Annual Secondary Care Survey

2013

NCSCT

Contents

1. Executive summary

The annual Secondary Care Survey 2013 provides an overview of stop smoking support and activity within secondary care:

- In total there were 148 respondents to the survey; twice as many compared to the 2012 survey. It should be noted that not all questions were mandatory.
- The majority (62%, n=92) of respondents worked as stop smoking advisors
- Many (74.3%, n=110) respondents indicated that there is a stop smoking advisor within their local area focused on secondary care
- Knowing the smoking prevalence of the local acute trust remains a challenge, with the majority (80%, n=81) of respondents not knowing this
- Most (61%, n=77) respondents did not know if there was a smoking related CQUIN (Commissioning for Quality and Innovation) indicator in place within their local acute trust(s)
- Only 38% (n=27) of respondents stated that, in their local acute trust, patients are routinely asked their smoking status
- Just 37% (n=35) of respondents indicated that, in their local acute trust, 'Very Brief Advice' is routinely delivered by frontline staff
- It is encouraging that the majority (79%, n=74) of respondents stated that the referral of hospital patients onto local stop smoking support is being offered as the norm with the three most popular ways of making referrals were (respondents could choose more than one answer): via telephone (59%, n=49), as a self-referral (59%, n=49) or using a paper referral form (50%, n=42).
- It is vital that patients are offered the provision of stop smoking support while they are in hospital and it is pleasing that the majority (72%, n=67) of respondents indicated that this was the case; 69% (n=46)of respondents stated that this support was provided by a stop smoking advisor available in the hospital

2. Introduction

This third annual Secondary Care Survey was undertaken by the NCSCT to capture levels of activity and stop smoking support in secondary care in 2013. Anyone whose work includes the provision of stop smoking support in a hospital setting was invited to complete the survey during January and February 2014.

3. Results and commentary

3.1 The positioning of stop smoking support in acute trusts

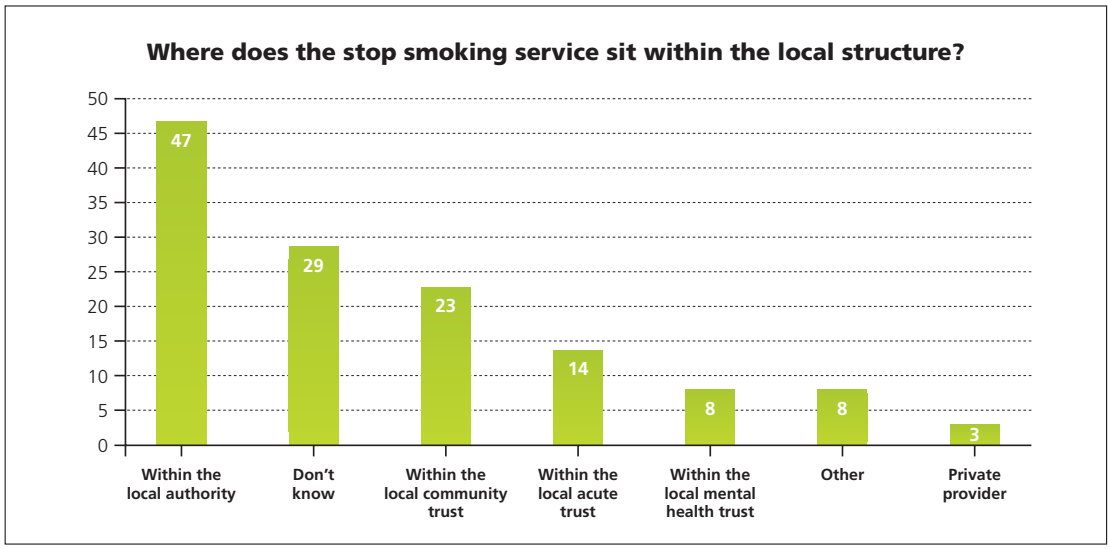
The majority (62%, n=92) of respondents worked as a stop smoking advisor, with nearly a quarter (24%, n=22) doing so as a full-time position in secondary care, and a half (n=46) spending one to three days a week in this role.

