



# SMOKING CESSATION IN PRIMARY CARE

A CROSS-SECTIONAL SURVEY OF PRIMARY CARE HEALTH  
PRACTITIONERS IN THE UK AND THE USE OF VERY BRIEF  
ADVICE

**MARCH 2019**

# REFERENCE

This report should be referred to as follows:

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# CANCER RESEARCH UK

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# FOREWORD

In 1948, Sir Richard Doll joined a research team which went on to show that smoking could cause serious health damage, by which time the UK had the highest prevalence of smoking the world: in 1948, a staggering 82% of males and 41% of females aged 16 and over were using tobacco products.

Since then, through a multi-pronged approach by politicians, policy-makers and medical professionals, prevalence of smoking in the UK has dropped impressively, with 2018 NHS data showing that 15.1% of adults in the UK were still current smokers. This equates to around 7.4 million adults in the UK still smoking – increasing their risk of 15 types of cancer, as well as a range of cardiovascular and respiratory conditions. Within these statistics are found marked inequalities – in England, data suggests that smoking accounts for half the difference in life expectancy seen across the deprivation gradient, with the most deprived quintile smoking at rates more than two times higher than those seen in the least deprived quintile. Smoking prevalence rates in 25 to 34-year olds are almost two and a half those seen in the over 65s.

If we are to enable smoking prevalence to continue to fall, then renewed engagement is needed by all who are in positions of influence. Across the UK, nations are increasingly prioritising the prevention of those factors that impact on health. With smoking remaining the largest preventable cause of ill-health and premature death across the UK, primary care must make every contact count. Recent data from England alone showed that General Practice had delivered 307 million appointments in the previous 12 months – representing 90% of all NHS patient contacts. This presents primary care with a great opportunity to improve the health of the UK and, in particular, engage in activity that will help lower smoking prevalence further.

This report highlights the impact that very brief advice (VBA) can make, and primary care is well

placed to engage with the smoking population. The report goes on to demonstrate that the current pressures in primary care are presenting a significant barrier to primary healthcare practitioners engaging in smoking cessation activity. This, combined with insufficient training and cuts to smoking cessation services, has left an activity vacuum for what is the most cost-effective health intervention.

With political, policy and profession will, with adequate resourcing, and proactive training for primary care practitioners, there is the opportunity for the UK to become smoke free; where less than 5% of the adult population smoke by 2035 across all socioeconomic groups. If this target is achieved, we will have addressed the biggest preventable risk factor for cancer, the largest cause of death in the UK.



**Dr Richard Roope**

Clinical Champion for Cancer  
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# EXECUTIVE SUMMARY

## BACKGROUND

Smoking is still the single biggest cause of preventable illness, cancer, and avoidable death in the UK<sup>(1)</sup>, placing an enormous burden and cost on the UK's health service. Alongside national and local governments, the health service has a vital role in providing evidence-based support to help existing smokers to quit.

It is important that smokers are offered treatment to quit in both primary and secondary care settings. In the secondary care setting, evidence-based models that routinely provide treatment to smokers admitted to hospital are already being rolled out. NHS England has committed to implementing this model in secondary care and mental health trusts in England by 2023/24<sup>(2)</sup>, which could achieve net savings between £30-60m after just one year<sup>(3)</sup>.

However, primary care remains a crucial part of the prevention pathway and will typically reach a larger number of generally healthier and younger smokers. Cost-effective, proven smoking cessation interventions can be delivered simply and quickly through primary care to help reduce the number of people smoking in the UK.

Primary care health practitioners often have limited time to deliver comprehensive smoking cessation support during consultations. NICE guidance recommends that primary care health practitioners deliver Very Brief Advice (VBA) to patients that smoke, which takes less than 30 seconds<sup>(4)</sup>. VBA uses the 'AAA' framework<sup>(5)</sup> where practitioners:

- **Ask** their patient about smoking to establish their smoking status, and record;
- **Advise** their patients on how they can stop smoking; and
- **Act** by offering help to support them to quit. This includes referring patients to stop smoking services (SSS) or prescribing pharmacotherapy with brief advice.

## KEY FINDINGS

**PRIMARY CARE HEALTH PRACTITIONERS ARE MORE LIKELY TO DELIVER VBA IF THEY ARE AWARE OF LOCAL STOP SMOKING SERVICES**

### Completing very brief advice (VBA) for smoking cessation

Around half of primary care practitioners frequently complete VBA with patients



Despite NICE guidelines recommending universal use in primary care settings, around half (53%) of health practitioners reported frequently completing VBA.

When examining VBA steps individually (that is, examining reported frequency of each step occurring is isolation of the previous step), health practitioners often ask their patients about their smoking (84%) and advise patients on how to quit (87%). However, fewer health practitioners reported frequently taking action to support their patients to quit (64%).

These findings could reflect the declining availability of community SSS and reports that some commissioners are withdrawing pharmacotherapy for smoking cessation from their formularies. Both of these may limit health practitioners' ability to act and therefore complete VBA fully during consultations.

Completion of VBA is also linked to health practitioner awareness of local SSS in their area. Health practitioners are around twice as likely to refer if they are aware of local SSS or they agree that they are sufficient in their area. This illustrates the importance of raising awareness of local SSS among health practitioners when and where they are available.

### LOW REPORTED PRESCRIPTION OF PHARMACOTHERAPY AND RECOMMENDATION OF E-CIGARETTES FOR SMOKING CESSATION

When combined with behavioural support, there is good evidence for the use of both pharmacotherapy and e-cigarettes in supporting smokers to quit. However, the number of health practitioners who reported frequently prescribing pharmacotherapy for patients who smoke is relatively low, with 22% prescribing nicotine replacement therapy, 16% prescribing varenicline and 4% prescribing bupropion.

NICE guidance recommends health practitioners provide smokers interested in using an e-cigarette to quit smoking with information and advice<sup>(4)</sup>. However, only 1 in 4 (27%) health practitioners reported frequently providing patients with advice about e-cigarettes as a tool to quit.

### REFERRAL TO STOP SMOKING SERVICES IS VARIABLE ACROSS THE UK

There is geographical variation in the action taken by health practitioners for referring patients to SSS. In England and Northern Ireland, health practitioners most frequently refer to in-house SSS, whilst in Wales and Scotland, referral to external SSS in the community (commonly pharmacy or specialist services) is most common.

This may in part reflect inherent differences in how local public health and primary care services are delivered across the UK. Since the transfer of public health responsibilities from the NHS to local authorities in England in 2013, referral pathways from primary care to local SSS appear to not be as strong as in Scotland, Wales and Northern Ireland, where the health service retains responsibility for services.

### PRIMARY CARE HEALTH PRACTITIONERS REPORT THAT AN OVERLOADED HEALTH SYSTEM, LACK OF SUITABLE SERVICES, AND INSUFFICIENT TRAINING PREVENT THEM FROM DOING MORE

Patients having too many issues to address in a consultation was the most frequently reported barrier (59%) for health practitioners initiating conversations about smoking cessation with patients, and was more pronounced for GPs compared to nurses, with nearly three quarters (72%) citing this factor.

Some 40% reported that they perceived that patients were unreceptive to smoking cessation advice and around 15% were concerned about negative patient reactions. Additional barriers reported were the perception that other health care practitioners are

responsible for this type of intervention (15%) and the lack of referral options (15%).

## POLICY RECOMMENDATIONS

In response to the report findings, Cancer Research UK has several recommendations.

### Primary care service commissioners and planners across the UK should:

- Prioritise smoking cessation and tobacco control in regional plans.
- In England, work with local authorities to ensure shared understanding of tobacco control responsibilities, seamless referrals to local SSS, and availability of pharmacotherapies to all smokers.
- Signpost to and/or provide all primary care health practitioners with training in the delivery of VBA.
- Ensure pharmacotherapy for smoking cessation is available on prescription and encourage primary care health practitioners to prescribe pharmacotherapy with brief advice for smoking cessation.
- Support the use of e-cigarettes as an aid to stop smoking, recommending that they can also be used alongside behavioural support.

### Primary care health practitioners across the UK should:

- Complete training in VBA and employ this tool to initiate conversations with all patients about stopping smoking.
- Be aware of treatment options available to patients in their local area, including prescribing pharmacotherapy or referring patients to SSS in their practice or community.
- Support the use of e-cigarettes as an aid to stop smoking, recommending they can also be used alongside behavioural support.

### Barriers to initiating conversations about smoking cessation in primary care



Overloaded health system



Lack of suitable services



Insufficient training

In England, to ensure that smokers can access support in all parts of our public health system, smoking cessation support in the NHS should be delivered alongside and in partnership with local authority smoking cessation services in the community. The UK Government must provide local authorities with sufficient funding for these services. A “polluter pays” approach should be adopted so that the tobacco industry makes a greater contribution to the healthcare costs caused by smoking, via a Tobacco Industry Levy.

