Evaluation of the introduction of smokefree policies in two North East NHS Foundation Trusts Northumberland, Tyne & Wear NHS FT and Tees, Esk & Wear Valleys NHS FT

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Research team

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Contents

Glossary

CQUIN	Commissioning for Quality and Innovation
DH	Department of Health
DHSC	Department of Health and Social Care
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPT	Normalisation Process Theory
NRT	Nicotine Replacement Therapy

Executive Summary

Background

People with mental health conditions die on average 10-20 years earlier than the general population, largely due to the presence in their lives of many risk factors associated with socioeconomic conditions and dependency on tobacco (Department of Health and Social Care (DHSC), 2017). Seeking parity of esteem for this group is one focus of the latest Tobacco Control Plan (DHSC, 2017). This builds on updated National Institute for Health and Care Excellence (NICE) *Public Health Guidance: 48, Smoking: Acute, maternity and mental health services.* This was published in 2013, with the aim to "support smoking cessation, temporary abstinence from smoking and smokefree policies in all secondary care settings". In support, the National Health Service (NHS) Five Year Forward View (Department of Health (DH), 2014) made a commitment to make all NHS trusts, both mental health and acute, smokefree by 2020. These guidance documents have been supported by the Commissioning for Quality and Innovation (CQUIN) framework promoted by NHS England (2016), which offers financial incentives to organisations who meet the CQUIN indicators.

In line with NICE guidance (2013), two mental health trusts in the North East of England – Northumberland Tyne and Wear (NTW) NHS Foundation Trust (FT) and Tees, Esk and Wear Valleys (TEWV) NHS FT – have taken up the challenge and went smokefree on-site on the 9th March 2016 (NTW NHS FT, 2016a; TEWV NHS FT, 2016). Both Trusts had been preparing for this change for several years and intensively for the previous year. They had implemented the Lester Tool in 2014 to monitor measures of physical health among service users (Shiers, 2014). In 2017 Trust A adopted the *Preventing ill health by risky behaviours (Tobacco)* CQUIN, whose indicators focus on introducing and embedding smokefree policies. The Lester Tool was adapted to meet CQUIN requirements (Shiers, 2014). Other initiatives within the wider smokefree agenda, introduced across the region, included: developing a smoking cessation strategy, reviewing existing Trust policies, appointing smoking cessation leads, improving data collection, developing support for

quitters, providing staff training, developing communication and engagement plans and ensuring appropriate facilities and estates involvement. Staff have been trained to National Centre for Smoking Cessation Training (NCSCT) Level 1, with selected staff trained to level 2 in Trust A or the Local Authority equivalent in Trust B. Once off-site, smokers are encouraged to access smoking cessation services provided in the community, which are delivered using multiple delivery models.

Aims and scope

- To provide the trusts with some insight into the effectiveness of the move to being smokefree
- To explore and share opportunities and challenges from the implementation with other trusts.

The research project was specified to undertake two work packages (WP):

- Quantitative evaluation (WP 1) - changes in the prevalence of smoking over time among service users
- Qualitative evaluation (WP 2) - attitudes towards the smokefree policy and experiences of implementing it, among staff and service users, to assist in understanding the process.

Methods

WP 1 has used routinely collected data on smoking status. Aggregate data was collected for every other quarter (three-month period) between 2013 and 2017, by querying the Trusts' computer-based, patient administration systems (PAS). Within each quarter, the proportion of inpatients with a valid measure of smoking status, and the proportion of inpatients that smoked, was calculated, separately, for admissions, discharges and all inpatients. Each group was subdivided further, by age band, gender, broad ethnic group and QRISK score (a score predicting the risk of a future heart attack or stroke).

WP 2 has collected data between November 2016 – April 2017 through semi-structured interviews with staff (*n=51*), members of partnering organisations (*n=5*), service users (*n=5*) and carers (*n=2*). Staff were primarily invited to take part via adverts circulated within Trusts, except for Level 2 Stop Smoking Advisors in Trust B who were recruited via a pre-existing working group. Some staff and the members of partnering organisations were purposively sampled due to their job roles. Twenty staff were from Trust A and thirty-one

from Trust B; the disparity can be accounted for in the size of the focus groups conducted with Level 2 Advisors (Trust B = 14, Trust A = 4). Outpatient service users and carers responded to information sent via North East Together and inpatients were approached by ward staff. Normalisation Process Theory (NPT) was used to design the data collection tools and analyse the data (May & Finch, 2009). A framework approach was taken with the analysis using the four core concepts of NPT: coherence, cognitive participation, collective action and reflexive monitoring (Ritchie & Spencer, 1994; May & Finch, 2009).