Seventy four percent (n=110) of respondents indicated that there was a stop smoking advisor within their local area focused on secondary care. The largest proportion (40%, n=39) of stop smoking advisors were employed, and based, within the stop smoking service.

Respondents were asked to describe where the stop smoking service sits within the current local structure, and as expected there was a range of responses, as illustrated in Figure 1.

From April 2013 the responsibility for commissioning stop smoking services moved from primary care trusts to local authorities and as such the Secondary Care Survey 2013 reveals a very different looking graph to the one published in the 2011 and 2012 reports.

Figure 1: Stop smoking service position in local structure



3.2 Concerns / challenges

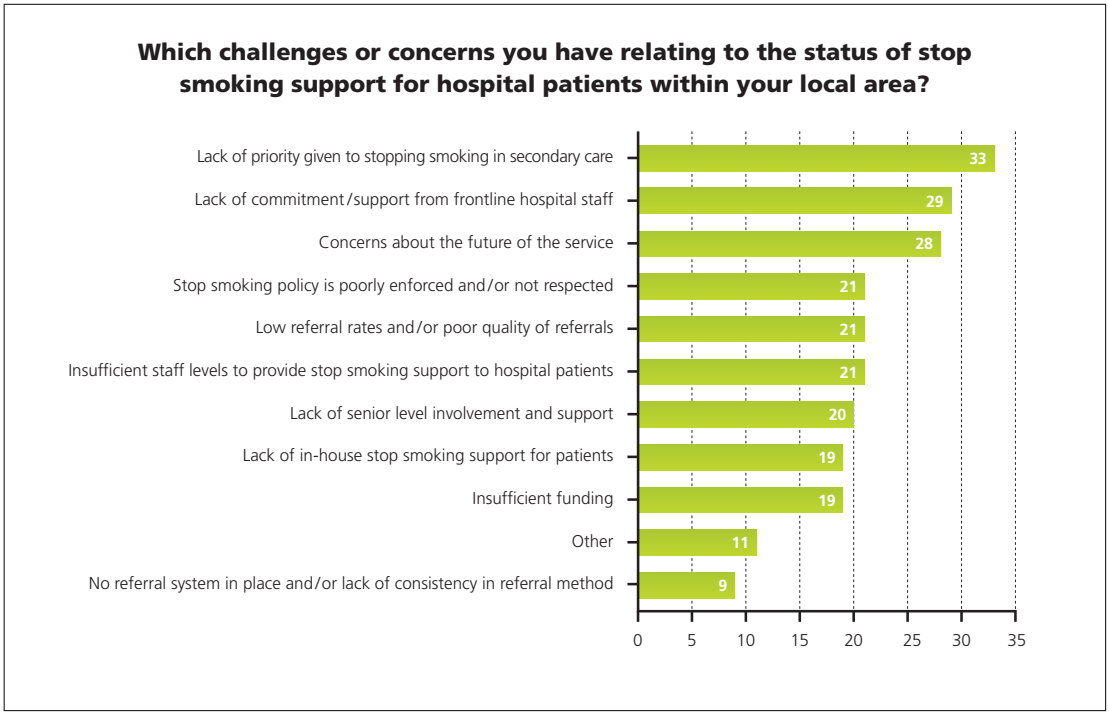
Respondents were asked if they had any concerns or challenges relating to the status of stop smoking support for hospital patients within their local area and more than a third 39% (n=51) admitted they did.

The more frequently cited concerns were:

- lack of priority given to stopping smoking in secondary care (66%, n=33)
- lack of commitment / support from frontline hospital staff (58%, n=29)
- concerns about the future of the service (56%, n=28)

Figure 2 illustrates the answers given to this question. Multiple answers were allowed.

Figure 2: Challenges or concerns relating to the current status of the stop smoking service for hospital patients



3.3 Commissioning for Quality and Innovation (CQUIN)

Respondents were asked if their local acute trust had a smoking related CQUIN indicator, or other smoking related quality or performance indicator, in place and only a fifth indicated that there was. The majority (61%, n=77) of respondents did not know if there was any.