## **METHODOLOGY**

Cancer Research UK conducted a cross-sectional survey of primary care health practitioners to explore the factors that impact the delivery of smoking cessation interventions across the UK. The online survey of General Practitioners and Practice Nurses, delivered between January and March 2017, aimed to better understand the type of smoking cessation advice reported by primary care health practitioners, their awareness of smoking cessation services in their local area and their perceived barriers to referring patients to these services.

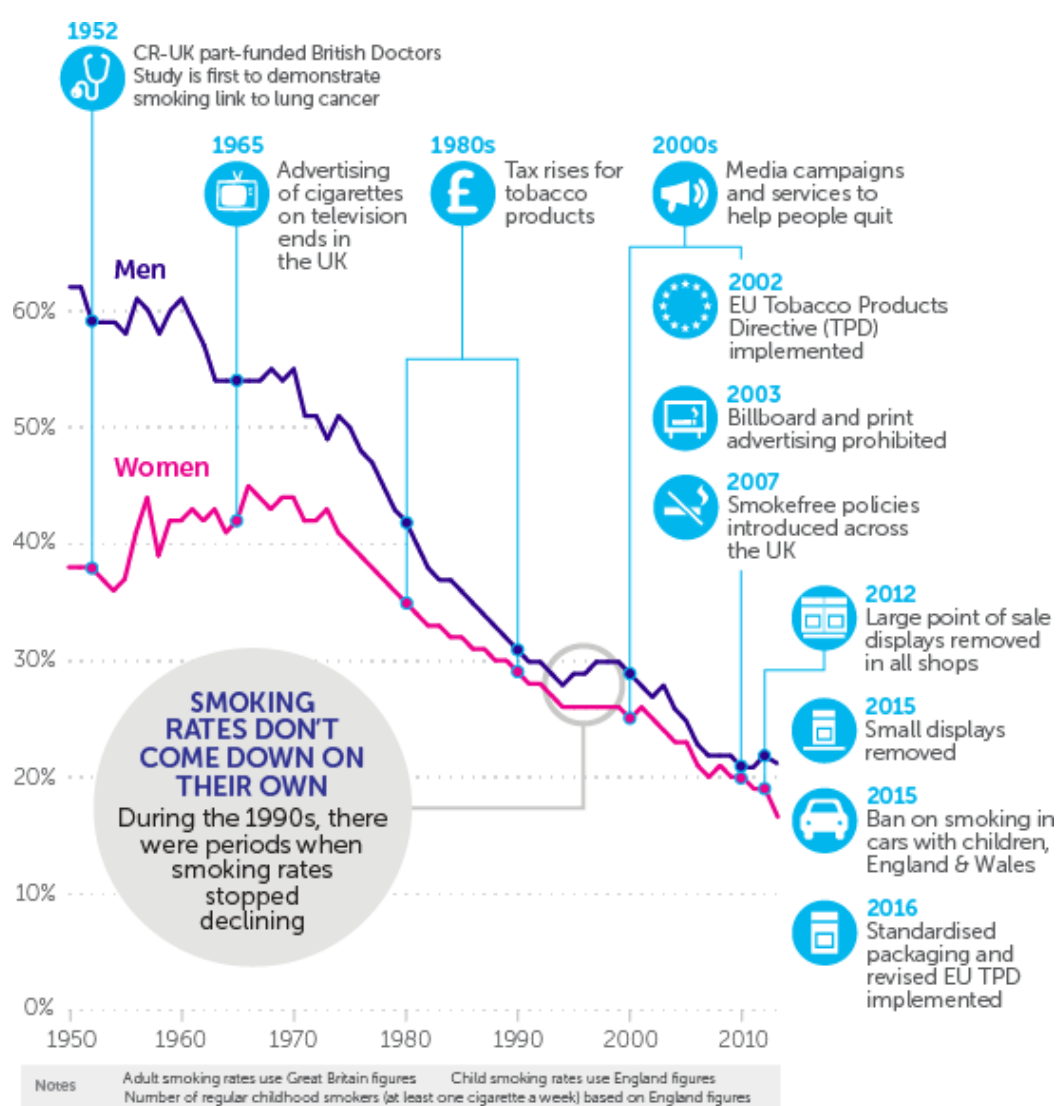
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# INTRODUCTION

Smoking is the single biggest cause of preventable illness and avoidable death in the UK<sup>(1)</sup>, accounting for 115,000 deaths per year<sup>(1)</sup>. Smoking is still the biggest cause of cancer in the UK, causing around 54,300 cases of cancer a year and is associated with at least 15 different types of cancer<sup>(6)</sup>. This includes 72% of all lung cancer cases<sup>(6)</sup>, which has one of the lowest cancer survival rates<sup>(7)</sup>. It is estimated that the cost to the NHS of treating smoking related illnesses in England is approximately £2bn a year<sup>(8)</sup>.

The proportion of the UK population who smoke has declined over recent decades, from 46% in 1974<sup>(9)</sup> to 15% in 2017<sup>(10)</sup>. Furthermore, smoking prevalence in certain groups is significantly higher e.g. nearly 26% in routine and manual workers<sup>(10)</sup>. For declines in the rate of smoking to continue, tobacco control policy must continue to be both evidence-based and well implemented, following in the footsteps of successful tobacco control policies that were instrumental in the declines of the past 35 years (see Figure 1).



**FIGURE 1: TOBACCO CONTROL POLICIES AND THE DECLINE IN SMOKING RATES**



National and local governments and the health service play an important role in providing smoking cessation support. In the secondary care setting, there is growing appetite for implementing best practice initiatives that routinely identify and treat smokers in hospitals to support patients to quit: this model of care is known as the Ottawa Model<sup>i</sup>. In the NHS Long Term Plan, NHS England committed to implementing this model across all secondary care trusts by 2023/24<sup>(2)</sup> which could achieve net-savings of between £30 to £60 million after just one year<sup>(3)</sup>. In Greater Manchester, a pilot of this model has estimated a conservative cost-saving of almost £10 million per year and an additional 84 beds per day available in the area<sup>(11)</sup>. In Scotland, Wales and Northern Ireland a similar offer is provided in selected trusts. These initiatives provide support to relatively small numbers of patients admitted to acute care, who are typically sicker, older or living with multi-morbidities.

To reach a larger number of generally healthier and younger smokers, interventions offered through primary care have great potential to drive down smoking rates across the UK. There is strong evidence that cost-effective, successful smoking interventions can be delivered in primary care, to contribute to a continued decline in UK smoking rates<sup>(12; 13; 14; 15; 16; 17; 18; 19; 20; 21; 22; 23)</sup>. Quit attempts made by smokers accessing NHS stop smoking services are around three times more likely to be successful than unaided attempts<sup>(24)</sup>, and primary care interventions are often simple and quick to implement<sup>(25)</sup>. Recently updated NICE guidance on stop smoking interventions and services<sup>(4)</sup> states that:

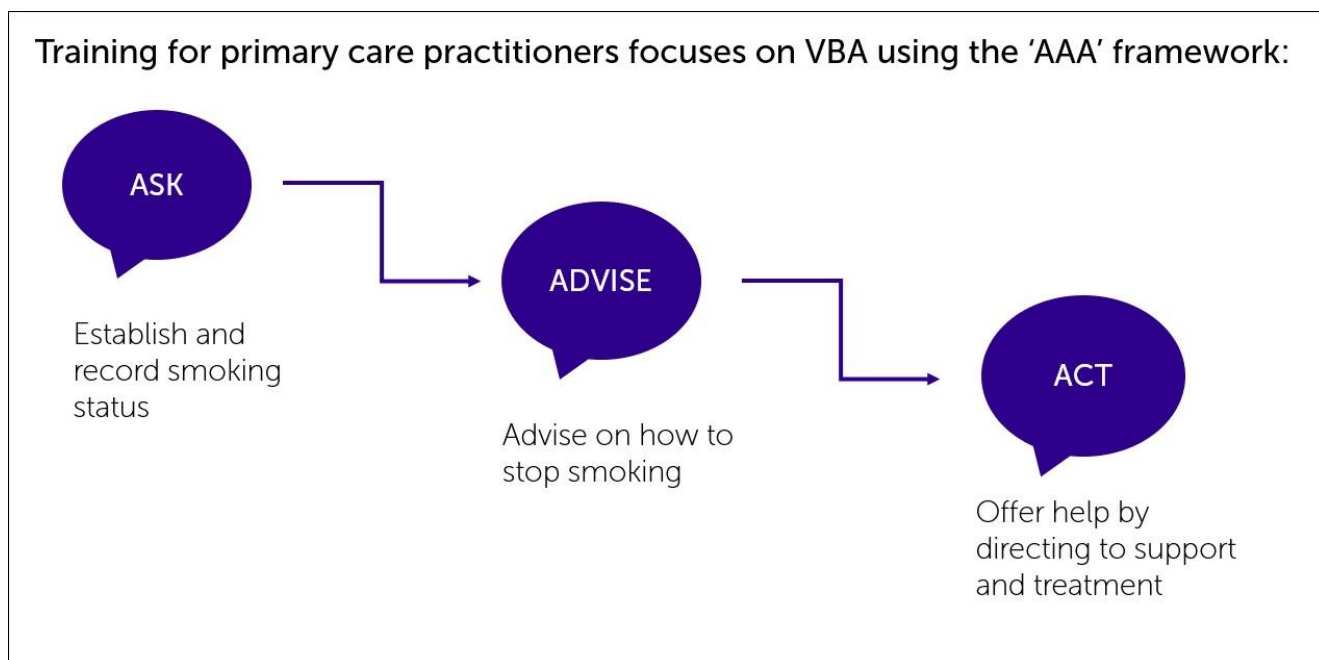
- Evidence-based stop smoking interventions and services should be available to everyone who smokes, including: individual and group behavioural support, pharmacotherapy, nicotine replacement therapy (NRT) and very brief advice.
- Health practitioners should, at every opportunity, ask people if they smoke and advise them to stop smoking in a way that is sensitive to their preferences and needs.
- Health practitioners should refer people who want to stop smoking to local stop smoking services; and if people opt out of referral, health practitioners should refer them to a professional who can offer pharmacotherapy.

