British Thoracic Society
National Smoking Cessation Audit Report 2019
National Audit Period 1 July – 30 August 2019

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Number of records submitted: 13,647
Number of Participants: Part 1 = 125 Institutions; Part 2 = 124 institutions (101 Trusts)

Summary/Abstract

The 2019 national BTS Smoking Cessation Audit was the second comprehensive audit of smoking cessation activity in NHS acute hospitals using BTS[1] and NICE[2,3] standards for secondary care. Since the first audit conducted in 2016, the NHS has made a commitment to offer **all inpatient smokers NHS-funded tobacco treatment by 2023/4 in England** within 'The NHS Long Term Plan.' However, the findings of this audit, whilst demonstrating a modest improvement when compared to 2016, suggest that this target is unlikely to be met.

When compared to 2016, more smokers are being asked if they would like to have support with their tobacco dependence and are subsequently being referred to a hospital or community-based stop smoking service. Furthermore, a greater proportion of patients are being offered licensed Nicotine Replacement Therapy. However, the improvements are from a very low baseline and **multiple generations of smokers continue to miss out on the indisputable benefits of stopping smoking.**

At an institutional level, whilst more hospitals are enforcing completely smoke free grounds, this figure stands at only 23% and many trusts still report a lack of support from senior members of staff. Dedicated hospital smoking cessation practitioners and formal, accessible referral pathways are still lacking. Most hospitals had one or more form of basic smoking cessation pharmacotherapy available but provision of non-nicotine replacement therapy such as Varenicline continues to be poor. Additionally, only 50% of frontline staff are offered formal regular smoking cessation training. Staff are therefore not receiving the right training or tools to help smokers quit.

In summary, whilst there has been a modest improvement when compared to the 2016 audit, adherence to the national standards continues to be poor. The NHS Long Term Plan aims to offer all inpatient smokers across England NHS-funded tobacco treatment by 2023/24. Similarly the Scottish government's tobacco control action plan 2018-2022[4] aims to ensure "that all smokers admitted to hospital or attending out-patient appointments are provided with timely advice and support to tackle their nicotine addiction, even if their reason for attending is not itself smoking-related"., Likewise the Welsh Respiratory Health Delivery Plan[5] aims to "increase the provision of smoking cessation within Welsh hospitals". This audit demonstrates unequivocally that without a fundamental change in how helping smokers quit is perceived, prioritised and resourced by NHS organisations across the four nations, these targets are currently unachievable. The BTS supports all NHS organisations across the nations in striving to achieve this goal in secondary care.

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National Improvement Objectives:

1. Support ALL patients who smoke with a referral to an on-site specialist stop smoking service. **Target: 90%**
2. Offer nicotine replacement therapy to ALL patients who smoke to reduce symptoms of nicotine withdrawal and promote smoking cessation. **Target: 90%**
3. Trust boards must take immediate steps and be held accountable to regulators in ensuring the leadership structure and resources are in place to develop a service that will offer ALL smokers, that spend one night or more in hospital, support in stopping smoking in line with the NHS Long Term Plan. **Target: 100%**

Timeframe: To be achieved by 2023/24

Key Findings

1. Just under 1 in 4 patients were not asked about their smoking status, similar to the 2016 audit.

2. The proportion of current smokers who were asked if they would like help to quit increased to almost 1 in 2 compared to 1 in 4 being asked in the 2016 audit.

3. One in eight patients who smoke were referred to a hospital or community-based smoking cessation service; an improvement on the data from 2016 where the figure was 1 in 13.

4. Licensed Nicotine Replacement Therapy (NRT) was offered to 1 in 3 current smokers to help them quit compared to only 1 in 20 in the 2016 audit.

5. 14% of patients had use of non-cigarette based products (e.g. e-cigarettes, marijuana, shisha, heat-not-burn) documented compared to a figure of 2% in the 2016 audit.

6. One in five hospitals completely enforce smoke-free grounds compared to 1 in 16 in the 2016 audit.

7. Almost twice the number of hospitals compared to 2016 have a hospital based stop smoking service, whether community or hospital funded (37% vs 16%).

8. A consultant lead supporting a smoking cessation service was present in 35% of hospitals compared to less than 25% in the 2016 audit. However, only 1 in 3 hospitals had a hospital funded smoking cessation practitioner compared to 1 in 2 in 2016. There was reliable outpatient access to hospital smoking cessation practitioners in only 1 in 6 hospitals.

9. A formal referral pathway to hospital or community-based smoking cessation services was only available in 42% and 69% of hospitals respectively (compared to 2016 when the figures were 54% and 62% respectively).

10. The majority of institutions (86%) utilised standard medical admission proformas which contained a dedicated space to document a patient's smoking status. This was less common for elective admissions (64%); obstetrics and gynaecology admissions (60%) and general surgical admissions (72%).

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11. Provision of pharmacotherapy within hospital formularies continues to be poor with only 1 in 2 trusts having Varenicline on its formulary.

12. Only 50% of frontline healthcare staff were offered regular smoking cessation training; a similar figure to the 2016 audit.

Standards / Guidelines / Evidence Base

This audit examined hospital-based smoking cessation services in UK hospitals from July to August 2019 and makes comparisons to a similar audit conducted in 2016. Part one of the audit focused on the key interventions of identifying people who smoke and offering them help to stop, and part two looked at the organisational infrastructure required to deliver these interventions.

