British Thoracic Society
National Smoking Cessation Audit 2021: Management of Tobacco Dependency in Acute Care Trusts: Audit Report

National Audit Period: 1 July – 31 August 2021
Audit leads: Dr Nikesh Devani, Dr Matthew Evison

Number of participating institutions and records submitted:
Part 1- 14579 clinical records submitted from 120 institutions
Part 2: 119 organisational records

Summary/Abstract

The 2021 BTS National Audit of the Management of Tobacco Dependency in Acute Care Trusts (the 2021 National Smoking Cessation Audit) is the third comprehensive audit of the management of tobacco dependency in NHS acute hospitals, spanning six years, using standards drawn from a range of evidence-based publications (BTS[1], NICE[2-5], RCP[7,8,] PHE[6]).

When compared to the 2019 audit, and indeed across the six-year period, little progress has been made and the opportunity has been missed to improve the health of sick smokers admitted to hospital, prevent premature mortality and realise healthcare resource savings. In the three audits alone, spanning a total of six months and 42,976 adult hospital admission episodes, a total of 7,641 active smokers were identified. This represents a tiny proportion of the number of smokers admitted to hospital in the six years (2017-2021) and only a fraction of these smokers were provided access to highly clinically effective and cost-effective interventions.

Access to evidenced-based and NICE recommended interventions has remained inadequate. NICE guidelines recommend all smokers are provided with access to the interventions most likely to lead to abstinence from tobacco (varenicline, vaping and combination Nicotine Replacement Therapy (NRT)) alongside Very Brief Advice (VBA) from non-specialists and specialist behaviour change support from tobacco dependency practitioners. In acute care NHS trusts, this is delivered by specialist tobacco dependency treatment services located on-site with ongoing support from hospital-based or community-based services after discharge. In this audit, VBA was provided to less than half of current smokers. Only 9% of current smokers completed a specialist assessment with a tobacco dependency practitioner during the admission. Only 5% were provided with a NICE recommended, most-effective intervention. Of the 2397 patients that smoked and were admitted during the audit period, just 117 were prescribed combination NRT, 3 patients were prescribed varenicline and 1 patient was provided with a vaping kit. Ongoing support after discharge was equally inadequate with only 10% of current smokers issued tobacco dependency pharmacotherapy on discharge and just 3% attending a follow-up service. 9% of smokers admitted to hospital were assessed for abstinence post discharge and <1% were recorded as successfully abstinent post discharge.

At an institutional level, hospitals continue to perform poorly in relation to enforcing completely smoke free grounds, with 1 in 5 still offering dedicated smoking areas for patients. Senior leadership of tobacco dependency services remains extremely poor with a lack of formal, accessible referral

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pathways and dedicated hospital-based tobacco dependency practitioners. Although most hospitals continued to report access to one or more forms of licensed pharmacotherapy, staff remained ill prepared to support current smokers in their efforts to quit, with only 50% offered tobacco dependency training. The use of vaping and varenicline was virtually non-existent, with only 2 trusts offering a vape kit as part of a comprehensive tobacco dependence support package.

This audit demonstrates unequivocally that major improvement is required in the provision of evidence-based interventions for people with tobacco dependence. BTS recognises the commitment made to improve tobacco dependency treatment in the NHS Long Term Plan for England and in the plans across all the home nations. BTS supports all NHS organisations across the United Kingdom in striving to improve the delivery of tobacco dependency services in secondary care.

National Improvement Objectives:

1. All hospitals should identify a healthcare professional(s) to lead on the delivery of a tobacco dependency treatment service and appoint an executive level board member to support the service **(immediate)**

2. All hospitals should introduce a system of regular local data collection of adult inpatient tobacco-dependency pharmacotherapy prescribing *to drive on-going improvement and further encourage delivery of NICE recommended interventions* **(3-6 months)**

3. Ensure all adult patients admitted to hospital have their smoking status recorded **(3-6 months)**

4. Introduce a training package available to all front-line staff to ensure a minimal level of competence in supporting and treating tobacco dependency (e.g. Very Brief Advice) and implement a system of monitoring uptake **(6 months)**

5. At least 90% of tobacco dependent adult inpatients to receive Very Brief Advice during the course of their inpatient stay **(before next national audit)**

6. Offer all hospitalised tobacco dependent patients a referral to a specialist on-site tobacco dependency treatment service **(before next national audit)**

7. Establish a system to monitor the number of patients provided with Very Brief Advice and referred to (and engaging with) a specialist tobacco dependency treatment services **(next 12 months)**

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Key Findings

1. Smoking prevalence amongst adult inpatients appears to have reduced (21% from 24% in 2019 and 25% in 2016)

2. Recording of smoking status in hospitalised patients remains inadequate. Between 1 in 4 and 1 in 5 patients were not asked about their smoking status, similar to 2019 and 2016 audits

3. Less than half (45%, 1070/2397) of current smokers were provided very brief advice ***(new metric for 2021 audit)***

4. 1 in 7 current smokers were referred to a hospital or community-based tobacco dependency treatment service (15%, 359/2397); a modest improvement from 2019 where the figure was 1 in 8 (12%, 293/2528), and 2016 where the figure was 1 in 12 (8%, 210/2716)

5. 9% (206/2397) of current smokers completed a consultation with a specialist tobacco dependency practitioner during their inpatient stay ***(new metric for 2021 audit)***

6. 1 in 3 smokers (32%, 776/2397) were **offered** licensed pharmacotherapy for tobacco dependency but only 5% (120/2397, 117 combination NRT, 3 varenicline) were actually **prescribed** NICE recommended most effective treatments ***(new metric for 2021 audit)***

7. Only 1 current smoker was provided with a vape kit as part of their tobacco dependency treatment plan ***(new metric for 2021 audit)***

8. Only 6% (9/146) of patients that vaped prior to hospital admission were allowed to use the existing vape kit during admission with no evidence of a discussion of using their vape kit in the remaining patients ***(new metric for 2021 audit)***.

