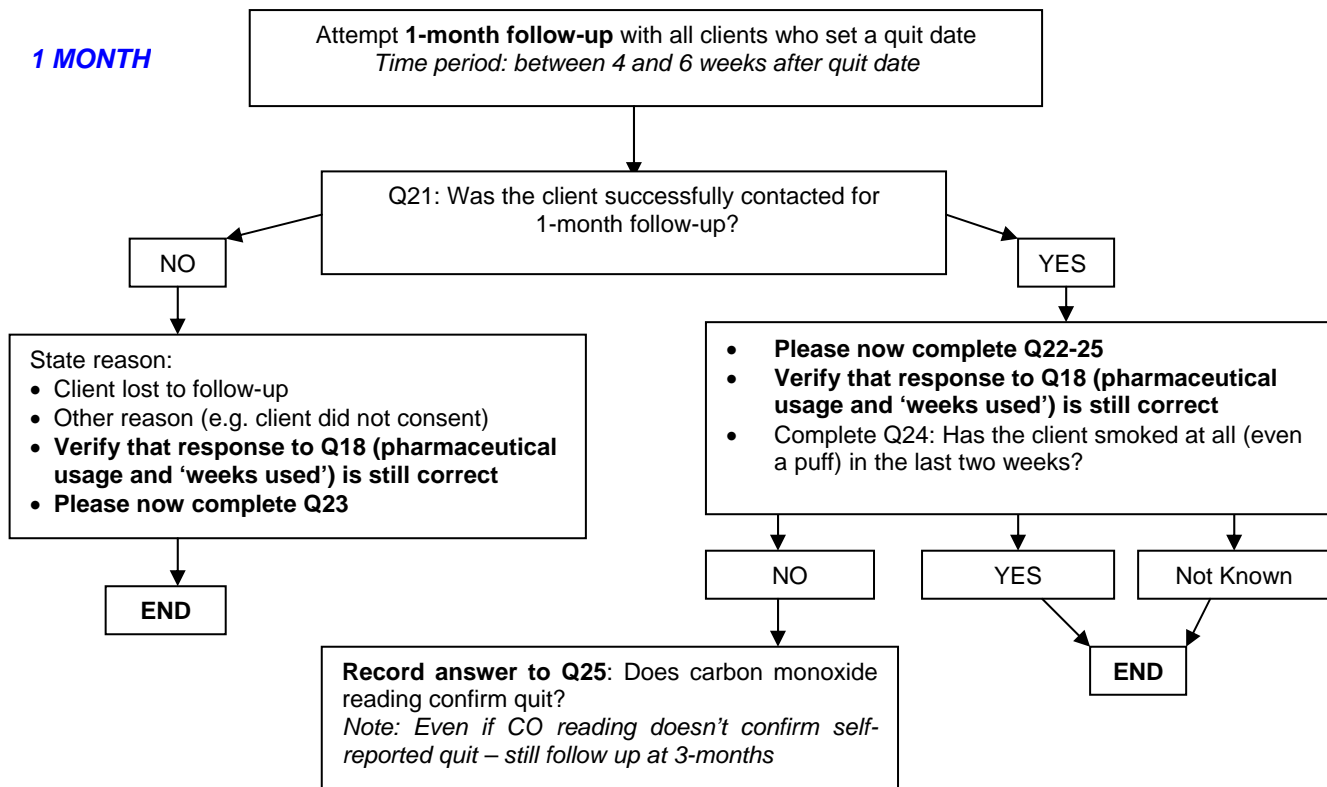
As with the 3-month follow-up criteria, and with the same rationale, either of the first two responses in the list above would classify the client as abstinent at the 12-month point.

Follow-up on this case would now be complete.