One recommended primary care smoking intervention is 'Brief Advice'<sup>(26)</sup>. These interventions, which typically last one to three minutes, have been found to increase the number of quit attempts made by smokers using primary care services<sup>(27)</sup> and promote smoking cessation<sup>(19)</sup>. Brief Advice in primary care has the potential to be highly successful and cost-effective, since it does not require specific equipment, and can be delivered by all types of primary care practitioners<sup>(27)</sup>. Primary care practitioners often have limited time in consultations, therefore NICE have recommended undertaking 'Very Brief Advice' (VBA), which can be delivered in 30 seconds<sup>(4)</sup>. Training for primary care practitioners in VBA uses the 'AAA' framework<sup>(5)</sup> (Figure 2):

- **Ask** their patient about smoking to establish their smoking status, and record;
- **Advise** their patients on how they can stop smoking; and
- **Act** by offering help to support them to quit. This includes referring patients to stop smoking services or prescribing pharmacotherapy with brief advice.

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<sup>i</sup>The Ottawa Model refers to the successful smoking cessation programme developed by the University of Ottawa Heart Institute, which ensures all patients who smoke are identified and offered evidence-based behavioural support and smoking cessation pharmacotherapies.



**FIGURE 2: VERY BRIEF ADVICE—3A'S FRAMEWORK**

In April 2013 the responsibility for public health in England was formally transferred from the NHS to local authorities<sup>(28)</sup>, and in 2015 the national public health grant experienced a £200 million in-year cut, which led to reduced budgets for smoking cessation in 6 in 10 local authorities in 2016<sup>(29)</sup>. This has made it increasingly difficult for primary care practitioners to implement the NICE guidelines, and further cuts have been announced until 2019<sup>(30)</sup>. Tobacco control leads in local authorities recently reported that, as a result of these cuts, specialist smoking cessation services are under threat, along with less staff time dedicated to tobacco control, fewer campaigns, and closure or suspension of the local Tobacco Control Alliance<sup>(29)</sup>. Alongside these challenges, barriers to primary care practitioners delivering smoking interventions have been reported. These include access to training for practitioners<sup>(31)</sup>, time constraints when undergoing training and for implementing the intervention itself<sup>(27)</sup> and (despite evidence to the contrary<sup>(32; 33)</sup>), the perception that the advice may be unwelcome or will harm the practitioner-patient relationship<sup>(27)</sup>. Vulnerable people, such as those in lower socioeconomic groups and people with mental illness, experience additional barriers to accessing stop smoking support<sup>(34; 35; 36)</sup>.

It is important to understand the factors that affect primary care practitioners and services in delivering effective smoking interventions. However, there is no recent UK-wide data on VBA in primary care, nor is there data on the barriers and enablers to implementing this tool in primary care. Moreover, little is known about how recent budget cuts and the transfer of stop smoking service to local authorities has influenced the delivery of VBA across primary care in England. Addressing these gaps will be highly valuable in ensuring that primary care fully contributes to smoking cessation in the UK.

## RESEARCH AIMS AND OBJECTIVES

A UK wide cross-sectional survey of primary care practitioners was conducted to investigate the following:

- What type of smoking cessation VBA is given in primary care;
- What smoking cessation referrals are made in primary care;
- What are the perceived practitioner barriers to effective smoking cessation interventions;
- What is the relationship between awareness of local service provision and smoking cessation VBA.

# METHODS

An online survey consisting of four modules, three modules about primary care practitioner practices for smoking, weight, and alcohol in their patients, and a demographic module was conducted. The three risk factor modules asked identical questions, collecting data on the three stages of VBA (ask, advise, act), service awareness, and perceived barriers. Results relating to the smoking and demographic modules are included in this report.

## SURVEY DEVELOPMENT

The survey was designed to be suitable for both General Practitioners (GPs) and Practice Nurses (PNs). Questions were drawn from other survey tools and adapted where necessary to be relevant to addressing smoking, weight and alcohol use in primary care in the UK. Where no existing tools could be found, new questions were developed and piloted using a health professional panel, made up of eight Cancer Research UK health facilitators who work with primary care practitioners, for length, clarity, content and style of questions. The survey was refined in response to this feedback, namely to ensure that the questions were suitable and understandable for both GPs and PNs across all four nations in the UK. A small number of questions were removed to reduce participant burden. The survey was further tested with a 'soft launch' by a market research company (Research Now) among 50 health professionals. This showed good completion rates with the expected range of responses and time taken to complete the survey. For the full details of the survey questions see Appendix 1.

## DEMOGRAPHIC INFORMATION

Job type, years qualified, age, gender and Clinical Commissioning Group (CCG)/health board were collected from survey participants.

## CASE STUDY

Survey participants were presented with a brief case study, tailored to their specific role. This allowed the respondents to consider their responses within the context of the consultation. For GPs, the case study read "John is a 47-year-old male who presents with a painful knee joint" and for PNs the case study read "John is a 47-year-old male who presents with painful ears". Different case studies were used for GPs and PNs to reflect the different types of patient that they would typically see in primary care. By adopting issues not related to tobacco, this prevents the responses to the survey questions from being affected by bias from the case study.

## ASK — CONVERSATION RATES AND PROMPTS

The frequency that practitioners asked patients about smoking status was recorded using a 5-point Likert scale ranging from always to never. The factors that prompted this were investigated in the case study by asking "Which one of the following are most likely to result in you asking John about his smoking status?". Response options were: previous smoking-related health condition; smoking associated symptoms; physical cues e.g. the smell of smoke; computer prompt; incentives payments; known smoker from previous medical records; NICE tobacco guidelines; other. These are generalised response options that may not all be applicable to the individual practitioner as some practices might not have computer prompts or might not have incentives payments (e.g. QOF payments which are no longer in place).

## **ADVISE — ADVICE GIVEN**

The frequency that practitioners gave smoking cessation advice to known smokers was recorded using a 5-point Likert scale ranging from always to never. The frequency of different types of advice was recorded using a 5-point Likert scale ranging from always to never. This included the suggestion that they cut down on their smoking; record smoking levels (i.e. keep a smoking diary); arranging a follow up appointment to further discuss smoking cessation; providing an information leaflet; highlighting stop smoking services within / outside the practice; discussing e-cigarette use.

## **ACT — REFERRAL/PRESCRIPTION**

The frequency that practitioners made referrals or prescriptions to known smokers was recorded using a 5-point Likert scale ranging from always to never. This included referring to a stop smoking service within / outside the practice and prescribing NRT.

## **SERVICE AWARENESS**

Participants were asked a free text question “What smoking cessation options do you know about in your area?”. The responses coded as at least one of: Smoking cessation services; in-house service; community pharmacy; hospital; NRT/Champix; online/telephone; no service; other; no response. This grouping and recoding was done to allow the quantitative analysis of these responses alongside other variables collected in the survey. These are generalised response options that may not all be applicable to the individual practitioner. Responses may reflect a lack of presence of a particular service, rather than merely a lack of awareness.

Participants were asked whether there are sufficient local stop smoking services and if budget cuts had negatively affected stop smoking services using a 5-point Likert scale ranging from strongly agree to strongly disagree, with an additional “don’t know” option.

