number 2

Health Improvement Action in Hospital Settings:
Action 18.1: Tobacco

hphs
health promoting health service

CEL (1) 2012 Annual Report Summary Briefings – Year 1

This paper is part of a series of briefing papers summarising national health improvement action within the hospital and community hospital setting, reported to Scottish Government as part of the formal governance requirements for delivery of CEL (1) 2012. Information within these reports has been extracted from Year 1 Annual Reports submitted on 30 April 2013 and, therefore, reflects reported health improvement action from January 2012–April 2013.

NHS Boards received individual feedback on their annual report submissions and these can be read alongside the briefings series in order to support local-level discussion.

Briefing papers within this series include: 1 Context for Delivery (Core Actions 1–5); **2** Tobacco; **3** Alcohol (covering selected performance measures not reported through the ADP Governance Framework); **4** Breastfeeding; **5** Healthy Working Lives; **6** Sexual Health; **7** Physical Activity; and **8** Active Travel.

NHS Boards received feedback on Action 18.4 Food and Health within their individual feedback.

To view the entire briefing series, and for all other secondary care health improvement support, please visit our NES Knowledge Network Portal at:
www.knowledge.scot.nhs.uk/home/portals-and-topics/health-improvement/hphs.aspx

CEL (1) 2012 Action 18.1: Ensure dedicated specialist smoking cessation support is available within the hospital/acute setting, which is integrated with community-based cessation services; and commit to the development and implementation of more comprehensive organisational tobacco policies.

To commit to the development and implementation of more comprehensive organisational tobacco policies. Wherever possible, consideration should be given to going beyond current legal requirements and moving towards the goal of being completely smoke-free.

Performance measures:

1. Increased quit attempts and successful quits amongst hospital in-patients, out-patients, day surgery and pregnancy. Community-based quit attempts and quit successes following a referral, or delivery of brief interventions and referrals, from a hospital setting.
2. Evidence of existence and application of integrated care pathways for smoking cessation in secondary care (and for patient flows to and from primary care).
3. Evidence of appropriate training and/or support in the delivery of brief advice for smoking cessation in secondary care.
4. Evidence of specialist smoking cessation support (or health behaviour change equivalent) available within (or to) secondary care sites within NHS Boards.
5. Implement more comprehensive organisational tobacco policies with specific timescales to enable progress to be measured.

Outcome:

Increased availability and uptake of specialist smoking cessation support by hospital patients who are motivated to quit smoking. Improved overall smoking cessation success (quit) rates by providing better access to, and continuity of, support for patients preparing for, or maintaining, a quit attempt while moving in either direction between primary and secondary care settings.

An increase in the number of NHS premises moving towards becoming completely smoke-free.

Background

Health improvement action on tobacco has been within the HPHS national policy requirements for hospital settings since CEL (14) 2008.

During consultation of the governance framework, several actions were taken in support of improving the consistency of recording health improvement action on tobacco, specifically seeking guidance from the Smoking Cessation Coordinators' Network on a) defining a 'referral' and b) creating consensus on the hospital settings to be represented in the data capture.

This process resulted in agreement that a referral should be counted into the recording of the smoking cessation services **'from a hospital-based health professional not limited to specialist smoking cessation staff'**. It also led to agreement that the numbers of cessation interventions should be widened to include out-patients, day surgery and pregnancy, in addition to in-patients as stated in the original policy. Implementation guidance recognised that the total sum of brief advice offered in relation to smoking cessation by clinicians across the hospital setting will not be fully represented in this data capture. However, the data provided by NHS Boards will be helpful to exemplify the extent of opportunities within hospitals and this nationally consistent approach will enable comparisons to be drawn.

Reporting on tobacco was subject to significant debate during the consultation process due to the varying models of delivery and local level reporting undertaken by NHS Boards. Leads were advised that data should be submitted wherever possible and reasons for gaps should be provided within the 'exception to evidence provision' dimension on the annual reports. It was agreed that rationale for evidence gaps will help inform year 2 evidence requirements.