9. 10% (235/2397) of current smokers were discharged on licensed pharmacotherapy for tobacco dependency (n=65 combination NRT, n=2 varenicline) and only 3% (71/2397) attended a follow-up service after discharge ***(new metric for 2021 audit)***

10. An assessment of abstinence at 4 weeks was available for 9% (222/2397) of patients. 10% (22/222) were abstinent at 4 weeks which represents <1% of all smokers admitted to hospital during the audit period ***(new metric for 2021 audit).***

11. 1 in 13 hospitals completely enforced smoke-free grounds compared to 1 in 5 in 2019. 30% (n=36) of the institutions permitted vaping on hospital grounds with 8% (n=9) having designated vaping areas and one institution also allowing this within selected internal sites.

12. More hospitals report having hospital-based smoking cessation services on their premises (41% versus 38% in 2019) but access remains poor with only 1 in 2 hospitals having a referral pathway accessible to all healthcare professionals.

13. Senior leadership of a hospital smoking cessation service was evident in 47% of hospitals compared to 35% in 2019. However, only 1 in 3 had a dedicated hospital funded tobacco dependency practitioner to support this work.

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14. When compared to the 2019 audit, more institutions reported a dedicated space to document a patient's smoking status (and act as a prompt for a clinician to inquire as such) within an acute admission proforma.

15. Provision of licensed pharmacotherapy for tobacco addiction remains variable and only 72% of hospitals report having a guideline to support prescribers.

16. Only 50% of trusts are offering frontline healthcare staff regular smoking cessation training, a figure similar to 2019 and 2016.

Background

Smoking tobacco remains the single biggest cause of preventable death, disability, illness and social inequality[8] and is the most cost-effective illness to treat in the NHS. Over half a million acute hospital admissions are directly linked to smoking[10] and previous audits in 2016 and 2019 have demonstrated comprehensively that acute trusts are failing to provide evidence-based care for tobacco dependent patients.

It is well established that effectively treating tobacco dependent smokers attending hospitals requires provision of very brief advice, the offer of evidence-based pharmacotherapies and interventions, and referral to specialist tobacco dependency service. The 2021 NICE guidelines[11] for the treatment of tobacco dependency have recommended the following interventions be available for all smokers as the most likely to lead to successful abstinence:

- Varenicline
- Vaping
- Combination NRT (short acting and long acting)

Furthermore, randomised controlled trials, Cochrane reviews and NICE technology appraisal have confirmed that Varenicline is superior to NRT and vaping is superior to NRT. Varenicline and vaping, therefore, represent critical interventions for the NHS to provide access to, including during acute care admissions. Combination NRT is also important and particularly pivotal as the most rapid, accessible and standardised intervention to commence at the point of admission to mitigate withdrawal and begin an effective treatment pathway in acute care trusts. This can be part of a standardised admission bundle (along with smoking status capture, provision of very brief advice) under the responsibility of frontline clinicians, with additional specialist counselling and discussion regarding varenicline and vaping offered by the specialist tobacco dependency teams and more experienced clinicians. There must also be maintenance of smoke-free hospital grounds, adequately trained healthcare staff and senior leadership allocated to hospital-based smoking cessation services. This is highlighted in the NHS Long Term Plan which aims for all smokers in England admitted to hospital to be offered NHS-funded tobacco treatment services by 2023/4[12].

The 2021 BTS Management of Tobacco Dependency in Acute Care Trusts Audit was therefore undertaken to determine how effectively national standards for treating tobacco dependent smokers attending hospitals have been implemented across the UK. It builds on the data collected from the audits undertaken in 2016 and 2019 and allows for benchmarking against the aims of the NHS Long Term Plan & the recommendations in the 2021 NICE guidelines.

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Aims and Objectives

The aim of the audit was to examine whether a properly led and staffed hospital tobacco dependency service was present and whether access to the most evidence-based and effective interventions for tobacco dependency was being provided. It also examined the provision of adequate training for staff; that smoking status was being recorded for all patients; current smokers were provided very brief advice; referral for specialised tobacco dependency treatment was made; ongoing support after discharge offered and accessed, licensed pharmacotherapy prescribed and continued upon discharge and that smoke-free hospital grounds were enforced.

The scope of the audit was hospital-wide, across all specialties (excluding maternity and mental health) and included elective and emergency admissions. This is the third such audit to be undertaken and thus the outcomes will be compared to the findings of the 2019 and 2016 audit. However, the 2021 audit aimed to provide additional granularity to previous audits and align with the 2021 NICE guidelines and NHS Long Term Plan. The following amendments were made to the audit:

- Assessing the provision of very brief advice, an evidenced-based intervention that all front-line staff can provide to patients that smoke
- To record the prescription of tobacco dependency pharmacotherapy (not just the offer of pharmacotherapy) as single agent NRT, combination NRT, varenicline.
- To record the provision of vaping kits as part of tobacco dependency treatment
- To examine the provision of tobacco dependency discharge medications
- To examine the uptake and engagement in post discharge treatment pathways
- To examine the feasibility to collect outcome data and the quit rates currently for smokers admitted to hospital during the audit period
- Examine the use of vaping-friendly smoke-free hospital policies to support the treatment of tobacco dependency

Key Objectives

1. To determine the number of patients with smoking status recorded in their hospital notes and whether the use of other substances or devices was recorded (e.g. heat-not-burn, marijuana, shisha).
2. To determine whether patients were specifically being asked about use of e-cigarettes/vaping and if this was being offered as part of a tobacco dependency treatment programme.
3. To determine the number of smokers who were provided very brief advice, whether they were referred to a tobacco dependency service; what referral pathways are available and how this was communicated in the hospital records.
4. To examine whether pharmacotherapy to treat smoking abstinence was on hospital formularies and supported by prescribing guidelines. If this was immediately availability to patients via prescription or supply by hospital smoking cessation practitioners and whether there was a record of offering treatment and then prescribing nicotine replacement therapy (single versus combination) and varenicline.
5. To examine whether vaping kits are being offered as part of a tobacco dependency treatment programme and whether hospitals support vaping on the grounds.
6. To establish if smoke-free hospital grounds policies were fully enforced.