Summarised findings

WP 1:

Recording of smoking status: Within Trust A, the proportion of inpatients with a valid measure of smoking status was less than 80% for most of the study period but improved in the final year. In the final reporting period, 87% of inpatients had a valid measure. Within Trust B, 85-90% of admissions and discharges contained a valid measure of smoking status across the last two years of the study. Within this Trust, data suggests that recording is less common among inpatients with a length of stay greater than 3 months. There would be greater confidence around measures of smoking prevalence if the proportion of inpatients whose smoking status is known, within both Trusts, could be further increased.

Smoking prevalence: Within Trust A, the proportion of inpatients for whom smoking status was unknown fell from 39% to 13% over the last 18 months of the study period. Given the high proportion of unknowns across most of the study period, it is not possible to say with any confidence whether smoking prevalence changed, based on routinely collected data. However, there is wider evidence from an annual clinical audit of smoking status, that smoking prevalence fell within the Trust from 43% in 2015 to 21% in 2018. The audit involved a detailed inspection of clinical records beyond fields that routinely capture smoking status. Within Trust B there is evidence that the prevalence of smoking fell in the two-year period surrounding the introduction of a smokefree policy in March 2016. Among admissions, the proportion who were known to smoke fell from 51% to 42% (13-15% smoking status unknown) and among discharges the proportion fell from 50% to 44% (9-10% smoking status unknown).

Smoking prevalence among discharged service users: Within Trust A, smoking status is not routinely measured on discharge. Within this Trust the proportion of inpatients that smoked was significantly higher based on the last measure of smoking status prior to discharge, compared to the proportion that smoked at admission. This gap between prevalence at admission and discharge was greatest among adults 18-45 years of age. This may be due to poor data quality or the fact that the difference is based on the comparison of two different cohorts of service users but requires further investigation.

Prescribing of nicotine replacement therapy (NRT) products: The monthly cost of prescribing NRT products is not excessive, varying between £3,000 and £4,000 per month within each Trust.

WP 2:

Coherence

Reasoning/ professional values

The findings suggest that some staff were satisfied that introducing smokefree policies was in the patients' best interest; other staff who, although they understood the motivation of smokefree policies, did not all agree with the reasoning behind them. In particular, suggesting that they viewed smoking as just one factor amongst others, which contributes to the reduced life expectancy of mental health services users. A concern for many staff, as they saw it, was the impracticability of enforcement and the potential for increased aggression, and risk to themselves and patients. Some staff thought it was unethical and contradictory, in terms of insisting patients quit, rather than waiting until they were ready.

Cognitive participation

Buy-in

There were mixed levels of buy-in; buy-in increased over time, although some staff were still looking to be convinced about the methods being used. Staff on secure units were found to have more buy-in to the policy than non-secure units; possibly as they found it easier to enforce, due to lower patient turnover and the changes being more consistent with their existing practice. For staff involved in the short-term care of patients, they more frequently reported concerns that the policy would not achieve the long-term benefits it

purported to. Preparation processes were often reported as good, especially regarding hearing experiences of introducing smokefree policies from other Trusts.

Enrolment

Myth-busting was seen as crucial to buy-in and a central benefit of training. There were reported barriers to enrolment into the changes, mainly by frontline staff, in relation to communication of policy and implementation for a variety of reasons (e.g. senior staff not passing on information, individuals not accessing disseminated information). Ongoing training, to all groups of staff (including those working unsociable hours), was seen as an important way to overcome these barriers to uptake, with some stating that evidence of improvement (which could be cascaded via further training) would potentially change the opinions of those resisting the policy. Applying the policies when a patient was in an acute crisis was often perceived as inappropriate and on occasion actively opposed by staff.