The standards for this audit were drawn from the NICE Public Health Guideline Smoking: acute, maternity and mental health services,[2] the NICE Quality Standard Smoking: supporting people to stop,[3] the BTS Recommendations for Hospital Smoking Cessation Services for Commissioners and Health Care Professionals[1] and the Department of Health 'Tobacco control plan: delivery plan 2017 to 2022' guidance[6] .

Background

Whilst smoking rates have fallen significantly, smoking still accounts for more years of life lost than any other modifiable risk factor[7] and over half a million acute hospital admissions are directly linked to smoking[6]. The 2016 smoking cessation audit was the first of its kind and provided a detailed and comprehensive overview of how good we were at helping patients admitted to acute hospitals with their tobacco dependence.

We know from national standards that the best ways to treat tobacco dependent smokers attending hospitals include asking whether the patient smokes and referring them to an evidenced-based specialist stop smoking service. There should be availability of smoking cessation pharmacotherapy, maintenance of smoke-free hospital grounds, and senior leadership allocated to hospital-based smoking cessations 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 in line with 'The Ottowa Model by 2023/4[7].

The 2019 British Thoracic Society Smoking Cessation 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 first such audit undertaken in 2016 and allows for benchmarking against the aims of the NHS Long Term Plan.

Aims and Objectives

The aim of the audit was to examine whether a properly led and staffed hospital smoking cessation service was present, with adequate training for staff, and that smoking status was asked, and recorded for all patients, referral for smoking cessation treatment was made, pharmacotherapy for temporary abstinence was prescribed 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 second such audit to be undertaken and thus the outcomes will be compared to the findings of the 2016 audit.

The key objectives were:

1. To examine smoking cessation treatment across all hospital services and age groups.
2. 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. e-cigarettes, marijuana, shisha).
3. To determine the number of smokers who were asked if they would like to stop smoking, whether they were actually referred, to whom they were referred, referral pathways available and how this was communicated in the medical records.
4. To examine whether pharmacotherapy to treat smoking abstinence was on hospital formularies, immediately availability to patients via prescription or supply by hospital smoking cessation practitioners and whether there was a record of prescribing nicotine replacement therapy.
5. Establishing if smoke-free hospital grounds policies were fully enforced.
6. To determine whether hospitals had senior clinicians leading smoking cessation services with allotted time and in conjunction with dedicated hospital smoking cessation specialists
7. To determine the provision of training for staff on smoking cessation.
8. To determine whether performance against these key objectives have improved when compared to 2016 audit outcomes

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 under the care of a hospital doctor and admitted during the audit period of July and August 2019 (excluding maternity and mental health).

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 tool.

Part 1 - audit smoking status documentation and smoking cessation provision
This part involved screening the notes of inpatients – both smokers and non-smokers – to establish whether patients were being asked the fundamental question “do you smoke?” and if this was being appropriately recorded. This information would not be captured if notes were retrieved of smokers only. If patients were recorded as being current smokers, further questions were asked about the services they were offered.

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 wherever they were in the institution.

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

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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 - audit of smoking cessation services and policies at participating institutions
Participating institutions submitted details on their smoking cessation policies and services as at the time of the audit. Participants were requested to submit one return per hospital, unless services were combined under one trust. (Data for Part 1 were entered at individual record level by each participating hospital)

Results/Findings

Part 1 - audit smoking status documentation and smoking cessation provision

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

125 institutions participated with 13647 patient records submitted, from across the UK. 42% of patients were from surgical specialties (see Figure 1) and 76% were emergency admissions. The median age was 67 years, 50% were female. There were 1,100 fewer patients in total compared to the 2016 audit.

Where recorded, smoking prevalence was 27% in males, 21% in females (see Table 1). The highest prevalence was for those aged 26-45 years (40%), in patients admitted to respiratory medicine (29%) and in patients admitted as emergencies (26%) in line with 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	6775	76% (n=5151)	21% (n=1091)
Male	6872	78% (n= 5333)	27% (n=1437)
All	**13647**	**77% (n=10484)**	**24% (n=2528)**

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=612)	73% (n=446)	37% (n=167)
26-35 (n=966)	75% (n=727)	40% (n=291)
36-45 (n=1085)	76% (n=823)	40% (n=332)
46-55 (n=1668)	80% (n=1328)	38% (n=511)
56-65 (n=2117)	80% (n=1694)	30% (n=505)
66-75 (n=2902)	79% (n=2292)	18% (n=422)
76-85 (n=2816)	76% (n=2151)	12% (n=260)
86+ (n=1481)	70% (n=1023)	4% (n=40)
All patients (n=13647)	**77% (n=10484)**	**24% (n=2528)**

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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	5687	76% (n=4301)	23% (n=1006)
Respiratory medicine	2006	87% (n=1736)	29% (n=497)
Other medical specialties	5291	75% (n=3955)	23% (n=918)
Other	381	75% (n=286)	22% (n=63)
Obstetrics and gynaecology (not maternity)	282	73% (n=206)	21% (n=44)
All patients	**13647**	**77% (n=10484)**	**24% (n=2528)**