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7. To determine whether hospitals had senior clinicians leading smoking cessation services with allotted time and in conjunction with dedicated hospital smoking cessation specialists.
8. To determine the provision of training for staff on smoking cessation.
9. To determine whether performance against these key objectives has improved when compared to 2019 and 2016 audit outcomes.

Standards

The standards for this audit were drawn from the following evidence-based documents:

- NICE Smoking Cessation in Secondary Care: Acute, maternity and mental health services November 2013 (PH48)[2]
- NICE Stop smoking interventions and service 2018 (NG92)[3]
- NICE Smoking: Harm reduction 2015 (QS92)[4]
- NICE Smoking Cessation: Supporting people to stop smoking 2013 (QS43)[5]
- BTS recommendations for hospital smoking cessation services for commissioners and healthcare professionals 2012 (BTS)[1]
- Public Health England: Use of e-cigarettes in public places and workplaces 2016 (PHE 2016)[6]
- Royal College of Physicians: Hiding in plain sight – treating tobacco dependency in the NHS (RCP 2018)[7]
- Royal College of Physicians: Smoking and Health 2021: a coming of age for tobacco control (RCP 2021)[8]
- National Respiratory GIRFT report 2021 (GIRFT 2021)[9]
- NICE Tobacco: preventing uptake, promoting quitting and treating dependence (NG209)[11]

Methodology

The audit was undertaken by clinical audit teams, doctors, stop smoking specialists and other volunteers at each participating hospital. The audit applied to all adult inpatients in acute hospitals admitted during the audit period of July and August 2021. Maternity and Mental Health services were excluded. Separate audits for these services are planned. The audit had two parts. Instructions and data collection questionnaires for each part were made available on the BTS audit website before the start of the audit, and data were entered onto the secure online BTS audit platform.

Part 1 – Smoking status documentation and current smokers' access to tobacco dependency services in hospital

Part 1 involved screening notes (electronic and/or written) of inpatients, including both smokers and non-smokers, to fundamentally establish whether smoking status was being determined, appropriately recorded and whether current smokers were being provided very brief advice. This information would not be captured if notes were retrieved of smokers only.

It was important that case selection provided a representative sample of the typical activity undertaken in the entire institution and not just a single specialty to ensure that patients were receiving the same level of service regardless of where they were being cared for or who their primary team was.

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Each hospital was therefore asked to request a set of 100 randomly selected notes: 50 from medical wards and 50 from surgical wards, covering at least 2 different specialties in each case. Each set of notes was entered into Part 1 of the audit until a total of 20 records of current smokers had been entered. If all 100 notes were entered and the number of recorded current smokers was less than 20, participants were asked to request a further set of 50 notes (25 medical and 25 surgical) and repeat the process until a total of 20 current smokers had been entered.

Part 2 – Organisational audit of smoking cessation services and policies at participating institutions

Participating institutions submitted details pertaining to their tobacco dependency policies and services as they were at the time of the audit. Participants were requested to submit one return per hospital, unless services were combined under one trust.

Results

Part 1 – Smoking status documentation and current smokers' access to tobacco dependency services in hospital

A. Scope of the audit and prevalence of smoking by age, route of admission and admitting specialty.

120 institutions participated with 14579 patient records submitted from across the UK. The median age was 67 years and 49.9% were female. Most patients (80.2%) were emergency admissions, 53% were from medical specialties, 42% surgical and 2% obstetrics and gynaecology.

Where recorded, overall smoking prevalence was 21%, compared to 24% in 2019 and 25% in 2016. 23.3% of male patients and 18.5% of female patients were smokers (see Table 1). The highest prevalence was for those aged 26-35 years (35.8%), patients admitted to respiratory medicine (23%) and amongst patients admitted as emergencies (22.2%) in line with 2019 and 2016 findings (see Tables 2 and 3).

Gender	Count	Percentage with smoking status recorded	Of those with smoking status recorded, percentage of current smokers
Female	7282	78% (n=5648)	19% (n=1047)
Male	7297	80% (n= 5805)	24% (n=1350)
All	**14579**	**79% (n=11453)**	**21% (n=2397)**

Table 1: Smoking status and prevalence by sex

Age	Percentage with smoking status recorded	Of those with smoking status recorded, percentage current smokers
16-25 (n=769)	77% (n=590)	29% (n=172)
26-35 (n=1100)	78% (n=858)	36% (n=307)
36-45 (n=1204)	78% (n=939)	33% (n=309)
46-55 (n=1706)	78% (n=1363)	32% (n=430)
56-65 (n=2223)	82% (n=1815)	28% (n=504)
66-75 (n=2902)	81% (n=2355)	17% (n=408)
76-85 (n=3029)	78% (n=2355)	10% (n=225)
86+ (n=1646)	72% (n=1178)	4% (n=42)

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All patients (n=14579)	**79% (n=11453)**	**21% (n=2397)**

Table 2: Smoking status and prevalence by age

Specialty	Count	Percentage with Smoking status recorded	Of those with smoking status recorded, percentage of current smokers
Surgical specialty	6135	77% (n=4733)	21% (n=972)
Respiratory medicine	1779	85% (n=1506)	23% (n=346)
Other medical specialties	6000	78% (n=4688)	21% (n=1007)
Other	377	77% (n=329)	14% (n=46)
Obstetrics and gynaecology (not maternity)	288	68% (n=197)	13% (n=26)
All patients	**14579**	**79% (n=11453)**	**21% (n=2397)**

Table 3: Smoking status and prevalence by specialty

B. How many patients had smoking, non-cigarette or vaping status recorded?

Smoking status was documented in 79% of medical records with 21% of patient's current smokers. Non-cigarette use (i.e. shisha, marijuana, heat-not-burn devices) was documented in 39% of medical records. Figure 1 provides a comparison to 2019 and 2016 data.

