

intensive quit-smoking support as treatment for their disease. The aim of this study was to assess the efficacy of standard quit-smoking interventions (NICE, 2008) for COPD-smokers, to determine levels of support required to improve quit rates.

Methods Current smokers with confirmed COPD were referred from within an inner-city general hospital (inpatients/outpatients) to a dedicated quit-smoking specialist (QSS) or from the community COPD-multidisciplinary team to an integrated QSS, who undertook domiciliary visits for housebound smokers. Both QSS had additional counselling skills. Demographics, disease severity (FEV₁), smoking history, duration of quit-smoking treatment, pharmacotherapy and quits (4 week) were prospectively recorded over 11 months (September 2010–July 2011).

Results 106 patients with moderate COPD M:F 39:67, mean±SD age 66.4±10.4 y range 49–85; FEV₁ 1.2±0.6l, n=76) were referred: 63 (69%) hospital patients (HP), 43 (41%) from the community (CP). Compared to the HP who had mean±SD FEV₁ 1.4±0.5 l, and smoked 23.5±11.4 cigarettes/day on referral, CP had significantly (p=0.03) worse lung function (FEV₁ 1.2±0.5 l) but smoked fewer (p=0.002) cigarettes/day (9.8±8/day). 25/106 (24%) patients quit, but quits were significantly lower (p<0.05) in the CP (20%) compared to the HP (30%). 45/106 (42%) were not able to set a quit-date, 5/106 (5%) set multiple quit-dates. 56/106 (53%) used nicotine replacement therapy (NRT), >2 products in 48/56. 18/106 (17%) used varenicline, seven sequentially following NRT. Duration of pharmacotherapy for quitters was 6.1±4.5 months (mean±SD, range 1–16). 38/106 (36%) were discharged after lost to follow-up.

Conclusions These data demonstrate that 1-in-4 smokers with COPD are able to quit using evidence based tobacco addiction treatment. However, quit rates for these smokers are much lower than the Department of Health (DH) expectation of >35%, despite intensive interventions by skilled QSS, domiciliary visits to housebound patients, and pharmacotherapy extended beyond the standard 8–12 weeks. Novel approaches, including addressing psychosocial issues, motivational quit-date setting, review of the DH 4-week quit-target and sufficient funding for extended NRT/Varenicline prescribing, may be required to achieve effective smoking cessation in this patient group.

P126 DOES A PERSONALISED AND NON-CLINICAL EXPLANATION OF LUNG HEALTH TRIGGER THE IMPULSE IN SMOKERS TO MAKE A QUIT ATTEMPT?

doi:10.1136/thoraxjnl-2011-201054c.126

J L Roberts, I Houghton. *NHS Blackpool, Blackpool, UK*

Introduction and Aim A Cochrane review concluded that there is a lack of evidence to support lung function and lung age measures as a method for increasing smoking cessation quit rates. This study aims to assess whether providing lung health checks in workplaces and community settings, combined with immediate access to high quality smoking cessation advice, will promote behaviour change in smokers.

Method The intervention consisted of spirometry followed by a detailed and personalised explanation of the findings. The results were delivered in plain non-clinical language, using lung age, visual tools and local analogies. The results were augmented by a written report and advice with regard to any action indicated. To capitalise on the tension created by the intervention, current smokers were strongly encouraged to seize the moment and have an immediate discussion with a stop smoking adviser who was positioned within easy reach. The smoking status of every individual tested was recorded, along with their age, gender, test results and action advised.

Results 1054 smokers have undertaken the lung health check. 953 were given brief advice to stop smoking. 467 (49%) subsequently registered with the stop smoking service.

Conclusions Regardless of the spirometry result, whether normal or abnormal, a clear understanding of your lung health appeared to be a powerful motivational trigger and teachable moment for behaviour change. This innovative model potentially provides all the ingredients in one location for promoting smoking cessation as described by Robert West in the 3 Ts strategy: Tension, Trigger, Treatment.¹ The offer of a lung health check was exceptionally popular in all settings, even among traditionally hard-to-reach groups, and could be targeted according to local need. Joint working with the smoking cessation service improved the outcome for smokers as it took advantage of the immediate situation, triggering the impulse to make a quit attempt. These results justify further work collecting follow-up data to establish whether the trigger of a lung health check converts to a successful long-term quit.