Summary of data provision

No NHS Boards are exempt from the tobacco health improvement action. Annual reports submission were received from all 14 delivery NHS Board areas and the Golden Jubilee Hospital Trust, therefore, unless specified n=15. The Golden Jubilee Hospital Trust reported, in advance of the annual reporting deadline, that they currently had no smoking cessation services or dedicated staff in place during 2012/13. They had used CEL (1) 2012 requirements to initiate requests for support from adjacent delivery NHS Boards.

The evidence provided varied in detail and relevance for each performance measure. The three evidence requirements for performance measure 1 (covering delivery of smoking cessation interventions) provided varied in quality. Performance measures 2–5, which mainly reflect the structures and policies in place for tobacco health improvement action in hospitals, had more comprehensive reporting across all NHS Boards. The findings below summarise the evidence provided.

Summary of findings

Performance measure 1: Increased quit attempts and successful quits amongst hospital in-patients, out-patients, day surgery and pregnancy. Community-based quit attempts and quit successes following a referral, or delivery of brief interventions and referrals, from a hospital setting.

Required evidence: i) Number of acute-setting referrals to community smoking cessation services ii) Number of acute setting referrals to attend first community smoking cessation services session/group iii) Breakdown of quit attempts of smoking cessation users referred from a hospital setting.

In total, 11 NHS Boards submitted information on the number of referrals from an acute-setting to community smoking cessation services. Overall, 6,364 referrals were reported within the annual report submissions. From those, approximately 57% were reported from three large NHS Boards. Other NHS Boards highlighted that although acute-setting referrals to community smoking cessation services were made from their hospital settings, quantitative data was not provided due to local IT systems not being in place to record and/or collate this information.

Six NHS Boards elected to submit more information or alternative data as evidence for performance measure 1 (e.g. referrals from different settings, types of community services provided, etc.). The majority of this data is beyond the scope of this analysis process, however, it was felt important to note that the total number of hospital referrals reported (and not just those specifically subject to an onward community referral) was 9,418 collectively.

NHS Boards were also required to submit information around patient attendance at their first community smoking cessation services session. In total, seven NHS Boards submitted the information required. From these, approximately 2 out of 10 patients referred from acute-settings to community smoking cessation services attended the first session/group or were able to be followed-up. Two NHS Boards reported that all acute-setting referrals attended their first community smoking cessation services session/group or were followed-up through phone support.

A total of eight NHS Boards had information on patient attendance at first community smoking cessation services session/group. Excluding the Golden Jubilee Hospital Trust, the other seven NHS Boards provided data excess to the evidence requirements. For example, some of the NHS Boards provided information on all first attendances and some others described details on the available post-referral support, but did not provided the quantitative data requested.

Finally, for performance measure 1, NHS Boards were required to submit information on the quit attempts of smoking cessation users referred from a hospital setting. In total, 689 successful quit attempts (i.e. 4 weeks) were reported in the annual reports by five NHS Boards. This figure equates to approximately 53% of those at first attendances that were able to be followed up.

The remaining 10 NHS Boards did not provide any quantitative information. Narratives submitted by NHS Boards generally described the IT issues that prevented having systems in place to collect and/or report on this information.

Performance measure 2: Evidence of existence and application of integrated care pathways for smoking cessation in secondary care (and for patient flows to and from primary care).

Required evidence: Evidence of existence and application of integrated care pathways for smoking cessation in secondary care (and for patient flows to and from primary care).

The information submitted for performance measure 2 indicates some level of consistency in progress toward integrated smoking cessation action. More specifically, 14 NHS Boards have either developed, or were at the last stages of developing, patient care pathways. The one outstanding NHS Board highlighted that commencement of developing a care pathway was underway.

Specified elements of the pathway in place were also requested and these included details on the alignment of their pathway to the Managed Clinical Networks (MCNs); if an opt-out approach is in practice; and if an approach to integrate with primary care is in place.