The 2021 audit was the first ask specifically about vaping (the inhalation of nicotine in a vapour (rather than smoke) using an e-cigarette or other device designed for this purpose). Vaping status was documented in only 6% (n=901) of medical records and 16% (n=146) of patients reporting current use of a vape device.

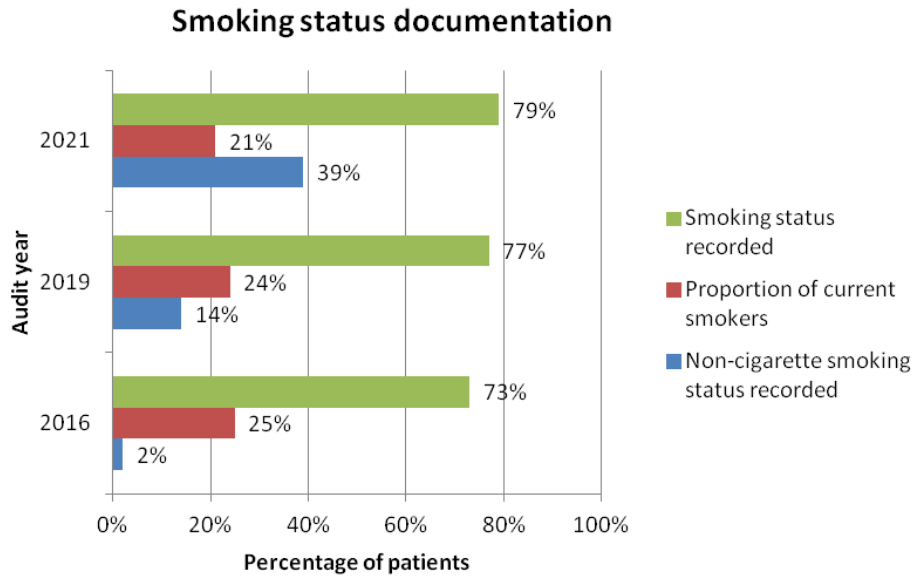

Figure 1: Comparison of smoking status data to previous audits

C. How many smokers were offered Very Brief Advice and a referral to smoking cessation services?

The 2021 audit asked specifically if patients were offered Very Brief Advice (VBA) after being identified as current smokers. Of the 2397 patients who smoked, 45% (1070) were offered VBA.

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There was evidence of a subsequent offer of referral to a smoking cessation service in 40% (n=966) of cases. This compares to 49% of patients in 2019. 47% (452/966) subsequently declined, 27% (260/966) were referred to a hospital smoking service and 10% to a community service (99/966). Of the patient's referred to a hospital smoking service, 80% (206/256) were reviewed by that service during their admission – this figure represents only 9% of the current smokers in this audit. See Figure 2.

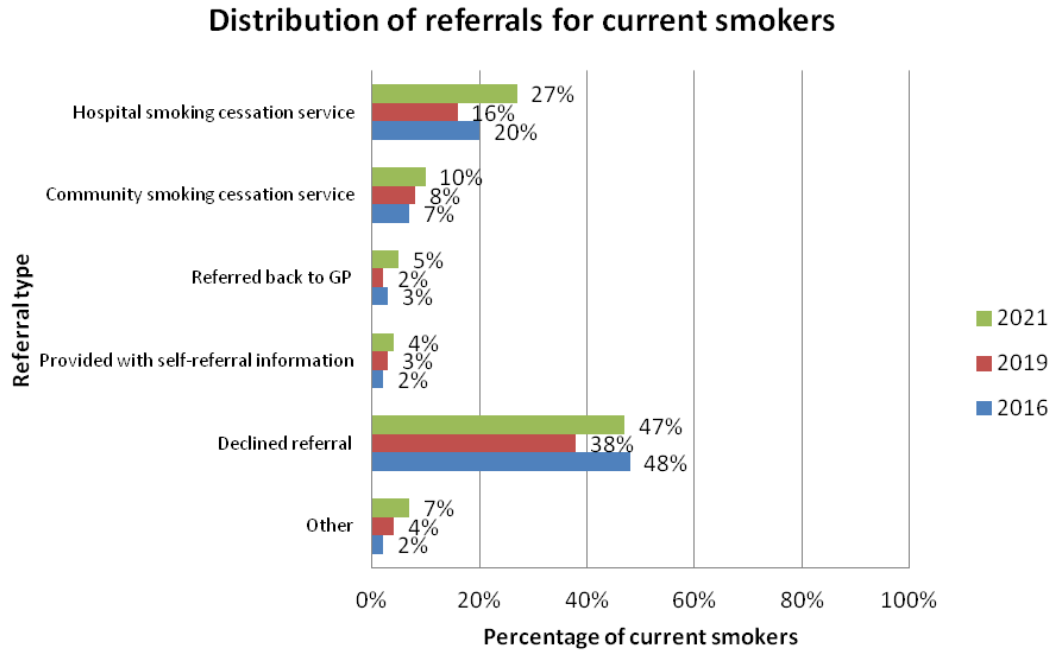

*Figure 2: Distribution of referrals made for current smokers (expressed as a percentage of the current smokers who had evidence of an offer of referral) *Note that values for 2019 and 2016 do not total to 100% owing to a difference in the phrasing of this question in the 2021 audit.*

D. How many smokers were offered licensed pharmacotherapy for tobacco dependence whilst an inpatient?

Evidence that licensed pharmacotherapy was offered to current smokers was present in 32% (n=776) of cases. This figure is similar to 2019 when 31% of current smokers were offered licensed pharmacotherapy and remains an improvement on 2016 when only 5% were offered this treatment. The breakdown of pharmacotherapy prescribed is provided in Figure 3.