Senior support

Fundamental to buy-in was seeing senior members of the organisation backing the policies. This gave those who were implementing it the authority to act, where this was not done there was anecdotal evidence of delays in progression. Critical to success was having a subgroup structure that was prioritised, tightly managed and well-focused, with key decision-makers round the table. This enabled implementation of the policies more effectively. Where delegation of responsibility occurred, it could lead to further delays, with decisions having to be referred back to the senior manager. Middle management support influenced the outcomes; buy-in at this level was not always translated to the frontline, who felt they lacked the authority to insist on the changes. A lack of consequences for non-compliance by staff was also reported. Enabling access to training was recognised as important in supporting the nicotine management message and overall implementation, however this varied between Trusts. Sufficient resource in terms of smoking cessation leads and Nicotine Replacement Therapy (NRT) were apparent and appeared to be securely funded.

Collective action

Planning

Communication of the reasoning behind the decision to bring in smokefree policies was seen as key in bringing all stakeholders on board. Many participants had found an early

stakeholder event useful. Nevertheless, some participants thought that service users, carers and frontline staff were insufficiently consulted. They expected to be able to discuss the pros and cons of the implementation of the policy and were unhappy with decisions being made at a senior level and handed down rather than co-created. Adequate time was thought to have been given to prepare for the going smokefree deadline, although there were a lot of hurdles to overcome to meet it. As well as planned communication strategies, informal communication routes were found to have been instrumental in disseminating the policy to patients and carers. Efforts were made to let patients in the community know about the introduction of the policy, however they were often ill-prepared on admission.

Implementation

Certain locations and units were reported as more successful than others in implementing smokefree policies. It was suggested that this was due to the length of stay or security of ward, as mentioned previously. Consistency of enforcement was key to success. Ambiguity in the policies over patients' leave compounded any inconsistencies. A number of other significant barriers to action were identified by participants, for example: lack of enforcement, lower staff levels of buy-in to the policy. Patients' leave from the ward was seen as a particularly difficult time to manage, when the policy was often likely to be challenged. Participants talked about the importance of avoiding the need for enforcement by changing the culture. Visitors entering open sites and smoking in the grounds was a particular challenge. There were many details that needed to be worked out following the introduction of the policies; there was a requirement for ongoing review and response in a timely manner.

Community links

Communication from healthcare professionals to patients in the community about changes to Trust policy was reported as weak. Although it was recognised that preparing smokers pre-admission was preferable, broken communication channels resulted in staff having to tell patients upon admission that they could not smoke. Similarly, patients admitted from prison reportedly had smuggled in smoking materials. Communication on discharge back into the community was also reported as incomplete, with receipt of messages to healthcare professionals responsible for providing smoking cessation services unclear. With variable smoking cessation services in the community, staff expressed a

concern that patients would simply be abstaining from smoking as opposed to making a long-term, lifestyle change. The focus of the policies is on-site only at present; therefore, these issues have not been explored by the evaluation.

Reflexive monitoring

Impact on staff

There was a view that staff had been more successful in quitting smoking since introducing the smokefree policies. Even so, several views on unintended, negative consequences of introducing smokefree policies in Trusts were also expressed by participants, such as an increase in smoking indoors, raised staff stress levels, increased violence and aggression, concerns over ethics, interactions with medication, the reaction from the external regulator (Care Quality Commission), divergence of opinion between staff and work-arounds to avoid compliance instigated by patients and staff. It is unclear if these are substantiated by Trust data from alternative sources.

Impact on patients

There were reports from staff of both positive and negative consequences on patients, both in terms of their physical and mental wellbeing. Mental health was seen to have improved as participants were no longer experiencing nicotine withdrawal symptoms; this had led to a more relaxed atmosphere on the wards, less anxiety in patients, and more time for therapeutic activities. In addition, patients felt a sense of achievement following their successful quit attempt. Where patients had informal leave, there were concerns about patients' smoking off-site or of being exploited by local individuals. Although this falls outside the remit of the policies and this evaluation, it is important in terms of holistic care for patients and the impact on-site e.g. it undermines patients' ability to abstain and staff's attempts to support them, potentially increases difficulty in monitoring antipsychotic drug levels. Staff expressed uncertainty over what was acceptable in nudging patients toward changing their smoking behaviours.

Staff-patient relationships

Whilst in some wards the smokefree policy was introduced relatively easily, some staff participants noted an increase in challenging or aggressive incidents. The therapeutic relationship was reported as both benefiting in some cases and being damaged in others, by the smokefree policies.