## **BARRIERS**

Participants were asked “looking beyond the factors of insufficient time and money, please select the three main factors you feel deter from you from providing smoking cessation interventions in consultations”. Seventeen potential barriers were listed including patients have too many things to address, patients appeared unreceptive to smoking cessation advice, and lack of referral options.

## **STAKEHOLDER ENGAGEMENT**

The survey was developed with guidance from internal teams at Cancer Research UK in consultation with practicing GPs, PNs and representatives of Cancer Research UK’s primary care facilitator team.

## **DATA COLLECTION**

A total of 2,026 GPs and PNs were recruited by Research Now, a market research company experienced in conducting surveys with health practitioners. For this study, practitioners from outside of England, Scotland, Northern Ireland or Wales were excluded (n=6), resulting in a final sample of 2,020. All participants were recruited from an online panel of members who had previously expressed an interest of completing surveys. The survey was distributed and completed via an online platform hosted by the market research company. Screening questions were conducted by the market research company, ensuring only GPs and PNs were included—practitioners such as physiotherapists and dentists were excluded prior to completing the survey. Automated sampling with geographical quotas for England, Wales, Scotland and Northern Ireland was applied to ensure a generally representative sample of the UK’s primary care GP and PN population. Data were collected between January and March 2017.

## DATA ANALYSIS

Data were analysed using IBM SPSS version 23 and Statacorp Stata Statistical Software release 13.

### WEIGHTING

Research Now administered the survey on behalf of Cancer Research UK. Weights were applied to geographical region to make the sample nationally representative with respect to the country of residence – see Table 1.

### STATISTICAL ANALYSIS

Responses were categorised as binary variables: positive (“Strongly agree” and “Agree”) and negative “Disagree” and “Strongly disagree”); frequently (“Always” and “Often”) and infrequently (“Sometimes”, “Occasionally” and “Never”) unless otherwise stated. Awareness percentages refer to percentage of “group” aware of service. Responses of “don’t know” were excluded from the analysis.

Categorical variables included in the analysis (type of primary care health practitioner, years qualified, practice size and country in UK) are shown in Table 1. Those with unknown practice size were also excluded from the analysis.

Multivariable logistic regression was used to estimate odds ratios and test for statistically significant associations in responses to the survey questions for type of primary care health practitioner, years qualified, practice size and country in UK. The final multivariable regression models were developed using backwards stepwise elimination of non-significant variables ( $p \geq 0.05$ ). Interaction terms were included for logistic regression models for analysis presented in section 4.2, 4.3 and 4.4 to determine if statistically significant associations in responses varied by provider type (i.e. whether responses were statistically significantly different between different groups, for instance for PNs and GPs qualified for different lengths of time, and practitioners in different countries. Only significant interaction terms (where investigated) ( $p < 0.05$ ) were retained in the final logistic regression model for each question. These differences have not been presented in this report.

Additional analysis was performed to investigate differences between health practitioners completing the VBA 3 A’s pathway compared to those that fail to complete the pathway. Multivariable logistic regression was used to test for statistically significant associations in responses to the survey questions with completion of each of the 3 A’s in the pathway (the categories included as a variable in each of the models are explained further below in section 4.7) with adjustment for type of primary care health practitioner, years qualified, practice size and country in UK.

Proportions reported are weighted percentages accounting for regional bias in sampling to be representative of the UK population, unless specified. Adjusted odds ratios from multivariable analysis are presented unless specified. Where relevant, significant results ( $p < 0.05$ ) and their corresponding p-values are reported. Full analyses are available on request.

## ETHICS

Ethical approval was granted in January 2017 for the study by the NHS, Invasive or Clinical Research (NICR) Committee at the University of Stirling, UK.

# RESULTS

## DEMOGRAPHICS

A nationally representative sample (n=2,020) of primary care health practitioners was surveyed and weighted by country of residence. Gender, profession, years since qualification and practice size were additionally recorded. The greatest proportion of respondents have been qualified for over 20 years (44%) and worked in practices serving 5,000–20,000 individuals (72.1%) in England (83.8%). A full demographic breakdown is shown in Table 1.

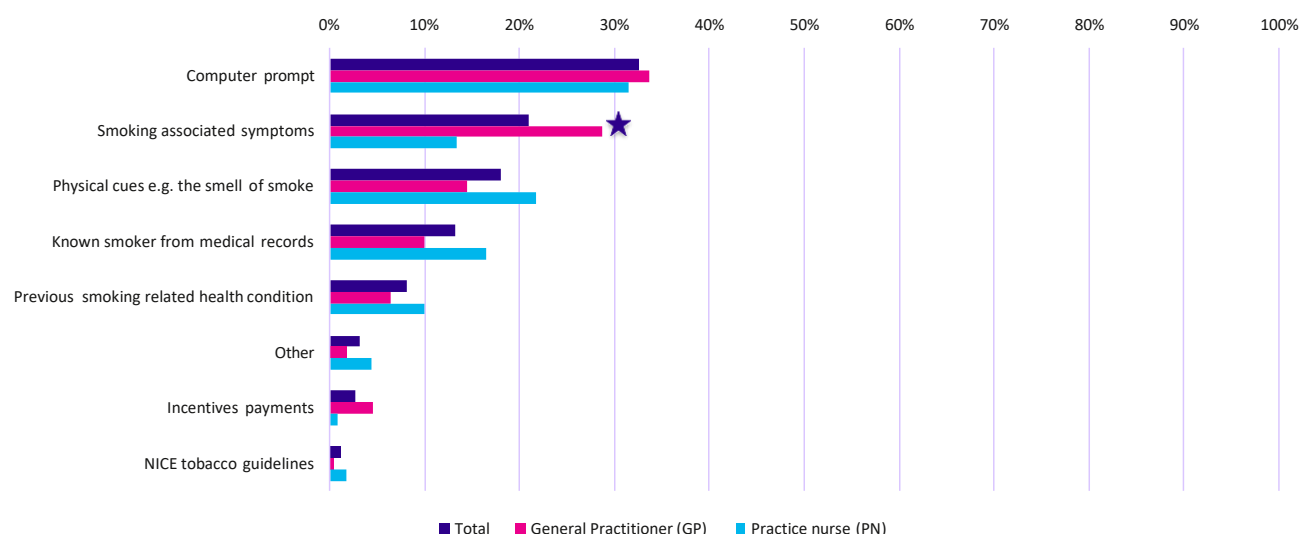
**TABLE 1: SAMPLE CHARACTERISTICS (N=2,020)**

	Groups	Unweighted Sample		Weighted Sample	
		n	%	n	%
<b>Gender</b>	Male	683	33.8%	681	33.7%
	Female	1,337	66.2%	1,339	66.3%
<b>Years Qualified</b>	0–5 years	169	8.4%	171	8.5%
	6–10 years	307	15.2%	308	15.2%
	11–15 years	331	16.4%	331	16.4%
	16–20	306	15.1%	306	15.1%
	More than 20 years	907	44.9%	905	44.8%
<b>Healthcare profession</b>	GP	1,006	49.8%	1,006	49.8%
	PN	1,014	50.2%	1,014	50.2%
<b>Practice size</b>	<2000	76	3.8%	76	3.8%
	2,000 to <5,000	317	15.7%	314	15.5%
	5,000 to <10,000	743	36.8%	739	36.6%
	10,000 to <20,000	711	35.2%	717	35.5%
	≥20,000	105	5.2%	107	5.3%
	Unsure	68	3.4%	67	3.3%
<b>UK Nation</b>	England	1,652	81.8%	1,693	83.8%
	Scotland	198	9.8%	172	8.5%
	Wales	102	5.0%	99	4.9%
	Northern Ireland	68	3.4%	57	2.8%

## VBA: ASK

Eighty four percent of primary care practitioners stated that they frequently ask patients about their smoking status. PNs would ask about smoking status more often than GPs (87% vs 78%, OR 2.78,  $p=0.008$ ).