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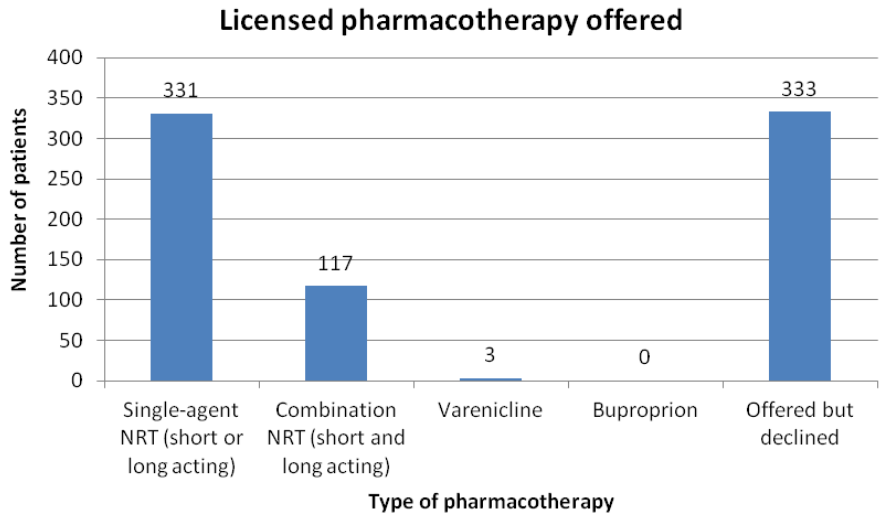

Figure 3: licensed pharmacotherapy offered to current smokers in the 2021 audit (NRT – nicotine replacement therapy)

E. Discharge and follow-up

Where recorded, only 10% (n=235) of patients were discharged with licensed pharmacotherapy for tobacco dependence. Most of these patients, 71%,(n=167) were issued single agent NRT; 28% (n=65) were issue combination NRT and 1% (n=2) offered varenicline.

Attendance at a follow-up smoking cessation service upon discharge was evident for only 3% (n=71) of patients (see Table 4). An assessment of abstinence 4 weeks after discharge was undertaken for 9% (n=222) of patients – 10% (n=22) of these patients self-reported abstinence, only 1 patient had chemical validation of abstinence and the rest, 90% (n=199) were not abstinent.

Type of follow-up	Proportion of smokers
Hospital stop smoking service	2% (n=42)
Community stop smoking service	1% (n=29)
Patient did not attend	2% (n=56)
No follow-up arrangements made	29% (n=696)
Patient declined follow-up	13% (n=300)
Not possible to ascertain	53% (n=1274)

Table 4: Attendance at follow-up smoking cessation service after discharge

F. Vaping as a smoking cessation tool

The option of vaping as a smoking cessation tool was not explored with the majority (98%, n=2359) of current smokers and <1% of patients (n=17) were offered a vaping kit for use during and after admission, with only 1 patient accepting this offer. Of the 146 patients reporting current use of a vape device, 6% (n=9) were allowed to use their existing vape kit during the admission and the remaining patients had no offer or discussion about use of vaping as an inpatient.

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Part 2 - audit of smoking cessation services and policies at participating institutions

A. Smoke free grounds

Of the 119 institutions, 90% (n=107) had a smoke-free policy prohibiting smoking anywhere on hospital grounds yet 18% (n=22) continued to offer designated smoking areas (compared to 28% in 2019). Enforcement of smoke-free areas continued to be poor (see Figures 4 and 5).

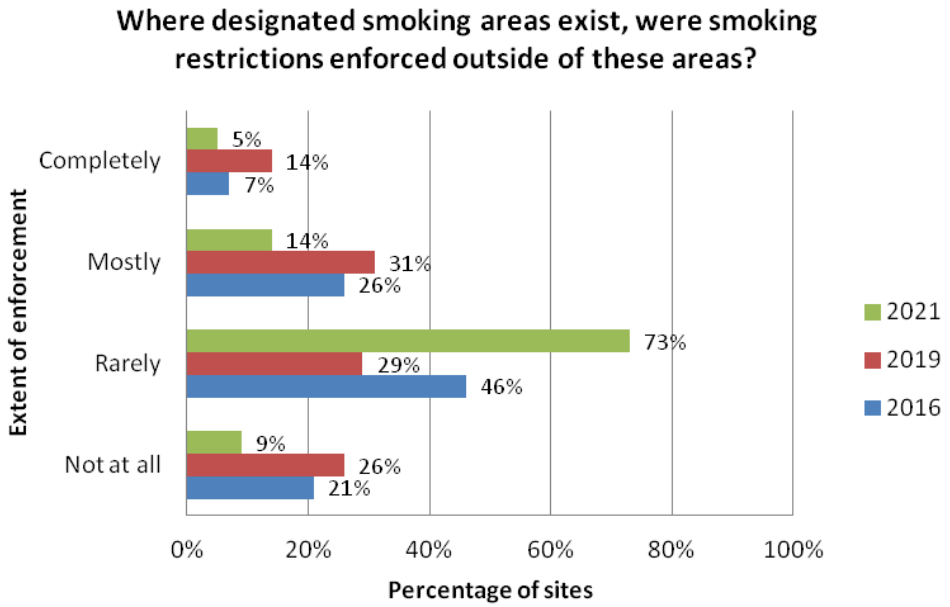

Figure 4: where designated smoking areas exist, to what extent were smoking restrictions enforced outside of these areas – comparison with 2019 and 2016 date (sample size 2021 = 22; 2019 = 35; 2016 = 57)

