1. **INTRODUCTION**

The high smoking rate in people with severe and enduring mental ill health is the largest single cause of health inequality and the poor life expectancy in those patients compared with the general population. In 2013, the trust’s Smoking Policy was strengthened and updated. It was seen as challenging in some areas and it was noted at the time that its full implementation may take some time and effort with a number of practical issues to resolve.

Since then, NICE has updated its public health guidance on smoking. This has introduced a number of further changes. A revised action plan, suggesting a local pilot on two wards was agreed by the Executive Leadership Team in August 2014. The pilot work was undertaken by Professor John Britton, Professor of Respiratory Medicine at Nottingham University and lead author for the NICE guidance nationally, and his research team. The first phase of this is now complete and this paper now proposes a full implementation of the NICE guidance PH 48. This is based on findings of the pilot phase and substantial experience from Cheshire and Wirral Partnership (CWP) (a Mental Health Trust), who completed their full implementation in 2013. Over the last year, policy impetus for implementing this guidance has strengthened.

**Implementing the NICE guidance**

In general, the actions required of the new guidance are sensible and uncontroversial and many are already in train. Full staff training on smoking cessation techniques will be challenging to complete but the benefits for patients are substantial.

Action for community-based patients is largely around enhanced staff training and better resources for patients within the community, including good signposting to existing community stop smoking resources and services.

2. **ISSUES IN NEW NICE GUIDANCE THAT REQUIRE A DECISION**

The two issues that represent a greater challenge are:

2.1. No staff smoking on trust premises, including grounds.

This is in the current Trust smoking policy but it has not been fully implemented with ‘smoking shelters’ remaining on all major Trust sites. It is not clear what the status of this action is with regard to discussion between staff and managers. If this was to be fully implemented, it would require all smoking shelters to be removed from Trust grounds, and further advice about staff behaviour just outside the grounds themselves.

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1. NICE PH48: Smoking cessation in secondary care; acute, maternity and mental health services Nov 2013
2. Closing the gap: priorities for essential change in mental health services. Jan 2014
Comment: Experience in other Trusts is that it has been challenging to ensure this does not result in unsightly collections of staff smoking close to exit gates or paths. However recent advice from CWP suggest that this is achievable and with strong HR and supporting services, staff successfully manage their nicotine use appropriately. It was also found to improve overall staff morale as staff smoking breaks no longer needed to be negotiated within staff teams.

2.2. To stop all patients smoking on Trust premises.

Currently patients are able to smoke when in-patients – using ward ‘fresh air breaks’ to do so. In fact, the majority of patients who go outside (usually in a ward enclosed outdoor area) use that opportunity to smoke. Current data suggest 80% of our in-patients smoke. These breaks are seen as ‘smoking breaks’ by many patients. The new NICE guidance advises banning all smoking by in-patients, with substitution using immediately available Nicotine Replacement therapy and high-class skilled smoking cessation advisors.

Comment: The banning of smoking indoors has paradoxically increased the dominance of ‘fresh air’ breaks in ward routine. As such the current situation should be seen as a transition phase. There are two major benefits of this:

Firstly, direct individual patient benefit. Our Trust has achieved full implementation in the Forensic division, with substantial patient benefit. An example of this is that a patient who smokes aged 45 with Diabetes and a population average BMI, cholesterol and blood pressure has a risk of a cardiovascular event in the next 10 years of 13% of they smoke but 6% if they don’t - smoking doubling heart disease risk in this example.

Secondly, recent research during the pilot phase on the Rowan wards by Professor Brittons team suggest very significant resource indeed is used on smoking breaks - negotiating, taking, supervising, and returning patients to indoor ward areas. This amounts to 270 minutes per ward peer day of staff time. Across the nine Local Services wards alone, this equates to over 13,500 staff hours annually used on this activity. This disrupts ward routines and focus, removes staff who could be providing psychologically therapeutic interventions, anecdotally causes more anxiety on smokers, and disadvantages non-smokers.