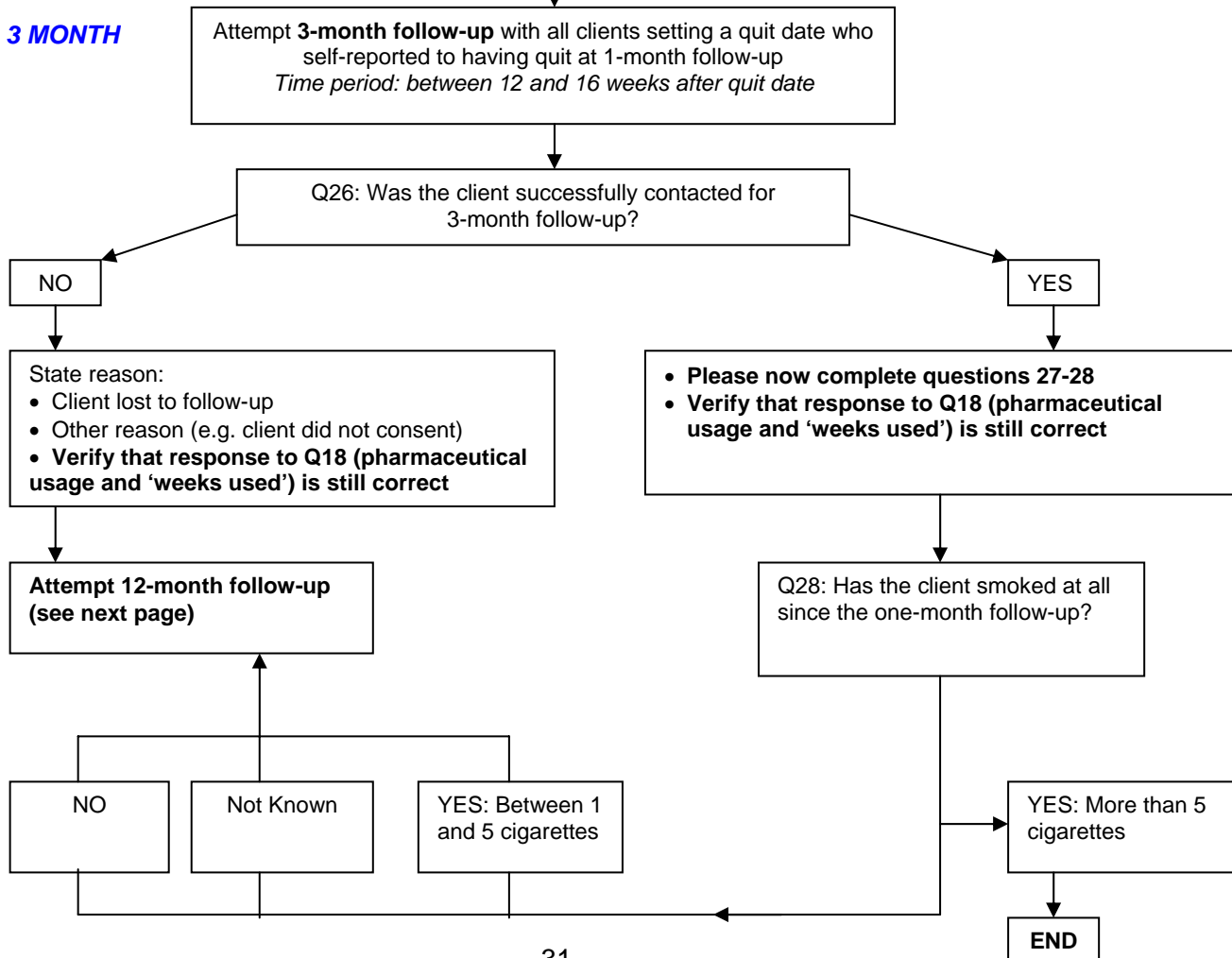
A flow chart summarising the procedures for the 1, 3, and 12-month follow-ups is given on the following pages.