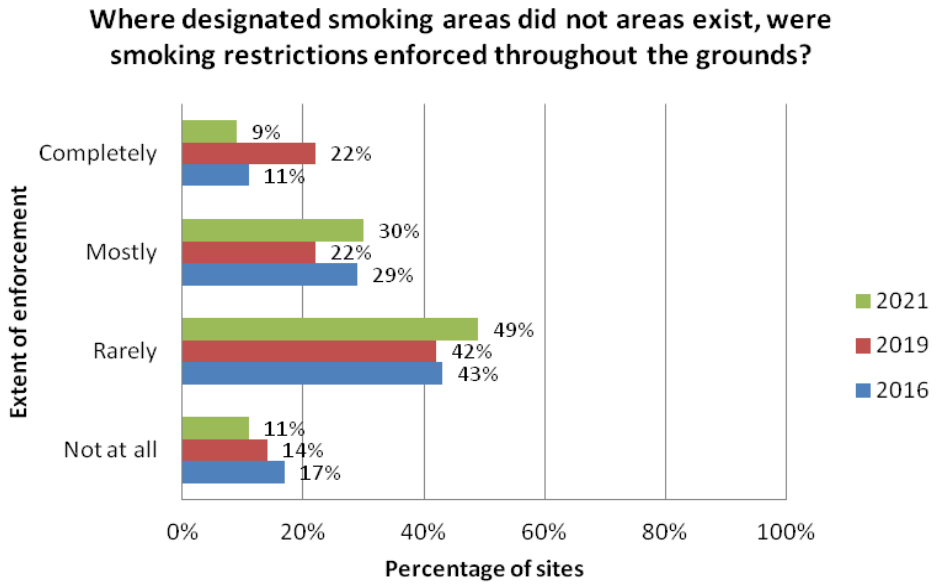

Figure 5: where designated smoking areas did not exist, to what extent were smoking restrictions enforced outside of these areas – comparison with 2019 and 2016 date (sample size 2021 = 97; 2019 = 89; 2016 = 85)

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B. Vaping on Hospital Grounds

30% (n=36) of the institutions permitted vaping on hospital grounds with 8% (n=9) having designated vaping areas and one institution also allowing this within selected internal sites. 56% (n=67) of institutions did not permit vaping anywhere on hospital grounds. Only 2 trusts reported offering a vaping kit as part of a tobacco dependence support package.

C. Access to smoking cessation services

When compared to the 2019 audit, more institutions reported a dedicated space to document a patient's smoking status (and act as a prompt for a clinician to inquire as such) within specialty specific admission documentation – see Table 5:

	2021	**2019**
Medical Clerking Proforma	90% (107/119)	86% (106/124)
Surgical Clerking Proforma	84% (99/119)	72% (89/124)
Obstetrics and Gynaecology Clerking proforma	71% (84/119)	60% (75/124)
Elective Clerking Proforma	71% (85/119)	64% (79/124)

Table 5: Capture of smoking status within specialty specific clerking proformas across 2021 and 2019 audits

Of the 119 institutions participating in the audit, 41% (n=49) had access to a hospital based-smoking cessation service **on the premises** compared to 38% in 2019. In 26% (n=10) of the cases, this was delivered by an external provider

Of those institutions with access to a hospital based smoking cessation service (on their premises or otherwise), only 49% (52/107) had a formal referral pathway to this service accessible to all healthcare professionals – a similar figure to 2019 (48%). Table 6 below outlines some of the specific interventions offered by hospital-based smoking cessation services. Furthermore, where recorded, only 37% of hospitals could always provide current smokers with access to a hospital smoking cessation practitioner (HSCP) as an inpatient compared to 49% in 2019 and 35% in 2016.

Intervention	**Proportion of institutions**
An initial consultation lasting up to 40 minutes	31% (37/119)
An initial consultation lasting 40-60 minutes	8% (10/119)
Weekly follow-up appointment 10-20minutes, for at least 4 weeks in the first month after stop date	19% (23/119)
A validated method for confirming a patient has stopped smoking 4 weeks after quit date	18% (21/119)
Phone call contact at 3 and 6 months	13% (16/119)
Self-reported quitters offered a final appointment at 12 months	9% (11/119)

Table 6: Proportion of institutions with hospital based smoking cessation services offering specific interventions to support current smokers.

90% (n=107) of institutions reported having access to a community based smoking cessation service, compared to 85% in 2019. Of these, 85% (91/107) had a formal referral pathway to this service accessible to all healthcare professionals compared to 75% in 2019.

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Following discharge, the majority of institutions (92%, n=109) had a system in place to allow follow-up and ongoing support of smokers who wished to quit: 20% (24/119) offered this via a hospital smoking cessation service and 86% (102/119) via a community-based service. These figures are similar to the 2019 audit

D. Leadership and delivery of the service

Of the 119 institutions, 47% (n=56) reported that smoking cessation was supported by a senior clinician (consultant, nurse consultant or equivalent) compared to 35% in 2019. However, 66% of the trusts (37/56) reported no allocated time in this clinician's job plan to support this work.

36% (n=43) of institutions had a dedicated Hospital Smoking Cessation Practitioner comprising a mix of nursing and non-nursing posts mostly at Band 6 (Agenda for Change) and working a median of 37.5 hours per week.