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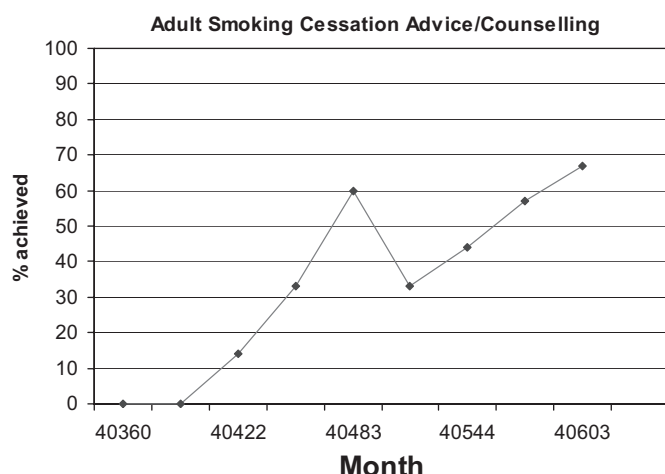
P127 IMPROVING SMOKING CESSATION ADVICE THROUGH THE IMPLEMENTATION OF A QUALITY IMPROVEMENT INTERVENTION

doi:10.1136/thoraxjnl-2011-201054c.127

L Hodgson, A Fairhurst, P Thorburn, A F Frew, S R Doffman. *Brighton & Sussex University Hospitals NHS Trust, Brighton, UK*

Background Smoking remains the main cause of preventable morbidity and premature death in England (DH data) and is estimated to cost the NHS £1.5 billion a year. Smoking counselling beginning during hospitalisation and including support after discharge increases smoking cessation rates (Rigotti *et al* 2008).¹ Health professionals in the hospital are expected to offer cessation advice. An audit was carried out in the acute medical unit of 118 consecutive medical patients which demonstrated that only 1/25 current smokers received any cessation advice. In July 2010, driven by a quality improvement project carried out locally in patients admitted with community-acquired pneumonia, key indicators of high quality care were established, one of which was to clearly document and offer smoking cessation advice to current or recently-quit smokers. Despite being a requirement, documentation regarding smoking cessation advice was poor. In the respiratory wards, only seven patients were referred to existing smoking cessation services over 6 months. Several interventions were planned to increase awareness. No additional resource was required and members of the multidisciplinary team were employed in a variety of roles. An educational programme was established, including presentations to key specialities (acute and respiratory medicine) and key ward nursing staff. An in-reach programme was developed by the smoking cessation lead nurse, targeting wards where high rates of smoking were identified. Several foundation trainees were employed as "smoking champions," raising awareness among their peers.

Results Since initiation of the interventions, documented cessation advice has steadily risen from 0% to 68% of patients with a smoking history (see Abstract P127 figure 1). On the respiratory wards, 77 patients over 6 months (cf seven prior to intervention) were referred to the service. Four-week cessation rates in the patients referred to the cessation service was 82% and of these patients 70% had still ceased to smoke at 6 months.



Abstract P127 Figure 1 Adult smoking cessation advice/counselling.

Conclusions Low cost, easily-deliverable interventions can act as important drivers to improve awareness and delivery of smoking cessation advice. We have demonstrated that simple strategies can be highly cost effective, of particular importance in this financial climate.

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P128 SMOKING CESSATION EDUCATIONAL POSTER CAMPAIGN

doi:10.1136/thoraxjnl-2011-201054c.128

¹J Ryder, ²L Davies, ³J Bibby. ¹Roy Castle Fag Ends, Liverpool, UK; ²Aintree University NHS Trust, Liverpool, UK; ³Liverpool Community Health NHS Trust (Sefton SUPPORT), Liverpool, UK

Introduction The health benefits of stopping smoking are well established and hospitals have a unique opportunity to contribute to protecting and promoting health through smoking cessation interventions. NICE published recommendations in 2006 stating that all health professionals should offer brief advice of the benefits to stopping smoking to their patients and a referral to a specialist service. However, despite this, smoking cessation interventions are not generally part of routine care in a hospital setting.