Impacts on Trusts

On reflection some participants stressed the importance of seeing the continued pursuit of a smokefree Trust as an area for ongoing investment.

Future steps

Despite differences in approach by each Trust, organisational input and review was underlined by participants as necessary, if short and long-term benefits were to be realised. Staff stated that having a champion was a vital requirement and recognised the hard work and need for continued prioritisation, if smokefree sites were to be sustained.

Participant recommendations

Some staff favoured including partial restrictions on smoking (reinstatement of designated smoking areas for patients only) although this is not supported by the NHS, government policy or this country's laws (Health Act, 2006). Indeed the national direction of travel is away from such measures, as seen in NICE guidance (2013). Some clinical staff supported allowing electronic cigarettes although pharmacy staff had reservations about regulating them.

Additional themes

Enforcement

Enforcement was a key theme that arose organically from the data, it was both a major concern and a signifier of contradictory expectations. Staff participants discussed confusion and frustration regarding *how* the policy was to be enforced successfully. Anecdotal evidence suggested a perceived increase in aggressive incidents related to smoking cessation. Where successful enforcement occurred, it tended to be in settings where patients were used to their behaviours being restricted. Some frontline staff implementing the policy felt that it was at odds with their professional values. Visitors to the Trust sites, who smoked, also created a challenge to smokefree policies. They may be members of the public crossing the site or visitors accompanying outpatients or visiting inpatients. Many of them brought smoking equipment on-site with them.

Risk

Staff who reported the notion of risk noted that this applied to staff, the patients themselves and the wider public. Several staff noted concerns about how insisting a

patient stop smoking could compromise their own safety (either from aggression or fire). However, some opposite views were also expressed, that there was no noticeable increase in risk from aggression or fire. Staff talked about how they felt caught, weighing up the risks between compliance and non-compliance with the policies. Monitoring risk from the interaction between medication and smoking was seen by staff as necessary but the risk was rarely realised, in their experience. Electronic cigarettes were seen as a potential risk by Trusts, who imposed different and changing restrictions on their use and kept them under review.

Smoking cessation resources

Policies arranged for provision of NRT shortly after admission and were generally adhered to, but there was uncertainty sometimes about access and administration. NRT was not universally accepted by patients as an alternative to smoking, who expressed dislike of NRT products. However, some patients who had the opportunity to try different products ahead of the deadline, tended to be more accepting. Smoking cessation behavioural support was reported as variable between Trusts and sites, partly due to challenges in delivering training.

Language use

It was clear that careful use of language was required to encourage smokefree policies to be seen positively. Adoption of a positive discourse varied between Trusts.

Patient experience

Only a small number of patients and carers were interviewed, so findings must be read with caution.

Behaviour change

Patients with learning disabilities in secure settings enthusiastically reported quitting successfully, as did a carer, when retelling the experiences of a service user who also quit.

Fears and unsuccessful change

This enthusiasm and success in quitting amongst patients with learning disabilities was not replicated among patients admitted to an acute or informal setting. In the latter, it was

felt, pressure and judgement increased but enforcement and successful quits decreased. Quits begun on-site were not seen as well-supported in the community, with patients expecting a negative impact on sustainability. Patients and carers reported that admission was seen as a time of abstinence rather than quitting altogether, which is consistent with the nicotine management focus of smokefree policies.

Coherence and cognitive participation

Both benefits and concerns were recognised. Overall patients and carers understood the policy and the practical implications. However, there were doubts expressed with regard to the reasoning for going smokefree in terms of the experience of patients. Whilst concerns were raised, for some patients, they believed that previously they would have resisted the policy but actually they had benefitted overall.

Planning and implementation

Positives with regard to physical health, environmental improvement, social interaction and a personal sense of achievement were expressed by patients/carers. Negatives including psychological stress, impact on social interaction, risk of breach of confidentiality, lack of smoking cessation support in the community and the construction of smoking as deviant were all reported by patients/carers.

Limitations

It may appear that restricting numerical data collection to routine queries which interrogate smoking status fields within the patient administration system (PAS) is a limitation of this study. Annual clinical audit in one Trust based on a detailed inspection of clinical notes, noted within this report, reveals far fewer inpatients with unknown smoking status. However, the intention within the study design was that the analysis would use queries similar to those that will be used to routinely query data for performance monitoring purposes going forward. If the report shows that data quality could be improved, then this is a useful message for Trusts, and any resulting work to improve data quality will enhance future management information.