The annual reports evidenced that the support from the MCNs in relation to tobacco action varies. The majority of NHS Boards indicated some collaborative work with the local MCNs. However, overall submissions highlighted that there is room for further improvement in MCNs sharing ownership for this action.

An opt-out approach is identified amongst eight NHS Boards. The opt-out approach is most commonly in practice for pregnancy, diabetic patients, spirometry outpatients' clinics and rheumatoid arthritis.

A total of three NHS Boards highlighted an approach to integrate with primary care.

Performance measure 3: Evidence of appropriate training and/or support in the delivery of brief advice for smoking cessation in secondary care.

Required evidence: Number of hospital staff by ward/setting trained in the effective delivery of brief advice and/or use of the integrated care pathways.

Overall 2,819 staff from nine NHS Boards received training in the effective delivery of brief advice and/or use of their local integrated care pathway. From those, just over 73% were staff in two large NHS Boards. One NHS Board provided no detail against this performance measure. Five NHS Boards described either plans to deliver training in 2013/14 or highlighted challenges of delivering training to hospital-based staff.

The staff that received training came from a range of different settings and backgrounds such as: charge nurses, midwives, dentistry, mental health, pharmacy staff, phlebotomists and medics. An encouraging theme throughout reporting on staff capacity-building activity was the engagement with health profession-related undergraduate students and junior members of staff. Over 490 medical students received training on smoking cessation, and over 300 midwifery and nursing students. Over 100 FY1 medics attended training within one NHS Board, and another NHS Board conducted 28 sessions with their FY1 and FY2 medics.

Performance measure 4: Evidence of specialist smoking cessation support (or health behaviour change equivalent) available within (or to) secondary care sites within NHS Boards.

Required evidence: Submission of outline of specialist smoking cessation support available within or to secondary care sites within NHS Boards (or health behaviour change equivalent).

For performance measure 4 there is a level of consistency across NHS Boards regarding the secondary care smoking cessation support that is available. In total, 13 NHS Boards had dedicated smoking cessation support. The support reported was mainly specialist services, described as dedicated smoking cessation advisors.

One NHS Board had no support in place (Golden Jubilee Hospital Trust as per data provision section details) and one had their smoking cessation referral protocol under review.

Performance measure 5: Implement more comprehensive organisational tobacco policies with specific timescales to enable progress to be measured.

Evidence required: Submission of local tobacco policy with update report on delivery.

Performance measure 5 required NHS Boards to submit evidence against the implementation of a local tobacco policy, and all NHS Boards provided some level of consistent data for this.

In total, 11 NHS Boards have a local tobacco policy established and submitted them as part of their annual report. The remaining four NHS Boards have a policy either under review or in draft, highlighting the current context of the new Tobacco Control Strategy launched by Scottish Government in March 2013.

Summary of reported action

Data provided within the CEL (1) 2012 Annual Reports for tobacco action within hospital settings provided a mixed picture of current progress.

Evidence submissions on investment in smoking cessation through staff training, developing pathways and comprehensive smoke-free site policies have been consistently and appropriately provided. Efforts in awareness raising and clinical engagement activities are encouraging. Continued capacity-building action through staff training should be undertaken. Sharing approaches on smoke-free policy enforcement and embedding pathways and/or creating integrated care pathways should be facilitated through the Smoking Cessation Coordinators' Network.

However, the acute to community referral data submissions were generally of a poor and inadequate quality. Data submitted in an incomplete or inaccurate format was a consistent challenge in analysis of this review for the referral data, which could not be compared. Rationale for gaps in data submission were provided by a small number of NHS Boards, and although some were able to provide the required information, most highlighted ongoing issues with both local and national reporting systems.

From the additional data provided on the total number of hospital referrals made (not just those referred onto community support), beyond the evidence requirements within the framework, it is evident that requesting acute to community referrals alone, prevents the full contribution of the hospital setting to be represented.

For all support on implementation of CEL (1) 2012, please contact the HPHS national support programme at NHS Health Scotland by emailing:
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