Table 3: Smoking status and prevalence by specialty

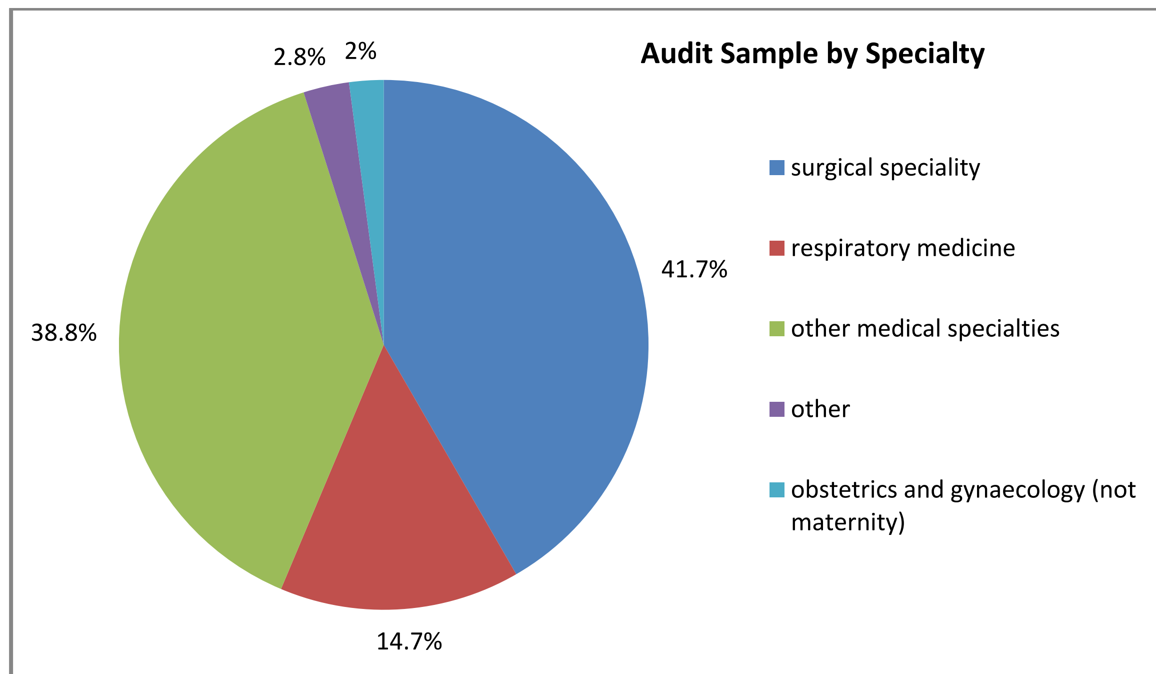

Figure 1: Audit sample by specialty

2. How many patients had smoking status recorded? *The expected standard is 100%.*

Smoking status was documented in 77% of medical records, with non-cigarette use (i.e. shisha, marijuana, e-cigarettes, heat-not-burn devices) documented in 14% of medical records (see Table 4). For patients where smoking status was recorded, 24% of patients were current smokers (see Table 4).

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	2019 Audit	2016 Audit
Smoking status Recorded	77% (n=10484)	73%
Non-cigarette smoking status recorded	14% (n=1911)	2%
Percentage of current smokers	24% (n=2528)	25%

Table 4: Comparison of smoking status data to 2016

3. How many smokers are asked if they would like to quit and were referred to stop smoking services?

Of 2528 patients who smoked, 44% (1105) were asked if they would like to quit (compared to 28% in the 2016 audit). Of those referred to smoking cessation services, 16% (196/1241[a]) were referred to a hospital smoking service and 8% to a community service (97) (see Figure 2).