The main limitation for WP 2 was the challenge of recruitment of participants. Suggested routes to recruitment within the organisations were not as fruitful as hoped. Collection of patient perspectives, in particular, remained limited in spite of multiple efforts by the

researchers. A consideration, rather than a limitation, was the wide variety of service types to meet different patient requirements. The variance in these environments reduces transferability of findings as they are context specific. Nevertheless, staff were recruited from a variety of settings, roles and perspectives in both Trusts and were able to reflect on their experiences.

Conclusion

The context for the introduction of smokefree policies into mental health Trusts is one of a deeply entrenched, smoking culture; however, inroads have been made into these assumptions and change has begun. It was not surprising that WP 1 and WP 2 identified some good practice but also many barriers to the full implementation of smokefree policies, assessment of their progress and sustainability. Findings from WP 1 have not been able to confidently establish a reduction in smoking amongst mental health inpatients within Trust A and Trust B. However, detailed clinical audit within Trust A, based on manual inspection of clinical notes, has shown a reduction in smoking prevalence over the study period. To routinely understand smoking behaviour, more detailed and high-quality data is required within the patient administration system. Although some relevant routine data is collected, addressing the gaps and collecting, accessing and reporting more meaningful data that will support the smokefree policy requires further effort.

WP 2 identified good practice, finding that some staff and patients recognised the benefits of thorough preparation, introduction of the policy and the importance of continuing support. Even so, many staff found themselves in receipt of mixed messages, feeling conflicted about how they should act and involved in an ongoing challenge with regard to enforcement. Where there was consistent senior support and prioritisation, clear communication lines, strong buy-in from all staff and statistical data to back their efforts, becoming smokefree on-site was more likely to be normalised; although it remained an uphill struggle, it was expected that sustained effort would be required to create the shift in culture. Partnership between agencies supporting patients in quit attempts, although essential in establishing a seamless transition on admission and discharge, was not generally apparent. However, the focus of this evaluation was implementing the policy on-site and did not fully explore this issue.

The quantitative logic model shows that, while all of the processes and activities outlined within the model have been initiated in both Trusts, the quantitative outputs are currently not being collected in a way that allows for routine reporting and analysis of many of these processes. The qualitative data made it clear that although progress had been made and that many of the activities outlined by the logic model had been initiated, there was still a lot to be done before the outputs were embedded, the outcomes more fully realised and a significant level of impact experienced.

Recommendations

Note recommendations 1- 5 arise from WP 1 and recommendations 6 – 16 from WP 2

Recommendation 1

Continue efforts to improve the consistency of recording of smoking status. Increase the proportion of inpatients for whom smoking status is known and recorded in routinely queried fields to more than 95%.

Who should take action?

Information team and staff responsible for capturing clinical information within the patient administration system

What action should they take?

- Record smoking status captured in clinical notes in the routinely queried data field with greater consistency.

Recommendation 2

Compare smoking prevalence at admission and discharge for a cohort of inpatients and thus better understand the efficacy of interventions designed to support inpatients to quit smoking.

Who should take action?

Information team within Trust A

What action should they take?

- Examine smoking status of a cohort of inpatients admitted in a quarter across a 12-month period, considering the smoking status on discharge or at year end, separately for the

group that were admitted as current smokers and the group that were admitted as non-smokers or ex-smokers.

Recommendation 3

Within Trust B, investigate the recording of smoking status among inpatients with a length of stay of more than three months, as the proportion of these service users for whom smoking status is unknown appears to be particularly high.

Who should take action?

Information team within Trust B

What action should they take?

- Identify the group of inpatients with a length of stay more than 3 months and calculate the proportion with a valid smoking status.

Recommendation 4

In reports to senior management, include measures of the proportion of patients that smoke, that are given very brief advice, are offered support from smoking cessation services, set a quit date, are prescribed NRT products, are provided with e-cigarettes and who are successful or otherwise in quitting at 4 weeks. These routine measurements will allow a more systematic consideration of the efficacy of interventions to support service users to give up smoking.

Who should take action?

Information teams

What action should they take?