E. Pharmacotherapy

98% (n=117) institutions provided one or more forms of licensed pharmacotherapy for tobacco addiction. This primarily consisted of nicotine replacement therapy (NRT) (see Figure 6). Only 61% (n=72) of trusts had Varenicline on formulary – this represents an increase on 2019 where the figure was 53% but is likely affected by the current product recall and supply disruption.

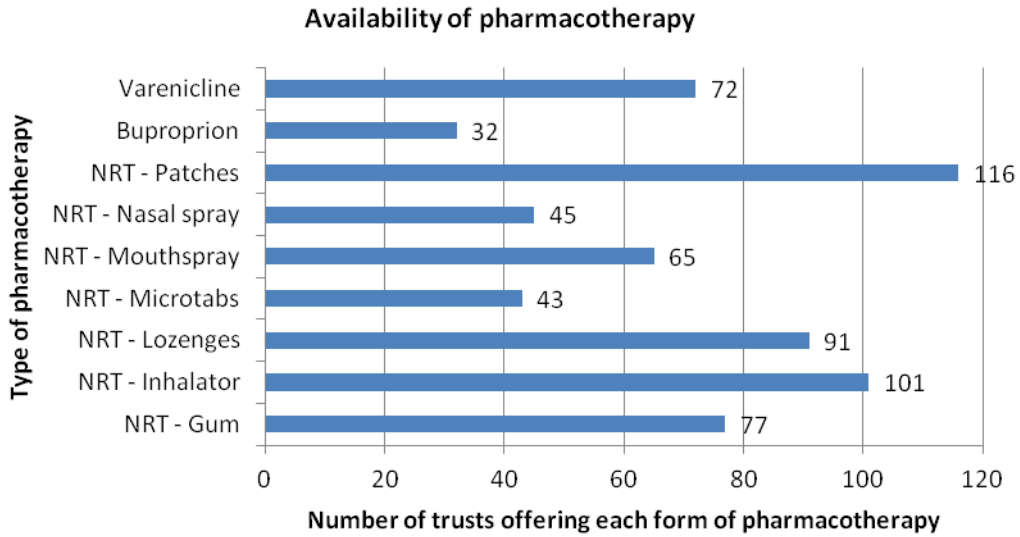

Figure 6: Availability of licensed pharmacotherapy (NRT – nicotine replacement therapy)

72% (n=82) of these institutions had a guideline/protocol to support clinicians when prescribing pharmacotherapy for tobacco addiction.

Where available, health and social care professionals were able to prescribe or supply pharmacotherapy in 47% (20/43) of institutions to inpatients which compares to 63% in the 2019 audit and 23% in the 2016 audit. Within most institutions, other professionals were able to prescribe or recommend pharmacotherapy (Figure 7).

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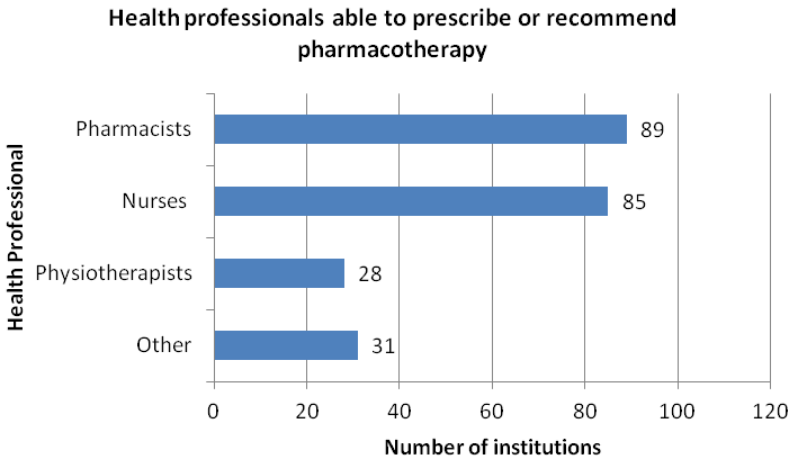

Figure 7: Health professionals able to prescribe or recommend licensed pharmacotherapy for tobacco addiction

F. Training of staff in delivering smoking cessation

Only 50% (n=59) of trusts report offering regular smoking cessation training to frontline staff; this compares to 50% (62/124) in the 2019 audit and 44% in the 2016 audit. This comprises a mix of professionals (Figure 8).

Figure 8: Number of institutions offering smoking cessation training to each staff group

Discussion

The 2021 BTS Management of Tobacco Dependency in Acute Care Trusts audit provides a new level of granularity into the provision of evidenced-based interventions for patients with tobacco dependency admitted to acute care trusts in the UK. Taken alongside the findings of the 2016 and 2019 national audits, the results shows that there has been little improvement over a six-year audit

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cycle. Therefore, radical action needs to be taken to stand any chance of achieving the NHS Long Term Plan aim by 2022/23.

The key findings of concern are:

- Only 9% tobacco dependent patients admitted to acute care trusts completed a specialist consultation with a hospital-based tobacco dependency practitioner. This misses the teachable moment of a hospital admission, during a period of enforced abstinence, away from the normal cues to smoke where a specialist treatment plan could be agreed and commenced.
- Only 5% of patients with tobacco dependency are provided with the most effective interventions, recommended by NICE, to treat this disease. The two most effective interventions (varenicline and vaping) are non-existent in acute care treatment pathways.
- Only 3% of patients with tobacco dependency access ongoing treatment services beyond discharge and therefore stand little chance of continuing a treatment plan and quit attempt.