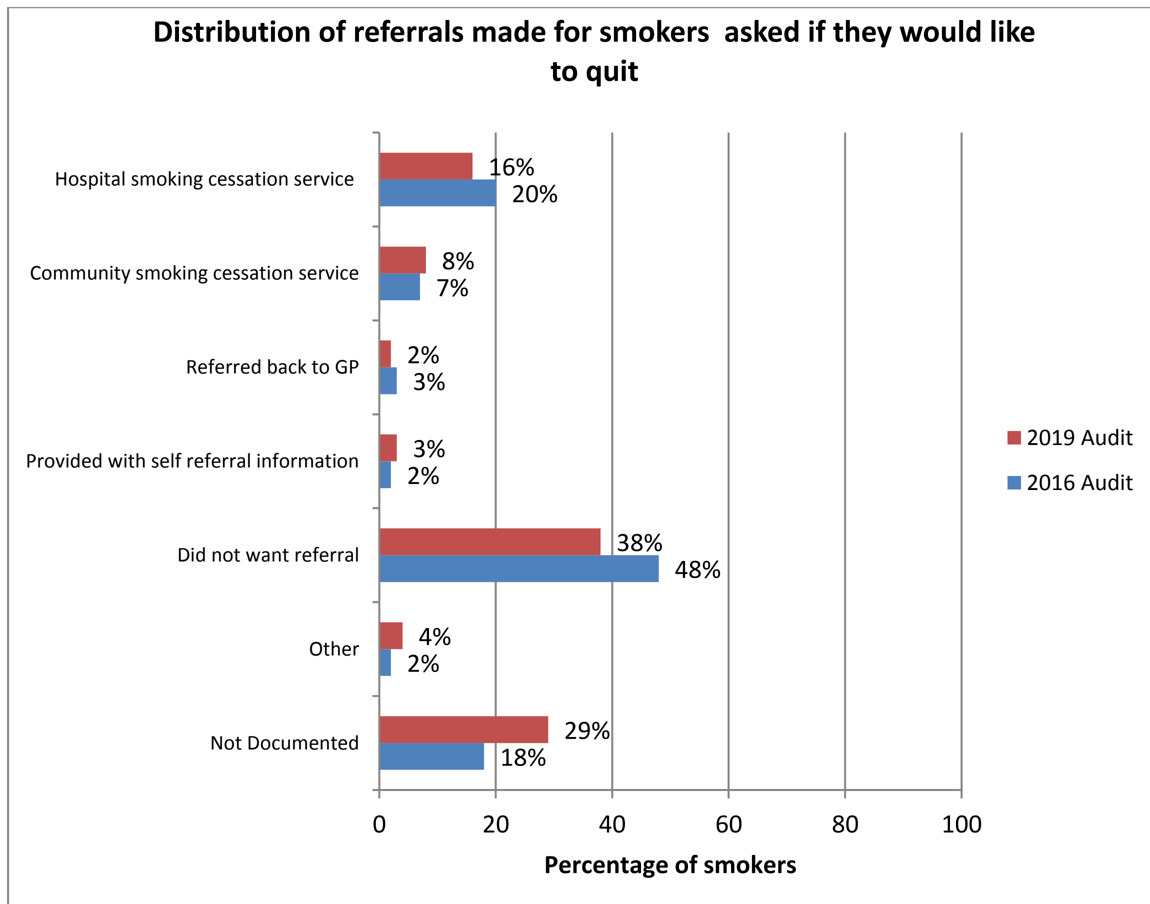

Figure 2: Bar chart showing distribution referrals made for smokers (expressed as a percentage of the total numbers of smokers in each audit sample)

[a] The distribution of referrals in 2016 was calculated according to whether a smoker was offered smoking cessation, whilst in 2019 the distribution of referrals was calculated according to all patients that were referred

4. How many smokers were offered licensed nicotine replacement therapy (NRT) to help them abstain from smoking whilst inpatients?

Evidence that current smokers were offered the use of licensed nicotine replacement therapy to help them abstain was present in 31% of cases (777 from a total of 2528 responses).

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

1. Smoke-free grounds

Of the 124 institutions, 28% had designated smoking areas compared to 41% in the 2016 audit (see Figure 3). Enforcement of smoke-free areas continued to be poor regardless of whether the institution had entirely-smoke free grounds or designated smoking areas (see Figures 4 and 5 below).

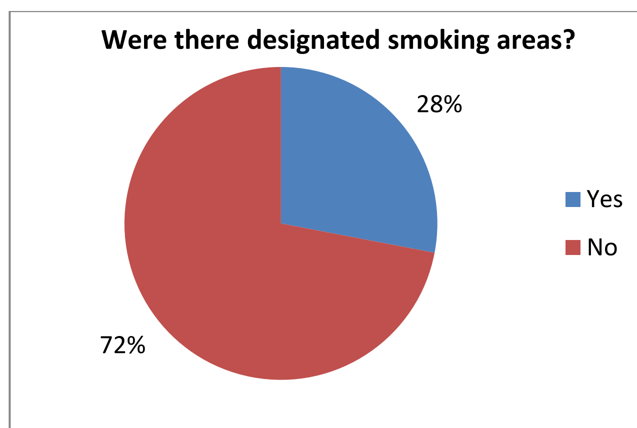

Figure 3: Were designated smoking areas put in place?