Practical considerations. The Trust has already achieved no smoking in the majority of patient areas in the Forensic division. Accepting that leave from the ward as occurs in Local Services poses much greater challenges, this was still achieved voluntarily on A43 for some time a few years ago. Despite initial experience at the Wells Road Centre resulting in an increase in the trading and value of illicit tobacco products and some problems with illicit smoking in rooms and consequent fire risk, this problem has diminished and CWP also found this was a relatively short and minor issue as long as strict and unwavering boundaries are set for patients, visitors and staff at the outset.

3. OTHER ISSUES

Training In-patient settings require our own staff to be able to provide basic (level one) and more specialist (levels two and three) stop smoking training. We have a training plan to achieve this but will be limited in part by staff capacity. We have invested in some equipment such as smoking CO monitors, required for level two interventions.

In the community, the evidence base suggests a much greater positive effect is likely (greater likelihood of stopping and far larger numbers of patients) but much of this capacity is planned to come for active referral of patients to the local stop smoking services (New Leaf) as well as some in house activity. It is likely that some training resources from L and D need to be provided for this work.

Costs The overall effect of implementing the existing Trust policy and additional actions in the NICE guidance will be cost-saving to the Trust in terms of increasing available time for high quality specialist psychiatric care and reduced smoking related incidents. There is anecdotal evidence of
Reduced admission rates and lengths of stay. There are up-front costs including training time and resources, and initially a substantial amount of project management and communication activity, particularly in Local Services.

**E-cigarettes.** Whilst it is true that these are substantially less dangerous than tobacco products, full safety of the inhaled vapour is not established either for users or those exposed to that vapour and current advice does not recommend their routine use. Importantly use of E-cigarettes would also not allow the benefits of removing ‘smoking breaks’ to be realized. At present, for in-patients, we are not recommending this as a viable option. CWP also did not support their use as part of the NICE implementation. There remain substantial wider problems of normalizing smoking behaviour, appeal to younger persons, and ongoing nicotine addiction promotion.

**Learning from others.** It is suggested that the programme of work is modelled on the successful planning implemented by CWP who, with Professor John Britton’s research team, are able to advise and support us in this work.

**Communication issues.** Careful and well-field tested Q and A, key facts, signposting, and championing mechanisms will be required. Experience from CWP identified that rather than ‘stop smoking’, in fact ‘nicotine management’ better reflected what the Trust was trying to do within this programme and this formed the basis of their messages in approaching this implementation.

**Divisional aspects.**

**Local Services** have the greatest challenges. This division has already resourced project management and the CO meters required to be able to train staff to the required Level Two training for ward-based nicotine management work. Protocols already exist on the wards to allow Nicotine Replacement to be given out in a very timely way without delays waiting for medical prescriptions (a vital aspect identified by CWP). In the community, it has been signaled by Council colleagues that they are keen to see targeting of the stop smoking services for more vulnerable citizens. At present New Leaf services are available to support community activity for our patients.

**Forensic Division.** Have already fully implemented the guidance for patients. The situation for staff is less uniform and would require some dedicated work.

**Health Partnerships.** NICE PH48 guidance does not apply to general community NHS health services. All Trust staff would be included in this programme of work. Experience in CWP was that the same programme should be implemented across the entire Trust. Project management would be required in each division (but less than that required in Local Services).

### 4. RECOMMENDATIONS

The Trust is recommended to:

4.1. Initiate a Trustwide programme during 2015 tailored for each Division leading to full implementation of NICE Public Health Guidance 48 for staff and patients. It is suggested a target date for implementation is set towards the end of the year 2015, allowing for the substantial preparation and any formal consultation phases required in preparation.

4.2. Support establishing a Trustwide lead, supporting leads in each Division and a project management and Communications approach to implementation.

Chris Packham. 4.2.2015