Flow chart guide for follow-ups

1 MONTH

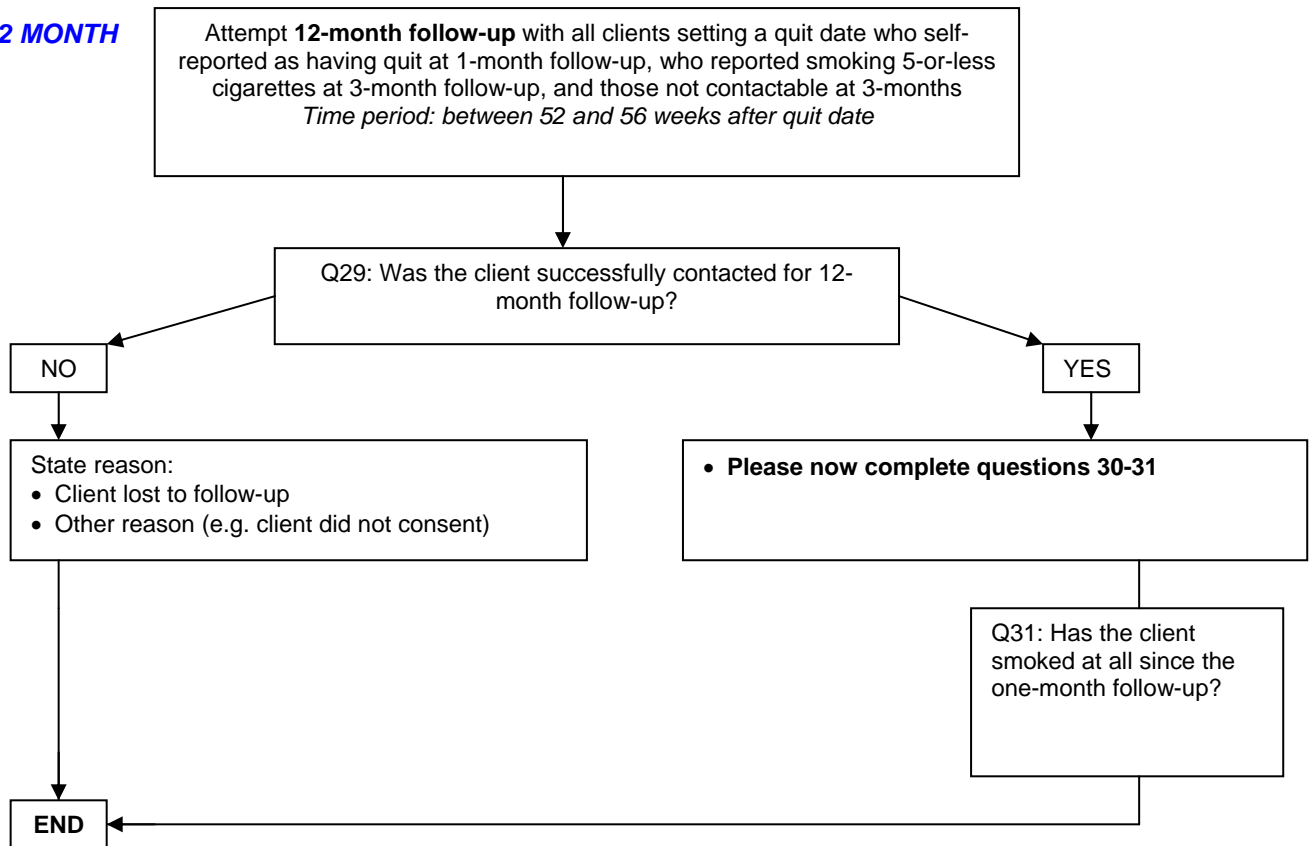


3 MONTH



Flow chart guide for follow-ups (continued)

12 MONTH



Additional Data Services May Collect

Services are strongly recommended to collect any further information from clients at initial assessment and follow-ups that are deemed useful for their own purposes, for example to guide treatment and/or assist in localised service planning and monitoring:

- There are many items of core data that need to be collected by smoking cessation services for their own use, but which are *not* required for anonymised national monitoring or included in the minimum dataset (e.g. client's name, address, and telephone number – these are obviously required for contacting client).
- Information could be collected at service level on the number of clients who access the service but do not set a quit date. Other service information that is useful includes source of referral, and number of sessions attended.
- Services may wish to collect further information on clients as a context to their quit attempt (e.g. details of client's GP and medical history, further details about a client's tobacco use and motivation to stop, number of smokers/non-smokers in their house).
- Services are encouraged to collect any additional information about the outcomes of intervention to provide further context to service achievements, for example recording positive changes to a client's knowledge, attitude and behaviours in relation to tobacco use, even if they have not successfully quit (e.g. smoking less, no longer smoking indoors, no longer smoking in front of children or other non-smokers) – there is provision to record data like this in the national smoking cessation database.
- Services may wish to report on other information relating to services, (e.g. staffing levels, funding and costs, waiting lists, number of enquiries, drop-out rates, education and prevention activities).
- Services may wish to offer clients the opportunity to evaluate the service, for example by filling in a questionnaire relating to aspects of service provision (e.g. about their experience of trying to quit, their overall satisfaction with the service, their thoughts on staff, materials, location, and the length, structure and number of sessions etc). This kind of information is useful for evaluating the strengths and weaknesses of the service, and for guiding future service developments.

Essentially, it is up to services what additional information they feel it is important to gather. However, at the very least, smoking cessation providers should be collecting the information in the MDS, as defined in this document, and should adapt data collection forms and procedures as appropriate.



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