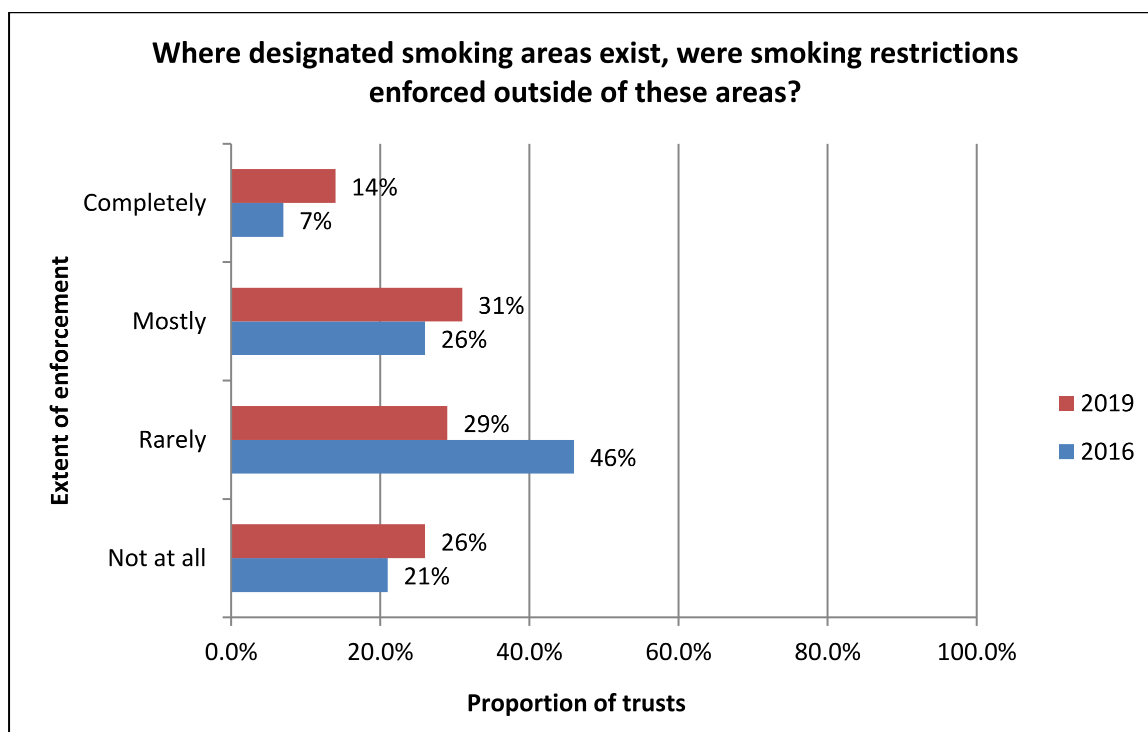

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Figure 4: Where designated smoking areas exist, were smoking restrictions enforced outside of these areas – comparison with 2016 data (total sample size in 2019 = 35 institutions; in 2016 =57 institutions).

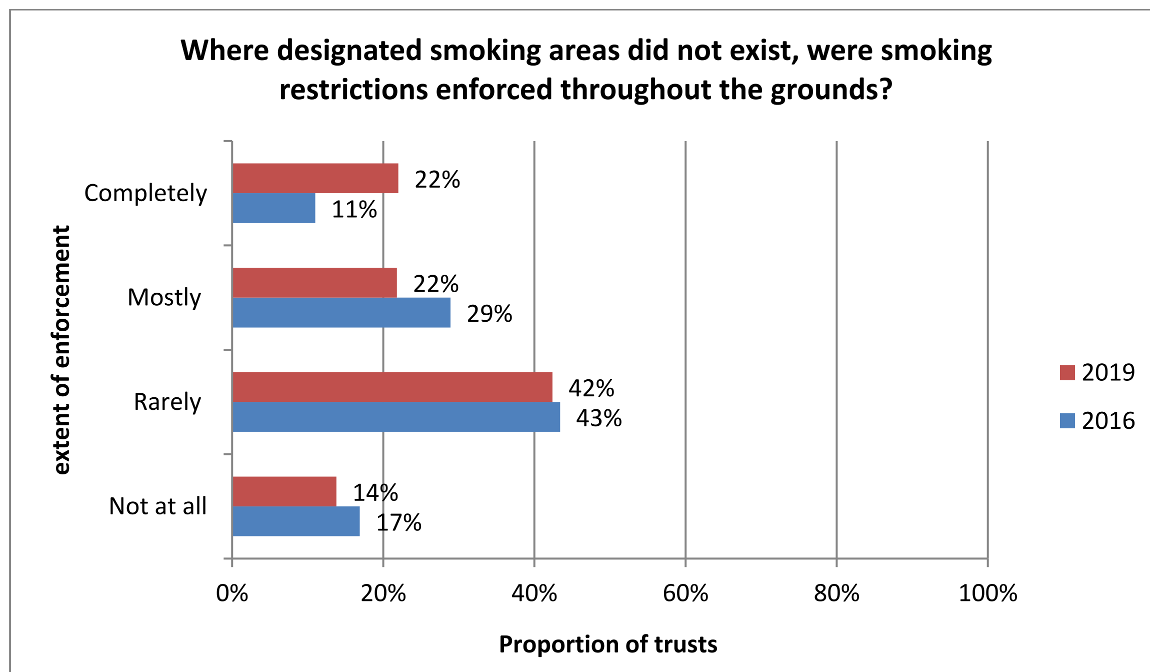

Figure 5: Where designated smoking areas do not exist, were smoking restrictions enforced throughout the grounds – comparison with 2016 data. (total sample size in 2019 = 89 institutions; in 2016 = 85 institutions)

2. Access to smoking cessation services

A dedicated space to document a patient's smoking status (and act as a prompt for a clinician to inquire as such) was present in most standardised medical admission proformas (86%). However, only 64% of elective proformas, 72% of surgical proformas and 60% of obstetrics and gynaecology proformas contained a dedicated space for the documentation of this information.

Of 124 institutions, 38% (n=47) had access to a hospital based- smoking cessation service **on the premises**. In 43% of the cases, this was delivered by an external "3rd party" provider whether commercial or otherwise. 85% of hospitals state that their trusts (n=105) had access to a community based smoking-cessation service.

This compares to 56.4% of institutions having access to a hospital-based service and 77.8% having access to a community based service in the 2016 audit.

Of all institutions with access to a hospital-based smoking cessation service, only 48% (52/109) had a formal referral pathway to this service accessible to all healthcare professionals. Where recorded, 49% could always provide inpatient access to a HSCP (Hospital Smoking Cessation Practitioner) during their stay compared to 35% in 2016. Only 15% could always provide outpatient access to a HSCP during their visit compared to 34% in the 2016 audit.