- Include these measurements in regular reports to senior management.

Recommendation 5

Smoking status is systematically recorded at discharge, in addition to being recorded at admission and clinical review. This offers the best chance of understanding the efficacy of care processes that support inpatients to give up smoking.

Who should take action?

Directors, senior managers and middle managers of mental health and learning disability services

What action should they take?

- Determine whether inpatients are asked if they currently smoke at discharge. If not, include smoking status among the information gathered at discharge.

Recommendation 6

Preparation to implement: Create a deadline for the introduction of smokefree policies, ensure a reasonable time allowance (18 months – 2 years) and prioritise progress towards the deadline.

Who should take action?

Directors and senior managers of mental health and learning disability services and/or their representatives (including occupational health services, estates management).

What action should they take?

- Appoint and resource a project lead
- Set a generous and realistic timescale to accommodate the amount of work and preparation required across the Trust
- Follow Trust A's model of several subgroups each tasked with their own function/speciality
- Those with authority to act or take decisions to be motivating, available and present at meetings
- Involve staff from estates at an early stage e.g. to plan signage, address fire safety issues.

Recommendation 7

Preparation to implement: Host an event to introduce stakeholders to the evidence from smokefree Trusts and the rationale for change and how it might be operationalised. Follow it up with subsequent events to maintain momentum and present feedback.

Who should take action?

Project lead

What action should they take?

- Organise an event bringing as many staff and patient representatives together as possible with those from other Trusts with experience of challenges and benefits of introducing smokefree policies
- Early consultation with patients and staff to incorporate concerns and give a sense of contribution and voice.

Recommendation 8

Senior support: Ensure senior support for the smokefree policies; starting with commissioners, the Chief Executive and Trust Board, through senior management, up to and including ward managers in mental health and learning disability services.

Who should take action?

Chief Executive and Trust Board, senior managers (clinical directors) and middle managers (clinical leaders) of mental health and learning disability services.

Health and wellbeing boards, clinical commissioning groups.

What action should they take?

- Clinical commissioning groups to incentivise on-site smokefree activity e.g. CQUINs
- Senior staff to be proactive in supporting the implementation of the policy via a series of sub-groups that are prioritised and bring key decision-makers to the table
- Adequate resources to be made available in a timely manner e.g. employ a project lead until changes are normalised, accessible and adequate staff training, numerical data management and collection, NRT as per policies, plan for sustainability (see logic models)
- Continued and visible senior support beyond the initial implementation of policies.

Recommendation 9

Communication: As part of the overall strategy, continued focus is required, after initial introduction of the policies, on ongoing communication of developments, changes and achievements arising from the implementation; to build further compliance and embed the changes.

Who should take action?

Directors and senior managers of mental health and learning disability services and/or their representatives (including communications teams, occupational health services, estates management)

Project lead

All staff in mental health and learning disability services.

What action should they take?

- Senior staff to be proactive in supporting communication via a series of sub-groups that are prioritised and bring key decision-makers to the table

- Continued sharing of information and successes to remind staff of the Trust's commitment to the policy via established Trust-wide communication links.

Recommendation 10

Training: Provide smoking cessation training for frontline staff (as per NICE guidance PH 48 Recommendation 14) to ensure staff feel well-prepared for the smokefree policy and confident in how best to handle patients at difficult times.

Who should take action?

Chief Executive and Trust Boards, senior managers (clinical directors) and middle managers (clinical leaders) of mental health and learning disability services

Health and wellbeing boards, clinical commissioning groups

Project lead

Organisations providing training.

What action should they take?

- Incentivise training provision
- Offer and deliver training to as large a number of staff as possible in preparation for introducing the policies
- Make training accessible for those members of staff who may struggle to attend due to unsociable hours or staffing requirements on wards
- Constantly deliver training to staff and refresh the skills to those already trained.

Recommendation 11

Facilitating a culture change: Create an environment of consistent, open dialogue that supports a strong commitment to the policy.

Who should take action?

Directors and senior managers of mental health and learning disability services and/or their representatives

Project lead.

What action should they take?

- Create a forum and maintain an environment for open dialogue that listens to staff concerns; present evidence of positive achievements of the smokefree policy
- Challenge the notion that those with reservations about the policy are simply personally against it

- Acknowledge legitimate concerns and work to address them
- Consult with service users.