It would appear that having a CQUIN, or other smoking related, indicator in place had a positive effect by: increasing engagement from the local acute trust (62%, n=8) and boosting activity within the hospital to support patients to stop smoking (54%, n=7).

With this in mind, it is concerning that more than a half of respondents did not know whether there was a CQUIN in place in their local acute trust, as awareness of the contracted outcome measures would potentially lead to an increase in activity and engagement.

3.4 Smoking prevalence, referrals and support

It is disappointing that the largest proportion (80%, n=81) of respondents did not know the smoking prevalence for their local acute trust; this is the same as in last year's survey.

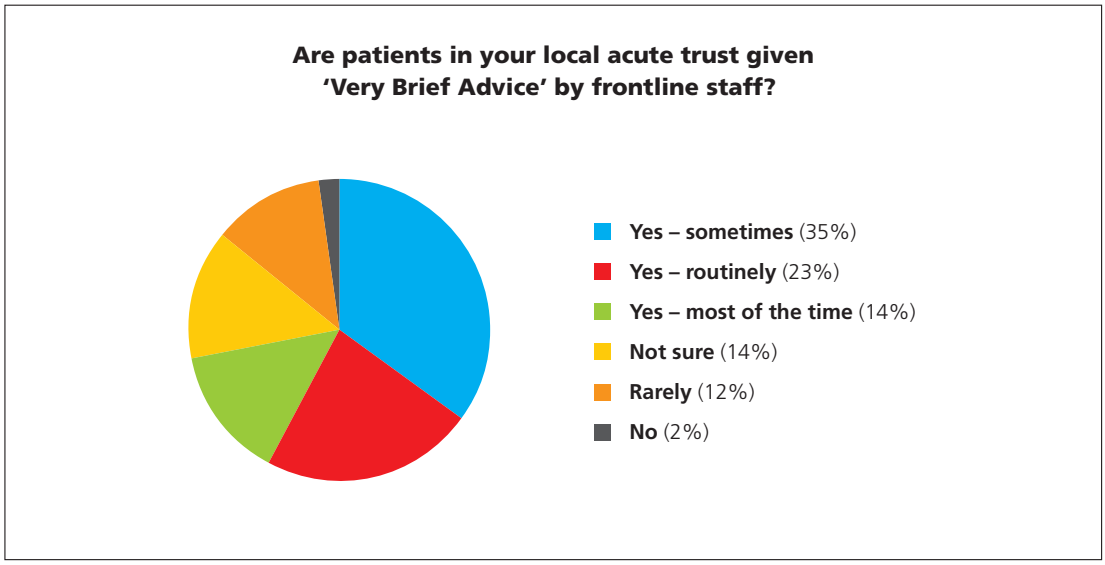
The responses received suggest that smoking status is being asked within the majority (79%, n= 77) of acute trusts, ranging from 'yes routinely' to 'yes sometimes', but that the recording of this information is not consistent. As such, an accurate picture of smoking prevalence among hospital patients does not exist.

With regards to the recording of smoking status, the most popular method used was a mixture of paper and electronic systems (41%, n=31); 36% (n=27) of respondents indicated they recorded smoking status electronically, while a quarter (n=19) stated they used paper notes.

The extent to which stop smoking support is provided to hospital patients is far from consistent, as illustrated in Figure 3. Although it is encouraging that very brief advice (VBA) is delivered in the majority of acute trusts, it is disappointing that its delivery is not routine. This is especially so considering that the delivery of VBA plays an important part of the Making Every Contact Count (MECC) agenda.

Respondents were asked if the frontline staff in their local acute trust were trained to give VBA, with the largest proportion (60%, n=56) indicating that they were.