Of all the institutions with access to a community-based smoking cessation service, 75% (79/105) had a formal referral pathway to this service accessible to all healthcare professionals.

Following discharge, most institutions had a system in place to allow follow-up and ongoing support of smokers who wished to quit: 20% (25/124) offered this via a hospital smoking cessation service and 82% (102/124) via a community-based service.

3. Leadership and delivery of a service /dedicated hospital smoking cessation practitioners

Of the 124 institutions audited, only 35% (n=43) had support by a consultant or nurse consultant.

32.5% of institutions had a dedicated Hospital Smoking Cessation Practitioner who worked a median of 37.5 hours per week.

4. Pharmacotherapy

98% of institutions provided one or more forms of pharmacotherapy (121/124) for smoking cessation which largely consistent of Nicotine Replacement Therapy (NRT) (see Figure 6). Only 53% had Varenicline on formulary (64/121).

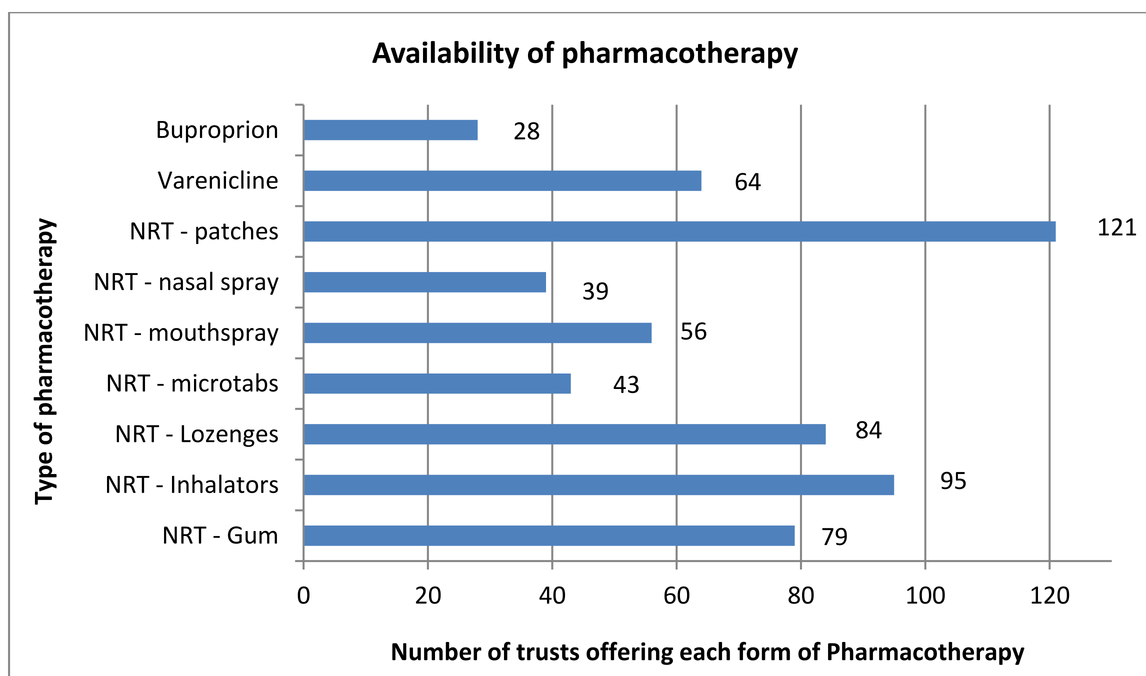

Figure 6: Availability of pharmacotherapy (total respondents = 121)

Where available, HSCPs were able to prescribe or supply pharmacotherapy in 63% (26/41) of institutions to in-patients which compares to 23% in the 2016 audit. Within most institutions, other professionals were able to prescribe or recommend pharmacotherapy (see Figure 7).

