

The case for a stop smoking CQUIN in London for acute hospital inpatients from NHS London Respiratory Team

Why smoking?

'...smoking is the single biggest preventable cause of early death and illness. The NHS spends over £2.7 billion a year on treating smoking related illness, but less than £150 million on smoking cessation.'ⁱ (i.e. only 1/20th the spend on quit smoking). Up to one in five deaths in London (depending on borough) is due to smoking yet there are extremely cost effective interventions that can be used in hospitals and in the community to reduce that mortality, improve health and prevent admissions across general medicine and surgery. There is already a QOF in general practice. Therefore this is an opportunity to incentivise hospitals to do much more. Codes already exist and hospital prescribing data could also be used to sense check progressⁱⁱ. The DH has funded the British Thoracic Society to develop a Stop Smoking Champion in every trust, therefore there should be someone/a team to support the introduction of this CQUIN. This is a very timely and appropriate precursor to the introduction of the stop smoking tariffⁱⁱⁱ.

The attached CQUIN incentivises improved support for inpatients who smoke, whether they are emergency admissions or elective admissions of more than a day.

Why inpatients?

Hospitalisation offers an opportune time to encourage patients to stop smoking for four reasons.

1. This time is often a "teachable moment" where patients are more receptive to intervention and are more motivated to quit.
2. The hospital smokefree environment creates an external force to support abstinence.
3. Patients are ideally placed to be given information about treatment options, support through withdrawal and signposted to specialist services.
4. Abstaining from smoking at this time can lead to significant health benefits

Why the Respiratory Team is proposing it

Our starting point was the significant impact that could be achieved for patients with COPD who account for a significant number of admissions, readmissions and bed days in London. In 2008-09 the total number of bed days in London for emergency hospital admissions for COPD as a primary diagnosis was 91,140. However, there is very sound evidence to extend to all adult smokers in hospital. We estimate that 20% of inpatients are smokers.

The evidence of effectiveness in hospital

A Cochrane Review of smoking cessation interventions shows the effectiveness for hospitalised patients regardless of admitting diagnosis. Interventions for hospitalised patients increase the rate of long term quitting if they include regular behavioural support and pharmacotherapy that is continued at least one month after discharge^{iv}.

Inpatient smoking cessation leads to a **reduced rate of wound infections, impaired wound healing and increased rate of bone healing**. Permanent smoking cessation **reduces the risk of heart disease, stroke, cancer and premature death**. The physiological benefits are seen starting from 8 hours of the last cigarette.

Case for surgical patients

Smoking is associated with local wound complications, pulmonary and cardiac complications, an increased need for postoperative intensive care and longer periods of hospitalisation. Specifically, poorer outcomes have been associated with gastrointestinal, hernia, orthopaedic, cancer, cardiovascular, day care and plastic surgery. Smoking has also been implicated in a need for increased anaesthetic dosage and increased experience of postoperative pain^v.

Case for medical patients

Smoking cessation is associated with a 43% decreased risk in hospitalization in COPD^{vi} and it reduces the risk of developing bronchitis and pneumonia compared to continued smoking; introduction before the initiation of radiation therapy in lung cancer is associated with an increased rate of complete response to treatment compared to those who continue to smoke through treatment; it reduces the risk of re-hospitalisation for people with heart disorders^{vii}.

The recommended intervention

For each patient:

ASK and record smoking status (Z720)

ADVISE the patient of the personal health benefits of quitting (instead of Z720 use F172)

ACT on the patient response

- prescribe NRT for patients in withdrawal
- monitor withdrawal and adjust pharmacotherapy accordingly
- refer to local NHS Stop Smoking Service

Description of indicator: Smoking cessation in inpatients in acute hospital

Numerator: all adult emergency admissions and all elective admissions of more than one day from all specialities excluding maternity coded as F172 ("Dependent smoker cessation advice given" (in this admission or previous ones)

Denominator: all adult emergency admissions and all elective admissions of more than one day from all specialities excluding maternity coded as F172 OR Z720 ("patient smokes").

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Target levels

We would expect the numerator to relate to the adult smoking prevalence in the local community which should be a matter of discussion with the commissioner as rates will be PCT based not catchment based. NHS London proposes that the expected prevalence should be 20% of eligible patients. The CQUIN target would be for recording of 50% of those patients. That is, 10% of the adult hospital population excluding maternity and stays of less than one day.

We would expect 90% of that 10% of inpatients who smoke receiving advice to trigger CQUIN payment.

In addition we might expect to see hospital prescribing for NRT and varenicline increase over time. Each hospital could take a baseline measure before the CQUIN is implemented and/or the commissioner can ask stop smoking services for referral rates from local hospitals.

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revised 09 December 2010

revised 7 January 2011

References

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