Recommendation 12

Community Support: Support patients to make a conscious and sustained lifestyle change by offering a seamless transition to a local stop smoking service, based on NICE guidance (2013), and ensure that it complements aid efforts on Trust sites.

Who should take action?

Local Authority commissioners of smoking cessation services within the community

Senior managers in Trusts

Managers and providers of smoking cessation services

Project lead

Health and social care practitioners in mental health and learning disability services.

What action should they take?

- Commissioners to incentivise smokefree activity in the community
- Pre and post admission support to be made available to attain stated aims of reducing smoking or promoting a smokefree lifestyle, to address "abstinence only" on-site
- Consult with primary and secondary mental health practitioners
- Consult with service users.

Recommendation 13

Implementation: Ensure that implementation of the smokefree policy takes into consideration the needs and requirements of the service users and carers.

Who should take action?

Local Authority commissioners of smoking cessation services

Directors and senior managers of mental health and learning disability services and/or their representatives

Project lead

Health and social care practitioners in mental health and learning disability services

Managers and providers of smoking cessation services.

What action should they take?

- Consult with service users

- Prepare staff to ensure wards are equipped to manage the transition and recognise the impact of diversity of wards, staff and patients
- Pursue and document subsequent offers of NRT and smoking cessation support after initial intervention on admission
- Provide diversionary activities
- Utilise the time potentially saved by introducing smokefree policies for increased therapeutic sessions for patients
- Staff to provide a visible willingness to challenge visitors smoking on-site
- Invest in NRT and consider how best to utilise e-cigarettes in order to support patients.

Recommendation 14

Implementation: Ensure that staff who smoke are supported to avoid smoking on-site and to quit.

Who should take action?

Directors and senior managers of mental health and learning disability services and/or their representatives

Project lead

Local Authority commissioners of smoking cessation services within the community

Managers and providers of smoking cessation services

Health and social care practitioners in mental health and learning disability services.

What action should they take?

- Encourage quitting smoking e.g. offer smoking cessation services at work
- Facilitate abstaining from smoking throughout the working day e.g. encourage the use of NRT at work
- Communicate clearly the consequences of smoking at work as stated in the smokefree policies
- Review disciplinary and grievance policies to ensure that they are congruent with nicotine management policies
- Apply Trust policies consistently, including nicotine management and disciplinary policies.

Recommendation 15

Reflexive Monitoring: Reflect on the process that has been undertaken to identify issues arising from implementation of the smokefree policies and celebrate successes.

Who should take action?

Senior managers of mental health and learning disability services and/or their representatives

Primary and secondary mental health practitioners

Service users

Project lead.

What action should they take?

- Senior managers to report back their reflections via a series of sub-groups that are prioritised and bring key decision-makers to the table
- Create a forum and maintain an environment for open dialogue that listens to staff concerns; present evidence of positive achievements of the smokefree policies
- Collect and discuss data on smoking related incidents/adverse events
- Consult with primary and secondary mental health practitioners
- Consult with service users
- Communicate continuing monitoring of evaluative practices via established Trust-wide communication links
- Acknowledge and support staff who have, or perceive they have, an increase in their workload
- Pre-empt the potential effects on the weight and eating habits of patients to mitigate the worst of any smoke cessation related weight gain.

Recommendation 16

Consistency/Enforcement/Risk: All members of staff to implement the smokefree policies with consistency.

Who should take action?

Senior managers of mental health and learning disability services and/or their representatives

Middle managers

Primary and secondary mental health practitioners

Project lead

Managers and providers of smoking cessation services.

What action should they take?

- Apply smokefree policies in a consistent manner, but recognise certain wards may require additional support/resources
- Regularly communicate policy to ensure clarity and understanding and to take account of staff turnover
- Review disciplinary and grievance policy to support smokefree policies.

Recommendation 17

Language: Carefully adopt language that best reflects the positive objectives of the policy.

Who should take action?

Senior managers of mental health and learning disability services and/or their representatives (including communications teams)

Primary and secondary mental health practitioners

Project lead

Managers and providers of smoking cessation services.

What action should they take?

- Use consistent language that focuses on 'smokefree', addiction and management and avoids negative connotations such as "smoking ban"
- Ensure careful wording both in promotion and general language used by staff.

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