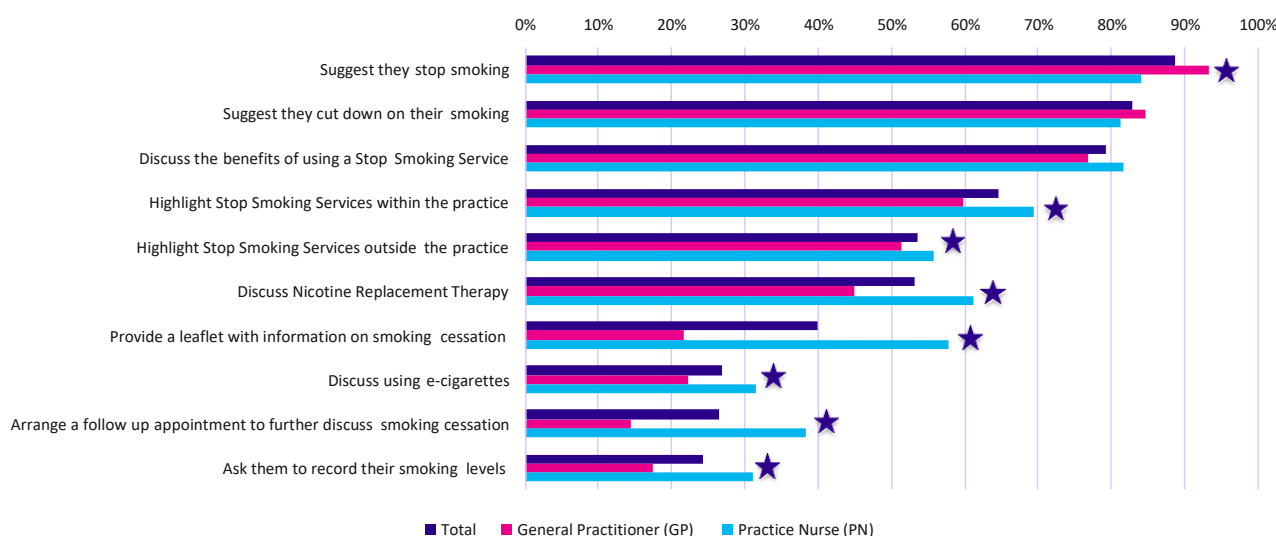
Practitioners were asked what would prompt an enquiry about smoking (Figure 3). A computer prompt was most likely to initiate a conversation around smoking for both PNs and GPs (33%). Smoking associated symptoms (22%), physical cues (18%) and known from medical records (13%) were the highest recorded incentives. Financial incentives (3%) and the NICE guidelines (1%) were unlikely to prompt GPs and PNs in primary care to discuss smoking status. GPs were more likely to respond to smoking associated symptoms than PNs, (29% vs 13%, OR 2.5,  $p<0.001$ ).



**FIGURE 3: FACTORS THAT WOULD PROMPT AN ENQUIRY INTO THE SMOKING STATUS OF A PATIENT PRESENTING TO PRIMARY CARE.** ★ Indicates where there was an independent significant difference in the responses given by GPs and PNs

## VBA: ADVISE

The vast majority of practitioners (87%) stated that they would frequently offer advice to smokers attending primary care. The type of advice given included asking patients to stop smoking (89%), asking patients to cut down (83%) and discussing the benefits of using a stop smoking service (79%). GPs and PNs were less likely to discuss nicotine replacement either as NRT (53%) or e-cigarettes (27%) (Figure 4).



**FIGURE 4: ADVICE GIVEN BY GPs AND PNs IN THE UK DURING PRIMARY CARE CONSULTATIONS.** ★ Indicates where there was an independent significant difference in the responses given by GPs and PNs

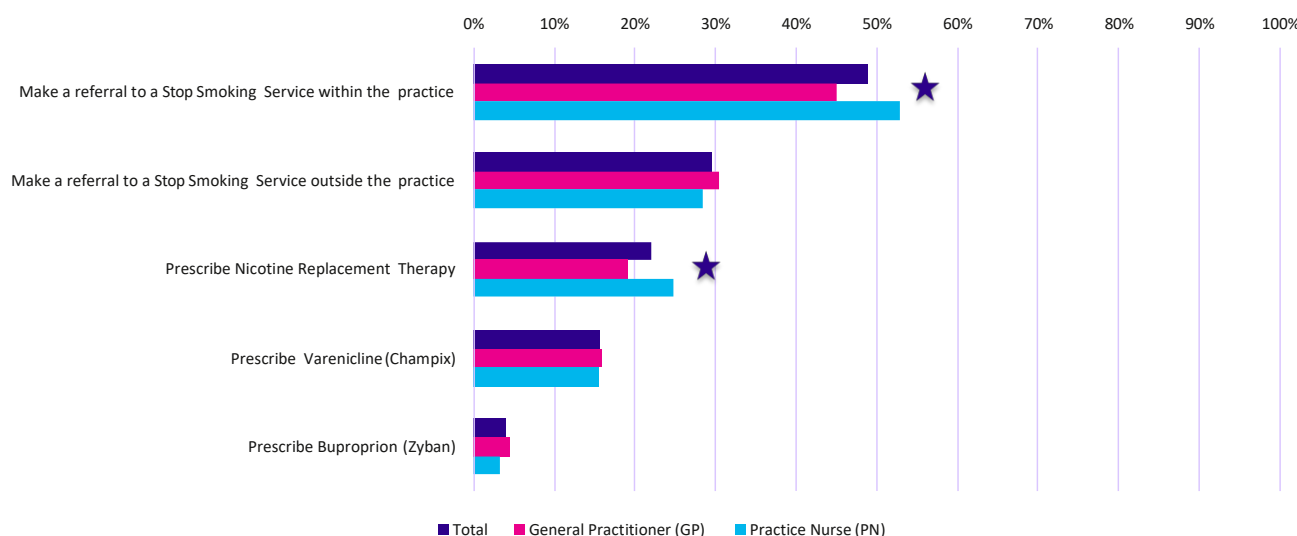
GPs and PNs reported significant differences in the advice offered to patients in primary care consultations. PNs are more likely than GPs to ask patients to frequently record smoking levels (31% vs 18%, OR 2.3,  $p < 0.001$ ), arrange a follow up appointment (38% vs 15%, OR 3.79,  $p < 0.001$ ) or provide a patient information leaflet (58% vs 22%, OR 5.32,  $P = 0.001$ ). PNs were also more likely to discuss smoking cessation options including using e-cigarettes (32% vs 22%, OR 1.6  $p < 0.001$ ) and highlighting



smoking cessation services within the practice (69% vs 60%, OR 1.6,  $p<0.001$ ). GPs were more likely than PNs to suggest patients stop smoking (93% vs 84%, OR 4.3,  $p=0.001$ ).

## VBA: ACT

Nearly two thirds of practitioners (64%) reported frequently taking further action when patients reported that they currently smoked. Further action was defined as referral to a stop smoking service present within the clinic or delivered externally, or the prescription of NRT or medicine to reduce craving (varenicline/bupropion). The most common action taken was referral to an internal stop smoking service within the practice (49%) followed by referral to a stop smoking service delivered outside the practice (29%). Prescription of pharmacotherapy to support smoking cessation was low for each of available licensed products: NRT (22%), varenicline (16%) and bupropion (4%), see in Figure 5.



**FIGURE 5: ACTION TAKEN BY PRIMARY CARE HEALTH PRACTITIONERS FOLLOWING A CONVERSATION ABOUT SMOKING CESSATION.** ★ Indicates where there was an independent significant difference in the responses given by GPs and PNs

Differences were found between doctors and nurses regarding the likelihood to refer to stop smoking services. PNs were more likely than GPs to refer to a stop smoking service within the practice (53% vs 45%, OR 1.2,  $p=0.01$ ). PNs were also more likely to prescribe NRT (25% vs 19%, OR 1.6,  $p<0.001$ ).

