Abstract S5 Figure 1 Secondary care smoking cessation product expenditure 2016/2017.

Results There was a 90-fold variation in expenditure on stop smoking products across London secondary care trusts (graph 1). Some of the highest expenditure was in trusts dealing with mental health. Comparing similar sized organisations to correct for bed numbers; within major teaching hospital groups, there was a 3-fold variation (£96 k vs £29 k). There was a 10-fold difference in smaller acute Trusts (£32 k vs £3 k) and specialist trusts (£14 k vs £1.4 k).

Discussion It is important to stress that expenditure does not equate to prescribing or use of these products. Also, this expenditure does not include any products bought in a hospital shop or provided by any on site external stop smoking services. Being unwell and admitted to hospital offers a unique opportunity for sick smokers to stop smoking. Heightened health concerns and being in an environment where smoking is not permitted enhances the motivation to quit. However, it appears that not all secondary care Trusts in London are providing the tools to help sick smokers quit. This may also reflect the lack of skilled advisors to provide support within these trusts. Hopefully, the variation in expenditure will narrow with the introduction of a national CQUIN for offering stop smoking products in secondary care coming into force for 2017–2019.

REFERENCE

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An update in pneumonia: from big data to cellular function

S6

ESTABLISHING THE TRUE INCIDENCE OF HOSPITALISED COMMUNITY ACQUIRED PNEUMONIA (CAP) IN THE UK: A HOSPITAL EPISODE STATISTICS (HES) ANALYSIS

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Introduction In November 2015, the Joint Committee on Vaccination and Immunisation (JCVI) recommended against including PCV13 for age based and risk based populations.¹ A

principal driver of this recommendation was the incidence of hospitalised pneumococcal pneumonia, reported by Rodrigo *et al.*² Using the Results from the study by Rodrigo *et al* a simple calculation can be performed to approximate the incidence of vaccine preventable pneumococcal CAP from all cause hospitalised CAP (ACH-CAP). The national Hospital Episodes Statistics (HES) database³ reports a significantly higher incidence of ACH-CAP which could impact the potential benefit provided by PCV13.

Aim To compare the incidence of ACH-CAP reported in the study by Rodrigo *et al.*² with the incidence of ACH-CAP coded in HES in the corresponding population, over a similar period of time.

Materials and Methods The study by Rodrigo *et al* ran from September 2008 for 5 years. Inpatients ≥16 years old, with symptoms suggestive of lower respiratory tract, new CXR infiltrates consistent with pneumonia, and treated for CAP, were included.² Our HES analysis included patients ≥18 years old with (ICD-10) codes J12–J18⁴ (April 2008 – March 2013) admitted to the hospitals in Rodrigo's study (Nottingham University Hospitals NHS Trust – City Campus and Queen's Medical Centre Campus).

Results Rodrigo and colleagues identified 2702 adults while our analysis of HES identified 11 059 across both sites.

Conclusion The study by Rodrigo *et al* was not specifically designed to capture total incidence of ACH-CAP, instead its objective was to report on pneumococcal serotype evolution.² Misclassification and misdiagnosis of pneumonia in HES is well-recognised⁵ but doesn't appear to explain the four-fold difference in these numbers. Further investigation to validate HES data against hospital records could be performed. Accurate incidence data would impact cost-effectiveness analyses and facilitate a more informed decision next time the data is reviewed.

Please refer to page A257 for declarations of interest in relation to abstract S6.

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