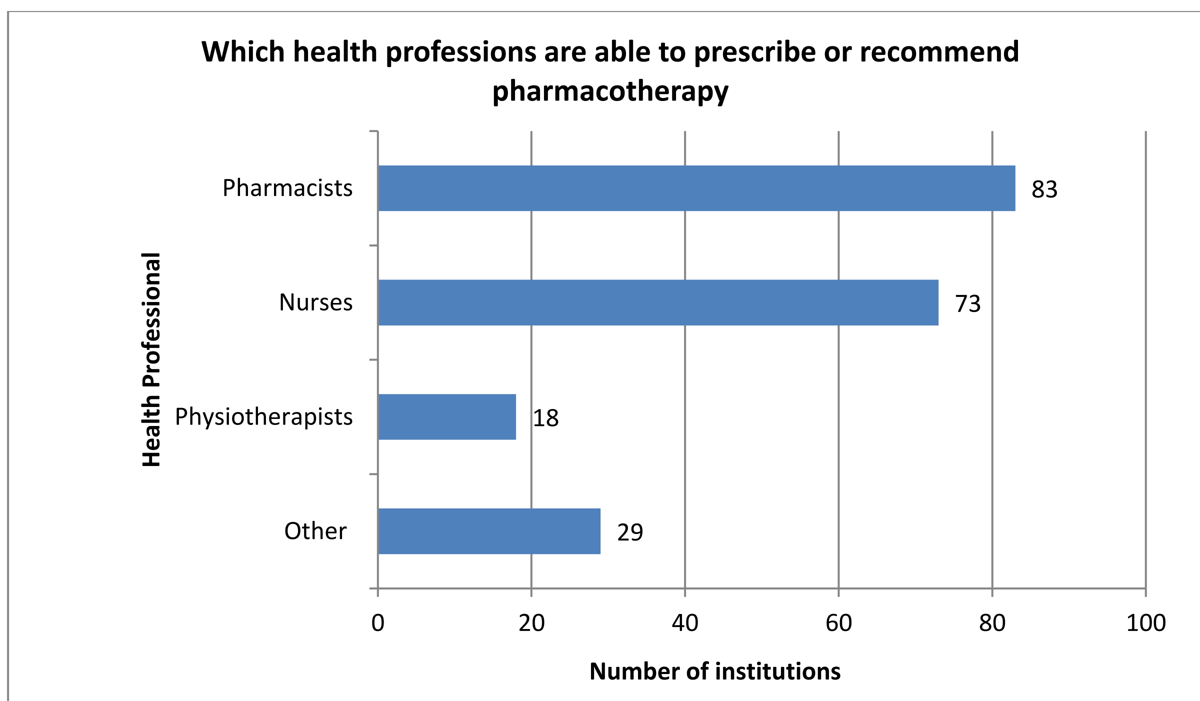

Figure 7: Health professionals able to prescribe or recommend pharmacotherapy (total = 108 records)

5. Training of staff in smoking cessation

50% of institutions (n= 62) offered regular smoking cessation training to frontline staff compared to 44% in the 2016 audit. This comprised a mix of professionals (see Figure 8)

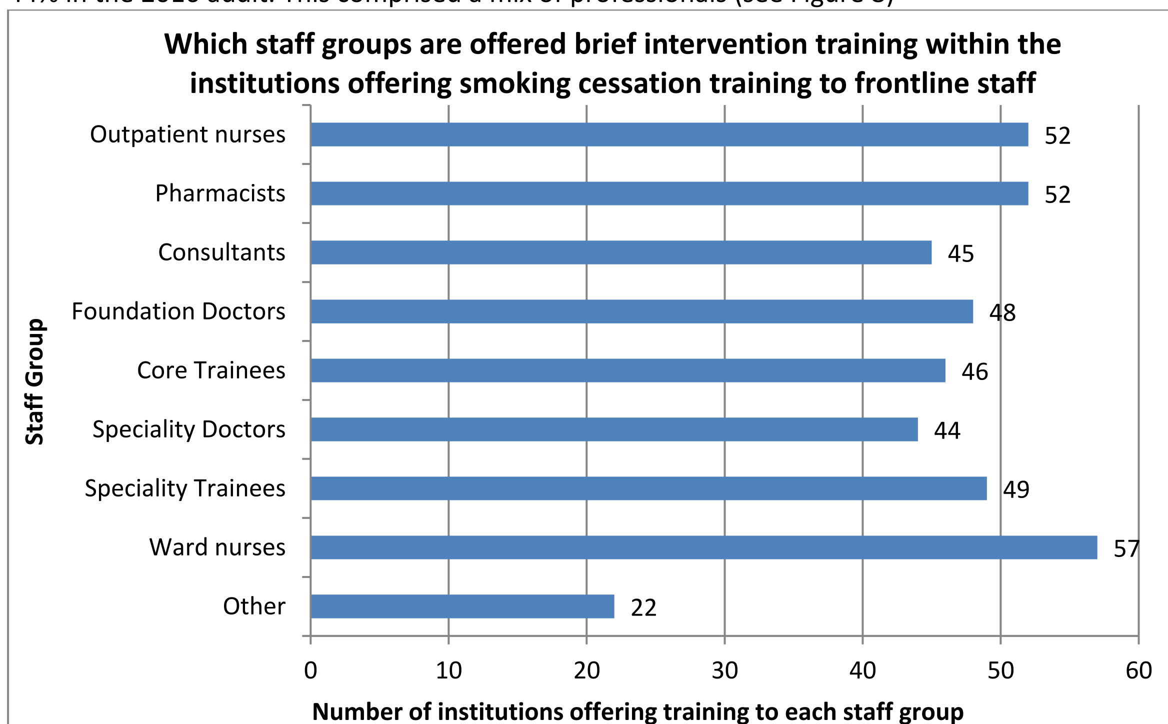

Figure 8: Staff groups offered brief intervention training (total number of respondent institutions= 62)

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Conclusions/Observations

This is the second national BTS Smoking Cessation Audit measuring how hospitals are treating people with tobacco dependence and provides an insight into the potential progress since the first such audit in 2016. Although the results of the audit, involving 125 hospitals and 13,647 patients, demonstrate modest improvements, significantly more needs to be done to stand any chance of achieving the NHS Long Term Plan aim by 2023/24. In particular, this includes asking smokers if they would like to quit; referring them to appropriate services and offering licensed NRT.