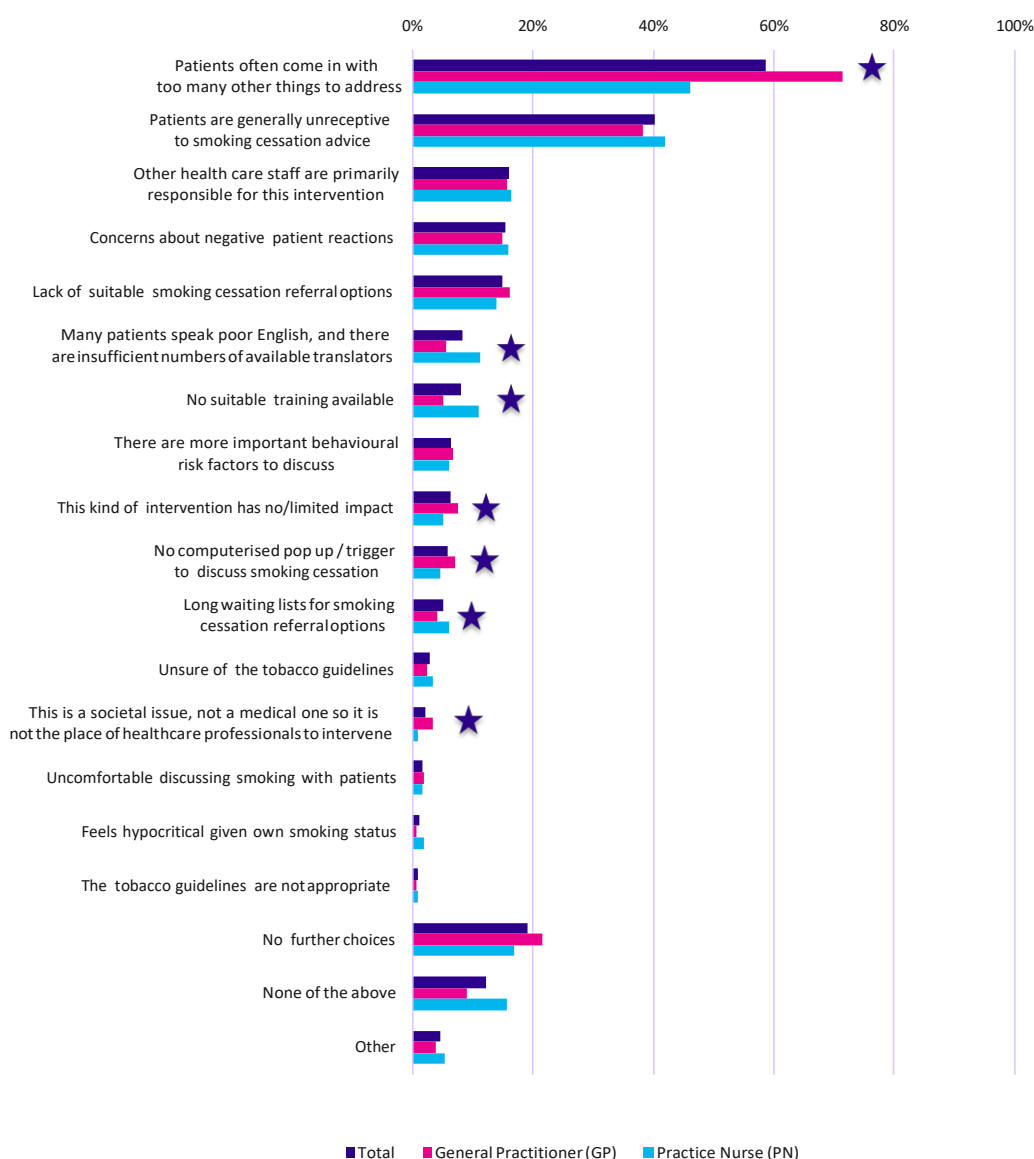
When considering all primary care practitioners, differences in the likelihood to refer to stop smoking services were observed by country in the multivariable models. Practitioners from Wales and Scotland were less likely to refer to stop smoking services present within primary care practices when compared to England (Wales 36% vs 51%, OR 0.54,  $p=0.003$ ; Scotland 34% vs 51%, OR 0.49,  $p<0.001$ ). This trend was reversed for stop smoking services outside of the practice. Practitioners in Wales and Scotland were significantly more likely to refer to external stop smoking services than practitioners in England (Wales 50% vs 27%, OR 2.67,  $p<0.001$ ; Scotland 39% vs 27%, OR 1.75,  $p=0.001$ ). Referral rates in Northern Ireland were not significantly different to rates in England.

Referral to external smoking cessation services was more likely from small practices with less than 5,000 patients than large practices serving over 20,000 (31% vs 18%, OR 1.74,  $p=0.04$ ). Intermediate practice sizes from 5,000–20,000 individuals demonstrated no significant change in referral rates for internal or external smoking cessation services.



## BARRIERS

Health practitioners were asked to select from a defined list of top three factors that would prevent the initiation of a conversation about smoking and smoking cessation in primary care. The top barrier reported by 59% of respondents is that they have too many other things to address in a single consultation with a patient. Forty percent reported that they perceived that patients were unreceptive to smoking cessation advice. An additional barrier reported was the perception that other health care practitioners are responsible for this type of intervention (15%), concerns around negative patient reactions (15%) and lack of referral options (15%) were also cited as the top five barriers for all primary care practitioners (see Figure 6).



**FIGURE 6: SELF-REPORTED BARRIERS TO INITIATING CONVERSATIONS ABOUT SMOKING CESSATION IN PRIMARY CARE.** ★ Indicates where there was an independent significant difference in the responses given by GPs and PNs

PNs were more likely than GPs to cite: lack of suitable training (11% vs 5%, OR 2.4,  $p<0.001$ ); many patients speak poor English and there is a lack of translators (11% vs 6%, OR 2.17,  $p<0.001$ ). GPs were more likely to cite: Patients attend clinic with too many things to address (72% vs 46%, OR 2.9,  $p<0.001$ ); and this intervention has no/limited impact (8% vs 5%, OR 1.59,  $p=0.01$ ).

Geographical variations were also seen in the perceived barriers. Respondents in Wales were more likely to cite: patients are unreceptive to advice (54% vs 40% OR 1.8,  $p=0.003$ ); and concerns around negative patient reactions (24% vs 19%, OR 1.9,  $p=0.01$ ), and less likely to cite other health care staff are responsible for this intervention as barriers compared to English respondents (9% vs 16%, OR 0.5,  $p=0.048$ ). Respondents based in Scotland were less likely to cite: the availability of smoking cessation services (8% vs 16%, OR 0.47,  $p=0.005$ ); that many patients speak poor English; and there is a lack of translators as barriers (5% vs 9%, OR 0.48,  $p=0.04$ ) when compared to English respondents.

## PRACTITIONERS DELIVERING VBA

Just over half the practitioners (53%,  $n=1,074$ ) frequently completed all steps in the ASK, ADVISE and ACT pathway for VBA (Figure 7). The responses of these practitioners were analysed and compared to those who did not complete the pathway (i.e. those that frequently did the ASK, ADVISE but not ACT) to identify barriers affecting referral specifically. Barriers more frequently reported by practitioners that don't complete the pathway include the perception of a "Lack of smoking cessation services locally" (22% vs 12%, OR 2.1,  $p<0.001$ ,  $n=1,541$ ) and that "interventions of this type have limited impact" (9% vs 4%, OR 2.1,  $p=0.001$ ,  $n=1,541$ ).



**FIGURE 7: PROPORTION OF HEALTH PRACTITIONERS DELIVERING ALL PARTS OF VBA**

## AWARENESS OF LOCAL SMOKING CESSATION SERVICES

Practitioners were asked to report their awareness of smoking cessation services or interventions available in their local area. Fifty three percent of respondents were aware of a smoking cessation service. About half (51%) were aware of in-house services and 29% were aware of services delivered through community pharmacy. Other responses included: 7% online/ telephone services; 3% Hospital delivered support; 8% Medicine/NRT and 1% e-cigarette. Four percent of respondents could not identify a relevant service or intervention.

Regional differences were also found in relation to the awareness of different types of services. In-house service awareness was greatest in England (54%) and lower in Wales (33%, OR 0.42,  $p<0.001$ ) and Scotland (31%, OR 0.38,  $p<0.001$ ). Awareness of pharmacy services was higher in Scotland (66%, OR 6.87,  $p<0.001$ ), and Northern Ireland (46%, OR 2.6,  $p<0.001$ ) when compared to England 25%.

## **AWARENESS IS LINKED TO REFERRAL**

There was an association between referrals and awareness of local smoking cessation services. Practitioners who frequently referred to a smoking cessation service were more aware of in-house smoking cessation services than those who did not (58% vs 39%, OR 2.1,  $p<0.001$ ,  $n=1,541$ ).

## **SUFFICIENT SERVICES**

Fifty nine percent of primary care practitioners reported that, in their opinion, there were sufficient stop smoking services in their area. Practitioners who frequently referred to a smoking cessation service more likely to agree that there were sufficient stop smoking services compared to those that did not (65% vs 48%, OR 2.1,  $p<0.001$ ,  $n=1,507$ ).

## **BUDGETS CUTS**

Forty two percent of primary care practitioners agreed that budget cuts to public health have negatively impacted smoking cessation services locally. Primary care practitioners who did not frequently refer to a smoking cessation service were more likely to agree with the statement compared to those who did (47% vs 39% OR 1.4,  $p=0.001$ ,  $n=1,433$ ).

# DISCUSSION

This report explores the factors that impact on the delivery of smoking cessation interventions by primary care health practitioners. It is based on a cross-sectional survey of GPs and PNs conducted between January and March 2017. Current smoking cessation activities of GPs and PNs were investigated with reference to the NICE recommended<sup>(37)</sup> VBA model of ASK, ADVISE, ACT. These findings were analysed alongside perceived practitioner barriers to identify key areas for improvement. A consistently strong association was found between the awareness of local stop smoking services and increased delivery of VBA in primary care.