Figure 3: Patients being given VBA in the local acute trust



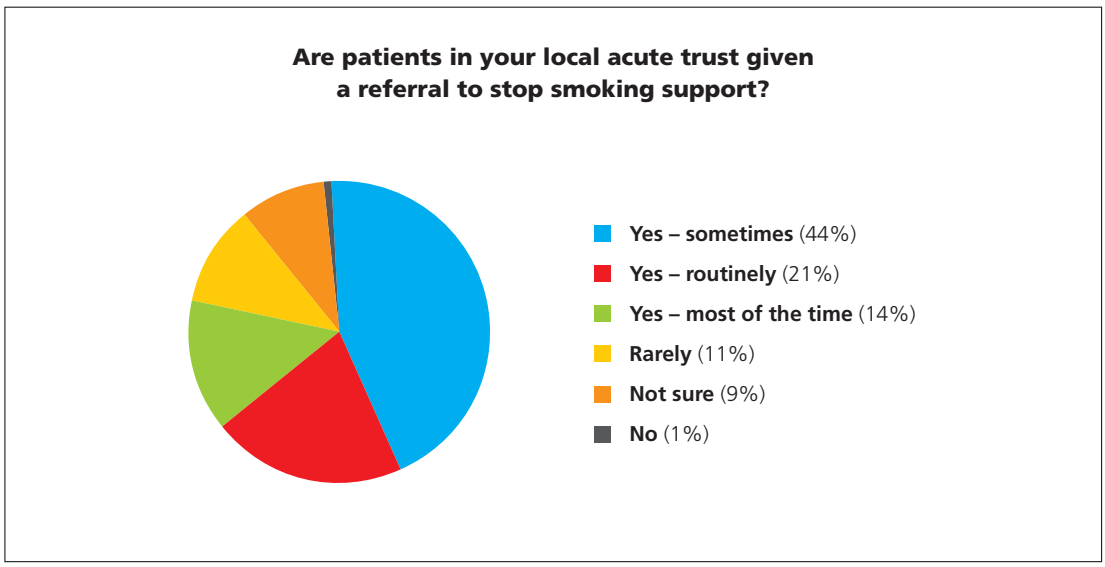
Respondents were asked if patients were supported to stop smoking whilst in hospital, with 36% (n=33) indicating that they were. An additional 37% (n=34) of respondents stated that patients received support; but only in certain wards or departments.

The nature of the support varied; it was common (69%, n=46) for an advisor to be available at the hospital and in some instances stop smoking support included the ready availability of nicotine replacement therapy (NRT) to hospital patients. Just over half (52%, n=35) of respondents had a stop smoking referral pathway and/or referral system in place, whereas 66% (n=44) of respondents indicated that patients were offered a referral to stop smoking support.

It is positive that the majority respondents indicated that patients who smoked were offered a referral to stop smoking support but it is unfortunate that if this is the case, that this is not routine (21%, n=20).

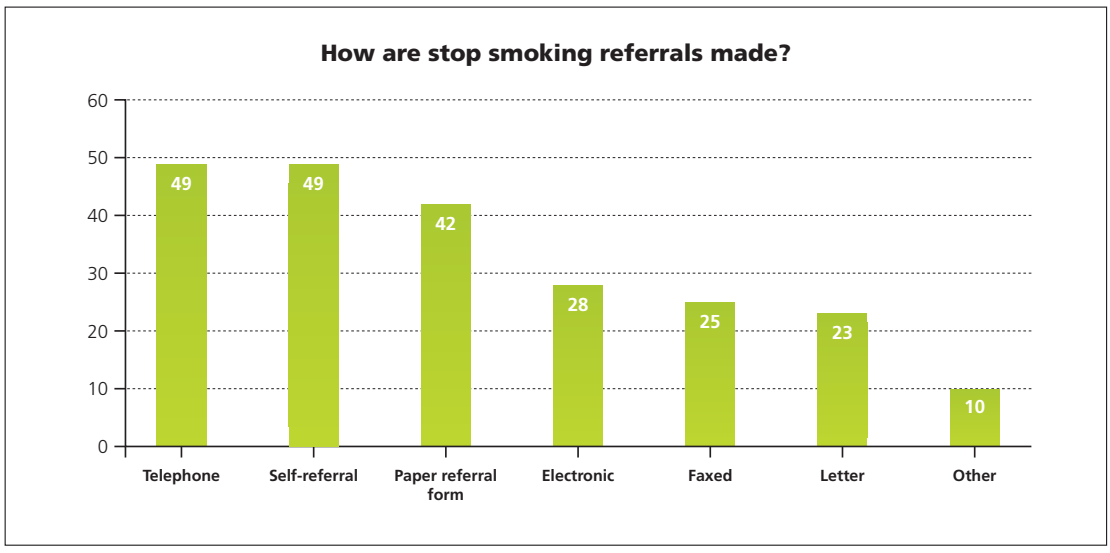
Figure 4 illustrates the extent to which patients are referred on to local stop smoking support.