Method A partnership with Aintree NHS Trust, Pfizer and a design agency was established to develop a creative campaign to promote the stop smoking service to hospital based health professionals who are influential messengers available to give expert advice to patients. Furthermore, we wanted to engage with the patients, friends and family directly to endorse the message. We trained staff on a number of wards to be champions for the campaign that was launched on No Smoking Day 2010. We agreed on the theme “Time to Quit” consisting of posters; leaflets; prompts in patient notes; and information folders for all wards and clinical areas.

Results The campaign met its objectives to increase the number of patients referred to the hospital stop smoking service. There was a 60% increase in the referrals at Aintree over the first 8 months compared to the previous year. We particularly noticed an increase on the wards with a Champion trained in delivering a brief intervention.

Conclusion A comprehensive educational campaign proved to be effective in raising awareness of the Hospital Stop Smoking Service and increasing referrals within the Trust. A similar campaign could contribute to an increase in referrals and support to patients in other secondary care settings, resulting in smoking cessation interventions becoming part of routine care in hospital settings. Moreover, the campaign contributes to supporting healthcare providers in their role in prevention and health education.

Abstract P128 Table 1

Period:	Referrals:	Estimated No. of quitters*:
May 2010–January 2011:	847	381
May 2009–January 2010:	529	238
Increase:	60%	143

*Numbers estimated, based on average quit rate of 45% at 4 weeks.

P129 REPORT OF A RESPIRATORY HEALTH CHECK IN A SELF-SELECTED GROUP OF MALE PRISONERS IN SUFFOLK

doi:10.1136/thoraxjnl-2011-201054c.129

L J Pearce, E Cecil, C Phillips, T B Pulimood, C M Laroche. *West Suffolk Hospital NHS Trust, Bury St Edmunds, UK*

Introduction A health bus sponsored by Pfizer Ltd was loaned to Suffolk PCT for a 2-week period in June 2011, for the purpose of health promotion in a range of Suffolk locations. During this period, two prisons were visited, each on one occasion only. At each prison, the Unit Manager allowed prisoners to attend for voluntary health checks. As part of this assessment, members of the Suffolk COPD nursing team carried out a respiratory-focused questionnaire and spirometry on each volunteer.

Method Each prisoner was asked a series of specific questions concerning respiratory status, including past and present history of smoking tobacco and other substances, presence of current respiratory symptoms, history of known respiratory conditions and respiratory medications. The questionnaire was administered by a respiratory nurse consultant, while a trained respiratory nurse carried out spirometry.

Results 136 prisoners underwent the respiratory health check. Age range was 19–55 years, average 33 years, median 31 years. 90 (66%) were current smokers (13% of whom had started smoking in prison), and a further 35 (26%) were ex-smokers. 85 (79% of current smokers and 40% of ex-smokers) had also smoked cannabis.

Conclusions In 2008, smoking rates for England were reported to be around 21% of adults.¹ This snapshot sample of two prisons in Suffolk is consistent with a higher prevalence of both current smoking (66%) and past smoking (26%) in prisoners, although the incidence may be artificially raised due to self selection for the health assessments. FEV₁/FVC ratio tended to be lower among smokers compared to ex smokers and never smokers. A more comprehensive study of prisoners should be considered, to reduce the burden of smoking related disease within the prison service.

Abstract P129 Table 1 Effect of smoking history in incidence of respiratory symptoms

Respiratory symptoms	Total	Shortness of breath on exertion	Cough	Sputum
Smokers	90	34	48	48
Ex-smokers	35	2	2	2

Abstract P129 Table 2 Effect of smoking history on spirometry

Spirometry	FEV ₁ /FVC ratio average	FEV ₁ /FVC ratio median	Range
Smokers	79%	81%	53–86
Ex-smokers	83%	84%	69–100
Non-smokers	90%	89%	86–100

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