Just over half of the respondents (53%) reported frequently completing the VBA pathway, despite the vast majority (84%) frequently initiating smoking cessation conversations. Those who did not frequently refer to smoking cessation interventions were more likely to state that budget cuts have negatively impacted on stop smoking services and were less likely to agree that there are sufficient services in their area. They were also twice as likely to cite a lack of local stop smoking services as a barrier to initiating smoking cessation conversations. Conversely, practitioners who were aware of an in-house stop smoking service were twice as likely to refer to smoking cessation interventions as those who were not. Where this resource is not available in the practice, practitioners may not understand the importance of delivering VBA, particularly if there is no local specialist external service available. The repeated association between the different stop smoking service variables and VBA reinforces the importance of knowledge of and access to suitable referral options for successful smoking interventions in primary care. To the author's knowledge, this is the first study to investigate and identify a clear link between action by primary care health practitioners and the awareness of stop smoking services to which to refer.

Geographical variation was seen in the action that practitioners reported taking in relation to referral. In England, the presence of a trained smoking cessation adviser within the primary care practice (an 'in-house smoking cessation service') was the most frequently cited option, whilst in Wales and Scotland, referral to external stop smoking services in the community (usually pharmacy or specialist services) were most common. This mirrored the awareness of local (external) stop smoking services, with a significantly higher knowledge of in-house services in England than in Scotland and Wales. In Northern Ireland the most common referral option was an "in-house smoking cessation service" and this was also the type of service with the highest awareness, however the sample size was too small for any further analysis.

These findings could reflect the different patterns of service provision across the UK<sup>(3; 36)</sup>. External services in Wales and Scotland are still under NHS provision whereas in England, external services sit with local authorities. Therefore, these results could be indicating that the links between local authority services in the community and primary care are not as strong as those between NHS services and primary care (as in Scotland and Wales). In England, although arguably across the UK, there is a need for better connections at a local level so primary care practitioners know where to refer if an in-house service is not available<sup>(3)</sup>. In addition although services in Scotland and Wales have experienced reductions in funding (in terms of budgets not keeping pace with inflation in particular), these services have not been cut in the same way as in England where actual reductions have been made to public health budgets annually since 2015<sup>(38; 39)</sup>

Given the association with increased VBA activity highlighted above, these survey results illustrate why it is vital that primary care practitioners know about the services available in their own local area. However, awareness raising will not lead to an increase in VBA activity if suitable local services do not exist.

Prescriptions for NRT or other pharmacotherapy (varenicline or bupropion) to reduce cravings and address withdrawal symptoms were a less likely ACT option than referral to stop smoking services. The best option for smoking cessation is referral to a stop smoking service. However, where this is not possible, pharmacotherapy should be prescribed with brief advice<sup>(4; 37; 40; 41)</sup>. The worrying overall decline in NRT prescriptions in primary care has been highlighted in a recent study by the British Lung Foundation (BLF)<sup>(42)</sup>; in England levels of NRT dispensed in primary care in 2016–17 were around 25% of what was dispensed in 2005–06. The BLF report also reflects guidance from some CCGs to not to prescribe this medication. Within our study almost 80% of health practitioners recommended cutting down on smoking, however less than a quarter frequently prescribed NRT. Research has shown that just recommending cutting down delivers limited health benefit unless this is accompanied by NRT to effectively reduce the “time” smokers inhale smoke for (number plus draw time). Therefore, it is important to that CCGs ensure pharmacotherapy for smoking cessation is available on prescription and encourage health practitioners to prescribe pharmacotherapy with brief advice for smoking cessation.

The barriers reported by GPs and PNs to initiating a conversation on smoking cessation fall into three broad categories: an overloaded health system; lack of suitable smoking cessation service provision; and insufficient training. Patients coming in with too many other things to address was the most frequently reported barrier (59%). This may be because embedding preventative or health promotion interventions in health systems is so challenging that it means these interventions are not often prioritised<sup>(43)</sup>. Alternatively, this could be reflective of the reality of managing patients with multi-morbidity in primary care<sup>(44)</sup>. This was even more pronounced for GPs compared to PNs, with nearly three quarters citing this factor. Prevention has been repeatedly flagged as a key area for NHS activity<sup>(45; 46)</sup>, however this finding highlights the challenges of delivering on this in an overstretched health system. The lack of appropriate provisions including suitable smoking cessation referral options and more general resources, like translators, reinforces the systemic challenges health practitioners face. Several barriers reported in this study, and in previous research<sup>(27; 31; 34; 35; 36)</sup>, could be tackled by improving smoking cessation training provision. To alleviate concerns about having insufficient time in consultation, training on how to deliver effective VBA should highlight that this is a very quick intervention, deliverable in 30 seconds. Training should also address dealing with patients who are perceived to be unreceptive but in reality, may respond to advice, particularly when this involves the offer of concrete support (i.e. referral to a service). An example of this type of training is the Royal College of General Practitioners and Cancer Research UK e-learning module<sup>(47)</sup>. This may be particularly important when delivering VBA to target groups who have high smoking rates. Furthermore, this study highlights the different approaches taken by GPs and PNs to smoking cessation interventions. This was seen across the whole pathway of VBA — from different prompts to asking about smoking status, different advice given to smokers and different preferred referral and prescription options. Therefore, it is also important that training and guidance on smoking cessation in primary care is tailored to practitioners appropriately.

There are a number of strengths to this research. It is the first UK-wide cross-sectional survey of health practitioners to examine smoking cessation interventions in primary care. The survey was designed to build on existing literature in this field to capture health practitioner activities, attempt to quantify their perceived barriers to undertaking these activities and link this to awareness and attitudes regarding smoking cessation services. The survey sample was large, with an equal number of GPs and PNs, and was weighted to be nationally representative with respect to country of residence to allow the findings to be generalised to the primary care health practitioner population across the UK. Therefore, these findings could be used to inform recommendations for best policy and practice in primary care to increase smoking cessation among patients.

This study also has limitations. It was cross-sectional in design and therefore only represents a snapshot of activity and views at one time, in the early months of 2017. Also, it was reliant on respondents

correctly remembering and reporting their activities over the previous year so may not accurately quantify smoking cessation activities in primary care. Furthermore, this study investigates correlation, not causation. Therefore, the analysis has focused on identifying associations, trends and consistent themes that are valid for this type of study, and useful for the identification of areas for improvement. The sampling strategy for this study was designed to ensure that the study was sufficiently powered for this analysis. However, a limitation of this approach was that the study sample was drawn from practitioners already registered with a market research company and may not be totally reflective of the UK primary care health practitioner population. Another limitation of this study was that it could only examine awareness and perception of local services, as opposed to actual service provision. It would be interesting to see if these reported variables were reflective of actual smoking cessation service provision 'on the ground'.

This study provides insights into the role of primary care in smoking cessation, however further research is needed in this area. Whilst this research shows the link between awareness of local services and smoking cessation activities, there is very limited data on what services are available to primary care practitioners in each area. It would be useful to map service provisions on to practitioners' awareness to identify if there is a need for more services or an increased knowledge of existing services. There are also different challenges exhibited by different groups when trying to quit smoking, for example those from a lower socioeconomic background who have greater barriers to quitting as well as higher smoking rates<sup>(36)</sup>. More work is needed to identify both how to improve quit rates in target groups and how to integrate these approaches into the primary care system. Current evidence suggests that e-cigarettes are much less harmful than combustible tobacco<sup>(48; 49; 50)</sup> and patients report being open to using them for smoking cessation<sup>(51)</sup>. Research is now needed on how the issue of e-cigarettes can be raised by primary care practitioners, given the popularity of these devices<sup>(52)</sup>, particularly when compared with licensed pharmacotherapies.

This research has identified key areas that can increase the effectiveness of smoking cessation interventions by primary care practitioners in the UK. The availability of local stop smoking services is essential for primary care practitioners to be able to deliver VBA and refer patients to services that are effective for smoking cessation. The use of prescriptions for pharmacotherapy should also be encouraged, particularly in the absence of local stop smoking services to refer to. Suitable training opportunities addressing the specific needs of primary care practitioners must be readily accessible. All of these options are reliant on adequate levels of funding for both primary care and public health. In the absence of these resources, opportunities to support patients to stop smoking and to reduce the burden of preventable cancers, and other conditions caused by smoking are being lost.

# POLICY RECOMMENDATIONS

People who smoke visit primary care services more regularly than those who do not: these visits present a unique opportunity for primary care health practitioners to support these patients to quit smoking and live healthier lives. It is important that primary care commissioners, planners and health practitioners work together with the support of national and local governments to prioritise smoking cessation nationally and locally.

In response to the report findings, Cancer Research UK has several recommendations.