Figure 4: Patients being offered a referral to stop smoking support in the local acute trust



In terms of how referrals are made, telephone remains the most common (59%) method. A lower proportion (34% n=28) of respondents indicated that they use electronic referral methods whereas 51% (n=42) of referrals were made using paper referral forms, as illustrated in Figure 5. It was possible for respondents to select this as well as other options available.

Figure 5: Referral method for hospitals in patients



3.5 Support required

Finally, respondents were asked if they required more support to help develop stop smoking provision for hospital patients in their local area, and the majority of those who responded to this question indicated that they would (60%, n=55).

The different type of support requested is illustrated in Table 1 below.

Table 1: Respondent's indication of the preferred form of support to develop stop smoking provision for hospital patients in the local area

Form of support provided	Number
Networking events specifically for secondary care	35
National updates from NCSCT	33
Regional secondary care event(s)	31
Regional secondary care updates	31
Provision of an online area for discussion and sharing of experience	23
National conference focussed on secondary care	20
National conference with a workshop or 1–2 hour session on secondary care	20
Other	4

4. Conclusion

The survey results have provided a useful overview of activity in secondary care in 2013, including the availability and provision of stop smoking support for hospital patients.

By comparing these responses with those from 2012* we can see that:

- There has been a significant decrease in the number of CQUIN indicators put in place.

In 2012 46% respondents stated there was a smoking related CQUIN indicator in place within their local acute trust(s), whereas in 2013 only 20% respondents indicated that there was.

- The largest proportion of referrals were made via telephone and in a form of self-referral, whereas in 2012 a majority of respondents indicated they made the referrals via fax.

As in the previous year, most respondents stated that they use letters / paper referral forms more often than electronic referral methods.

- There has been a high increase in the number of secondary care settings where an electronic referral system is used to make stop smoking referrals in comparison to 2012 (14% and 28% respectively).

Considering that this is the most efficient method and easiest method of referral to audit, the results are encouraging.

- There has been a significant decrease in the number of stop smoking advisors employed by the stop smoking service and based in the hospital (21% in 2013, whereas in 2012 it was 55%).

As per previous years, areas of need have been highlighted.It remains a challenge for stop smoking services to know the smoking prevalence of their local hospital, with 80% of respondents reporting that they did not know their local acute trust's smoking prevalence.

This issue could easily be resolved if the smoking status for all hospital patients was recorded electronically, as a mandatory field in the patient record and therefore enabling a local audit. Similarly the electronic referral of hospital patients onto local stop smoking support would be a significantly more efficient and reliable method for frontline staff to use and, perhaps crucially, the local stop smoking provider could respond quicker to the needs of the patient.

* It is recognised that we do not know if the same people responded in all three surveys.

Overall it is clear that progress in this setting has been made. As a relatively new area within the field of smoking cessation there is, however, considerable scope for growth and improvement to current systems and provision. It is highly concerning that lack of priority given to stopping smoking in secondary care and lack of support from frontline hospital staff have been indicated by a majority of respondents as the challenges they have faced.

The NCSCT is firmly committed to continuing its support of secondary care, in recognition of its importance within smoking cessation. The development of the National Referral System, a system that allows the robust and efficient identification and referral of hospital patients on to stop smoking support, is central to this: http://bit.ly/168gfMv.