Approximately 1 in 5 patients within this audit were current smokers, a slight reduction on the figure in 2016 (1 in 4). Documentation of smoking status is prompted by standardised admission clerking proformas across the range of hospital specialties, although more commonly in medical disciplines compared to surgical specialties. We are asking more patients (14% in 2019 vs 2% in 2016) about the use of non-cigarette products such as marijuana, shisha and vaping but this still remains an area requiring considerable improvement.

We appear to be getting better at asking smokers if they would like help quitting and subsequently referring a greater proportion (when compared to 2016) to hospital or community-based smoking cessation services. Furthermore, licensed nicotine replacement products are being offered to far more smokers (1 in 3) compared to 2016 (1 in 20) but availability of other pharmacotherapy continues to be poor with vareniciline on formulary in only 1 in 2 hospitals.

Identifying some of the drivers for the improvements established in this audit is crucial to ensure sustained and continued progress. Improvements since the last audit may be partly explained by the introduction of national CQUINs[7] relating to smoking (commissioning for quality and innovation), alongside specific actions taken by organisations following the first audit and the subsequent BTS Smoking Cessation QI Tool. However, it is important to reflect that the improvements are from a very low baseline in 2016, when up to 75% of smokers were not being asked if they would like to have help to stop quitting. Half of smokers are **still** not being engaged with in 2019.

The NHS Long Term Plan makes a commitment to offer **all inpatient smokers NHS-funded tobacco treatment by 2023/4**. The findings of this audit highlight that we are highly unlikely to achieve this and that immediate action has to be taken now by all NHS acute trusts. The gap in resources and leadership exemplified in this audit could not be clearer.

At an institutional level, clinicians are not being supported to take on leadership roles to support smoking cessation. Whilst a greater proportion of HSCPs were able to offer and prescribe smoking cessation pharmacotherapy, only 68% of institutions that employed such practitioners did so for 37.5 hours or more per week. Fewer trusts appear to have access to an on-site smoking cessation service and the referral pathways remain inaccessible to all.

Eighty percent of hospitals could not guarantee that hospital grounds completely enforced their smoking restrictions, whatever they may be. Furthermore, regular smoking cessation training to frontline staff is offered in only half of the hospitals audited. The cultural shift required for NHS organisations to demonstrate they are serious about supporting smokers with tobacco dependence is substantial. The NHS Long Term Plan goals relating to smoking will not be fulfilled without immediate intervention. Our recommendations are as follows:

1. Support ALL patients who smoke with a referral to an on-site specialist stop smoking service by 2023/24

The majority of patients are still not being referred. Referral needs to become a matter of course in which every single healthcare professional interacting with a patient is empowered to help a patient to stop smoking. The 2016 audit report highlighted the role information systems may have. Automating the identification and clinical coding of smokers with the increasing digitalisation of

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medical records should assist in achieving this goal[b], including mandating of recording of smoking status and monitoring on a day to day basis as an evolving quality improvement project.

2. Offer nicotine replacement therapy to ALL patients who smoke to reduce symptoms of nicotine withdrawal and promote smoking cessation by 2023/2024

This demonstrates a willingness to help patients with their tobacco dependence. It reflects how well healthcare professionals within an organisation are trained in identifying and helping smokers to remain abstinent during their stay. Once again digital support including prompting healthcare professionals to prescribe NRT for smokers will support in this endeavour.

3. Trust boards must take immediate steps and be held accountable to regulators in ensuring the leadership structure and resources are in place to develop a service that will offer ALL smokers that spend one night or more in hospital support in stopping smoking in line with the NHS Long Term Plan

This recommendation is not easily measurable and there are several different elements to consider:

- It is important for trusts to recognise the **leadership** required to effect change within their setting. Previously we have called for a dedicated clinical lead with programmed activity to deliver an evidence-based smoking cessation service, which is still missing in most trusts. Crucially it also requires leadership in nursing, service provision, pathway development and delivery and training, given the sheer scale of the intention to ensure every smoker is helped with their dependence. It will not be achieved by a clinical lead on their own.
- Healthcare professionals require **training** and guidance. They are the most important resource when it comes to help with tobacco dependence. Trusts must ensure all front-line staff have a minimal level of competence (e.g. very brief advice) through training and regularly updating, whilst ensuring those that wish to develop their skills further are supported in doing so.
- Investment in **hospital-wide smoking cessation practitioners** with access to a comprehensive range of pharmacotherapy. This is essential both in terms of training and upskilling staff as well as ensuring patients have access to expert care, the right medication and particularly follow-up, which is frequently not possible if community services are relied upon.
- Establishing and regulating **smoke free grounds** with engagement from all the senior leaders within a trust. It is important to create the right culture which is visible to all staff, patients and visitors both in terms of asking everyone to respect the smoke free grounds and by offering support to those who would otherwise be smoking on hospital grounds.

The second national BTS Smoking Cessation Audit has demonstrated how change is possible but far too many patients are having their tobacco dependence neglected. This report has set ambitious national improvement objectives but given that they are entirely aligned with the NHS Long Term Plan and the additional funding that this will bring, there has perhaps never been a better opportunity to fulfil these ambitions and turn the tide in an area of healthcare in which patients have been failed for far too long.

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[b] This will be further developed in future updates of the BTS Smoking Cessation Quality Improvement Tool.

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