## **Primary care service commissioners and planners across the UK should:**

- Prioritise smoking cessation and tobacco control in regional plans.
- In England, work with local authorities to ensure shared understanding of tobacco control responsibilities, seamless referrals to local stop smoking services and availability of pharmacotherapies to all smokers.
- Signpost to and/or provide all primary care health practitioners with training in the delivery of VBA.
- Ensure pharmacotherapy for smoking cessation is available on prescription and encourage health practitioners to prescribe pharmacotherapy with brief advice for smoking cessation.
- Support the use of e-cigarettes as an aid to stop smoking, recommending that they can also be used alongside behavioural support.

## **Primary care health practitioners across the UK should:**

- Complete training in VBA.
- Employ VBA to initiate conversations with all patients about stopping smoking.
- Be aware of treatment options available to patients in their local area, including prescribing pharmacotherapy or referring patients to specialist stop smoking services in their practice or community.
- Support the use of e-cigarettes as an aid to stop smoking, recommending they can also be used alongside behavioural support.

In England, to ensure that smokers can access support in all parts of our public health system, smoking cessation support in the NHS should be delivered alongside and in partnership with local authority smoking cessation services in the community. The UK Government must provide local authorities with sufficient funding for these services. A “polluter pays” approach should be adopted so that the tobacco industry makes a greater contribution to the healthcare costs caused by smoking, via a Tobacco Industry Levy.

# APPENDIX

## SURVEY

### GP Case study

John is a 47-year-old male who presents with a painful knee joint

### Nurses Case study

John is a 47-year-old male who presents with painful ears

1. Which one of the following are most likely to result in you asking John about his smoking status?
  1. Previous smoking related health condition
  2. Smoking associated symptoms
  3. Physical cues e.g. the smell of smoke
  4. Computer prompt
  5. Incentives payments
  6. Known smoker from previous medical records
  7. NICE tobacco guidelines
  8. other \_\_\_\_\_
9. You decide to ask John about his smoking status and he tells you that he smokes daily. How would you respond?
  - a. Free text
10. You decide to offer to refer John to a smoking cessation service. What smoking cessation options do you know about in your area?
  - a. Free text
  - b. Don't know

For the following questions please think about all the patients that you have seen at your practice over the last year

11. How often did you know a patient's smoking status from the patient notes that were open for the consultation?
  - a. Always
  - b. Often
  - c. Sometimes
  - d. Occasionally
  - e. Never

12. How often did you asked a patient about their smoking status?



- a. Always
- b. Often
- c. Sometimes
- d. Occasionally
- e. Never

13. When you did ask about their smoking status, how often did you record this in the patient notes?

- a. Always
- b. Often
- c. Sometimes
- d. Occasionally
- e. Never

14. Thinking now about all the patients that you saw in the last year who are smokers: How often did you give smoking cessation advice?

- a. Always
- b. Often
- c. Sometimes
- d. Occasionally
- e. Never

15. When you gave advice about smoking cessation, how often did you record this in the patient notes?

- a. Always
- b. Often
- c. Sometimes
- d. Occasionally
- e. Never

16. How often did you mention cancer in conversations about smoking cessation?

- a. Always
- b. Often
- c. Sometimes
- d. Occasionally
- e. Never

17. For all the patients in the last year that you gave advice about smoking cessation, how often did you

*(random order)*

	Always	Often	Sometimes	Occasionally	Never
a. Ask them to record their smoking levels					
b. Suggest they cut down on their smoking					
c. Suggest they stop smoking					
d. Arrange a follow up appointment to further discuss smoking cessation					
e. Provide a leaflet with information on smoking cessation					
f. Discuss the benefits of using a Stop Smoking Service					
g. Highlight Stop Smoking Services within the practice					
h. Highlight Stop Smoking Services outside the practice					
i. Make a referral to a Stop Smoking Service within the practice					
j. Make a referral to a Stop Smoking Service outside the practice					
k. Discuss Nicotine Replacement Therapy					
l. Prescribe Nicotine Replacement Therapy					
m. Discuss using e-cigarettes					
n. Prescribe Champix/Varenicline					
o. Prescribe Zyban/Bupropion					
p. Other _____					

18. When you made a referral for smoking cessation, how often did you record this in the patient notes?
- a. Always
  - b. Often
  - c. Sometimes
  - d. Occasionally
  - e. Never
19. Looking beyond the factors of insufficient time and money, please select the three main factors you feel deter you from providing smoking cessation interventions in consultations. If you do not feel three barriers exist, please select as many as you can and then select 'no further choices'. (*random order*)
- ☐ No suitable training available
  - ☐ No computerised pop up / trigger to discuss smoking cessation
  - ☐ Unsure of the tobacco guidelines
  - ☐ The tobacco guidelines are not appropriate
  - ☐ There are more important behavioural risk factors to discuss
  - ☐ This is a societal issue, not a medical one so it is not the place of healthcare professionals to intervene
  - ☐ Other health care staff are primarily responsible for this intervention
  - ☐ Uncomfortable discussing smoking with patients
  - ☐ Feels hypocritical given own smoking status
  - ☐ Concerns about negative patient reactions
  - ☐ Patients are generally unreceptive to smoking cessation advice
  - ☐ Lack of suitable smoking cessation referral options
  - ☐ Long waiting lists for smoking cessation referral options
  - ☐ This kind of intervention has no/limited impact
  - ☐ Many patients speak poor English, and there are insufficient numbers of available translators
  - ☐ Patients often come in with too many other things to address
  - ☐ Other \_\_\_\_\_
  - ☐ None of the above
  - ☐ No further choices

Now thinking about the Stop Smoking Service provisions available in your area

20. To what extent do you agree or disagree with the following statement: There are sufficient Stop Smoking Services in my area to refer my patients to.

- a. Strongly Agree
- b. Agree
- c. Neither agree nor disagree
- d. Disagree
- e. Strongly disagree
- f. Don't know

21. To what extent do you agree or disagree with the following statement: Budget cuts have negatively affected Stop Smoking Services in my area.

- a. Strongly Agree
- b. Agree
- c. Neither agree nor disagree
- d. Disagree
- e. Strongly disagree
- f. Don't know

Finally we are interested in some basic information about you and your practice to ensure we have a representative sample for this study

22. Are you?

- a. Male
- b. Female

23. How old are you?

24. How many years have you been qualified for?

- a. 0-5 years
- b. 6-10 years
- c. 11-15 years
- d. 16-20
- e. More than 20 years

25. How many days a week do you typically work in general practice

- a. One
- b. Two
- c. Three
- d. Four
- e. Five
- f. Six

26. What is the list size of the practice where you currently work?

- a. <2000
- b. 2000 to <5000
- c. 5000 to <10,000
- d. 10,000 to <20,000
- e. >20,000
- f. Unsure

27. What is the CCG of the practice where you currently work?

- a. Drop down list

## GEOGRAPHIC BREAKDOWN OF SELF-REPORTED BARRIERS TO INITIATING CONVERSATIONS ABOUT SMOKING CESSATION IN PRIMARY CARE

	<b>UK (n=2007)</b>	<b>England (n=1682)</b>	<b>Scotland (n=171)</b>	<b>Wales (n=98)</b>	<b>N Ireland (n=56)</b>
Patients often come in with too many other things to address	58.7%	59.0%	54.6%	58.4%	64.7%
Patients are generally unreceptive to smoking cessation advice	40.2%	39.5%	37.9%	53.9%	42.7%
Other health care staff are primarily responsible for this intervention	15.9%	16.3%	15.7%	6.7%	20.6%
Concerns about negative patient reactions	15.4%	14.6%	18.7%	24.7%	14.7%
Lack of suitable smoking cessation referral options	15.1%	15.6%	8.1%	14.6%	22.1%
Many patients speak poor English, and there are insufficient numbers of available translators	8.4%	9.1%	4.6%	4.5%	4.4%
No suitable training available	8.0%	7.8%	7.1%	11.2%	13.2%
There are more important behavioural risk factors to discuss	6.4%	6.3%	8.1%	6.7%	2.9%
This kind of intervention has no/limited impact	6.3%	5.7%	9.6%	9.0%	10.3%
No computerised pop up / trigger to discuss smoking cessation	6.0%	5.9%	3.0%	9.0%	10.3%
Long waiting lists for smoking cessation referral options	5.1%	5.5%	2.5%	2.3%	4.4%
Other	4.4%	4.7%	3.5%	2.3%	4.4%
Unsure of the tobacco guidelines	2.8%	2.9%	1.5%	3.4%	5.9%
This is a societal issue, not a medical one so it is not the place of healthcare professionals to intervene	2.1%	2.1%	2.0%	2.3%	2.9%
Uncomfortable discussing smoking with patients	1.7%	1.9%	1.0%	0.0%	1.5%
Feels hypocritical given own smoking status	1.3%	1.4%	1.0%	0.0%	1.5%
The tobacco guidelines are not appropriate	0.9%	0.9%	2.0%	0.0%	0.0%

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