In addition to these key findings there are broad indications of a lack of hospital-wide systems and services to support the implementation of best practice; 21% of all patients admitted to hospital do not have a smoking status recorded, 55% of patients who smoke are not provided with brief advice, 28% of trusts do not have a standardised prescribing protocol for tobacco dependency and 64% of trusts do not have hospital-based tobacco dependency practitioners. It is therefore of little surprise that outcomes to assess the effectiveness of acute care tobacco dependency services are not possible to ascertain and are likely to be very poor. Just 9% of smokers underwent a 4-week assessment of abstinence post discharge and a total of 22 patients that smoke admitted to hospital across the audit were identified to be smoke-free at 4 weeks (<1%).

The model of care for delivering effective tobacco dependency treatment in acute trusts includes the three care bundles described below:

Admission bundle – delivered by the admitting clinicians

- ✓ Screening of smoking status of all admissions supported by an electronic system
- ✓ Provision of brief advice to all patients that smoke
- ✓ Commencing combination NRT for all smokers in line with a standardised protocol
- ✓ Referral of every patient who smokes to the specialist tobacco dependency service (automated referral supported by an electronic system)
- ✓ Information on smoke-free site provided (supported by vaping-friendly external grounds)

Specialist bundle – delivered by the hospital tobacco dependency treatment service

- ✓ Specialist consultation including behaviour change support
- ✓ Review of NRT and amendments as required
- ✓ Offer of varenicline
- ✓ Offer of vaping kit
- ✓ Agree a support package after discharge

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Discharge bundle

- ✓ Provision of ongoing pharmacotherapy and specialist support beyond discharge
- ✓ Follow-up can be provided by hospital service, community stop smoking service or community pharmacy as per local pathways
- ✓ Outcomes captured and included in the performance report for the hospital service

This current audit and previous audits have demonstrated poor adherence and infrastructure to deliver this optimal service model.

National Improvement Objectives

The National Improvement Objectives are as follows.

1. **All hospitals should identify a healthcare professional(s) to lead on the delivery of a tobacco dependency treatment service and appoint an executive level board member to support the service** ***(Timeframe: Immediate)***

Most trusts are still lacking a dedicated clinical lead with programmed activity to deliver an evidence-based tobacco dependency treatment service. This must be supported by adequate executive-level support and programme management to ensure appropriate resourcing, pathway development, regular training and an emphasis on engendering a culture change recognising tobacco dependency as a medical problem rather than a lifestyle choice. Implementing and achieving compliance with smoke-free grounds will also be crucial and requires a commitment from all senior leaders within a trust. Staff, patients and visitors must feel empowered to be able to signpost and offer support to those who would otherwise be smoking on hospital grounds.

2. **All hospitals should introduce a system of regular local data collection of adult inpatient tobacco-dependency pharmacotherapy prescribing** ***to drive on-going improvement and further encourage delivery of NICE recommended interventions*** ***(Timeframe: 3-6 months)***

All patients who smoke must be offered, on an opt-out basis, NICE-recommended, most clinically effective tobacco-dependency pharmacotherapy. Evaluating the uptake of this crucial intervention through a system of continuous local data collection will allow trusts to evaluate the service they provide and drive forward further improvement.

3. **Ensure all adult patients admitted to hospital have their smoking status recorded** ***(Timeframe: 3-6 months)***

The tobacco dependency treatment pathway begins with the systematic identification of all active smokers admitted to hospital. An electronic system that records this status can then be utilised to support the uptake and provision of evidenced based interventions at the point of admission.

4. **Introduce a training package available to all front-line staff to ensure a minimal level of competence in supporting and treating tobacco dependency (e.g. Very Brief Advice) and implement a system of monitoring uptake** ***(Timeframe: 6 months)***

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The frontline healthcare workforce must be supported by targeted education in the delivery of very brief advice and the provision of combination NRT to all patients that smoke admitted to hospital as a minimum standard. The knowledge and training required for more expert interventions such as varenicline and vaping can be provided to clinicians with a greater depth of experience and clinical need. Treating tobacco dependency should be a matter of course and embedded into all clinical contact.

5. **At least 90% of tobacco dependent adult inpatients to receive Very Brief Advice during the course of their inpatient stay** ***(Timeframe: before next national audit)***

Frontline clinicians should be prompted to provide very brief advice during the admission process and provide combination NRT, in line with a standardised protocol, to begin mitigating the risk of withdrawal immediately and set the tone for a smoke-free admission. This approach should also allow for automated referrals to the hospital tobacco dependency treatment service and ensure an opt-out model of care.

6. **Offer all hospitalised tobacco dependent patients referral to a specialist tobacco dependency treatment service** ***(Timeframe: before next national audit)***

The NHS must provide an opt-out tobacco dependency service to all smokers that ensures access to the most effective and evidence-based treatments to this disease. All patients that smoke must be provided access to specialist assessment and behaviour change support and the more specialist interventions that require a greater depth of knowledge to discuss above that of combination NRT provided at admission. All smokers require access to varenicline and vaping as highly effective interventions to support them becoming smoke-free. Reviewing smoke-free policies to permit vaping where smoking is prohibited might further support tobacco dependent patients remain abstinent and actually allow smoke-free measures to succeed[8].

7. **Establish a system to monitor the number of patients referred for Very Brief Advice and to specialist tobacco dependency treatment services** ***(Timeframe: next 12 months)***

All hospital trusts should establish a system to monitor the uptake of these interventions to provide key performance indicators of the service they provide and to drive further improvements.

Conclusion

The third BTS Management of Tobacco Dependency across Acute Care Trusts Audit highlights inadequacies in the treatment of tobacco dependence amongst patients admitted to hospital and demonstrates little if no improvement from the 2019 and 2016 audits. This report has again set ambitious national improvement objectives which are entirely aligned with NHS Long Term Plan commitments on tobacco dependence treatment, and represent a real opportunity to finally tackle the largest cause of premature death and disability in the UK.

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