

Guidance for smokefree hospital trusts





Health Development Agency

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Endorsed by NHS Employers



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About the Health Development Agency

The Health Development Agency (www.hda.nhs.uk) is the national authority and information resource on what works to improve people's health and reduce health inequalities in England. It gathers evidence and produces advice for policy makers, professionals and practitioners, working alongside them to get evidence into practice.

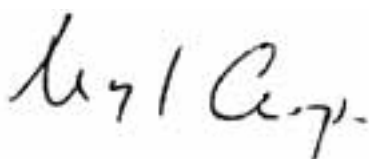
Foreword

The recent white paper, *Choosing Health*, announced that the NHS will be smokefree by the end of 2006. Even with the recent progress in reducing prevalence, smoking remains the largest single cause of death and disease in England. The harm caused by secondhand smoke is now well established. The NHS, as the foremost health promoting and treatment organisation in the UK and largest employer in Europe, will underscore these dangers and demonstrate strong leadership by becoming smokefree.

This guidance, drawing on lessons learned from successful case studies, surveys and consultation with hospital trusts, takes you through the steps needed to implement smokefree policies. Consultation will be important to ensure all staff and patients abide by the policy and understand why it is required. Communication with patients and carers will be important to ensure they are aware of the policy and can prepare for it. The widespread availability of cost-effective treatment for stopping smoking must be an integral part of smokefree policies and the guidance explains how to work with the NHS Stop Smoking Services in your area.

This guidance is about where people smoke, not whether they do so, although I hope that many people may use smokefree policies to make attempts to quit and in so doing improve their chances of living longer and healthier lives.

In the white paper, *Choosing Health*, the government stated its belief that the NHS can and will become an exemplar for public and private sector employers. Swift movement to a smokefree NHS will be a clear demonstration of that aim; and this document will help you to deliver that aim.



Sir Nigel Crisp
Chief Executive of the NHS

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Introduction

Background

In the 1990s the NHS was advised to adopt policies on smoking that allowed for limited, 'necessary' provision for smokers – but interpretation of this guidance has varied greatly. A recent survey has shown that there is still considerable and unacceptable exposure of staff, patients and visitors to secondhand smoke (see also Annex 1).¹ Secondhand smoke is a proven carcinogen² and apart from cancer causes a range of diseases including heart disease and respiratory infections.³ In addition, there is evidence that patients who continue to smoke while in hospital are at an increased risk of complications and delayed recovery.⁴

The time has now come for the NHS to become smokefree. The recently published white paper on public health, *Choosing Health*, stated that the NHS will be smokefree by the end of 2006.⁵ This is a measure which the Chief Medical Officer has recommended in his recent annual reports^{6,7} and which receives widespread public support.⁸

The white paper noted that the Health Development Agency (HDA) would shortly be publishing guidance for NHS organisations on the provision of smokefree buildings to protect staff, patients and others from the health risks of secondhand smoke. This guidance sets out these steps, building on previous guidance,^{9,10} and drawing on the findings of the recent survey of smoking policies across NHS hospitals as well as examples of good practice.¹ Box 1 defines what is meant here by a smokefree NHS.

Box 1

Smokefree means that smoking is not permitted anywhere within hospital buildings. No exceptions will be made for staff or visitors. For long-stay mental health patients in an acute psychiatric state or terminally ill patients exceptions may be made on a case-by-case basis. However, no blanket exceptions will be allowed for particular categories of patients.

Why become smokefree?

Since the 1990s knowledge of the dangers of secondhand smoke has continued to accumulate and it is now well established that secondhand smoke causes a wide range of diseases including lung cancer, coronary vascular disease and chronic respiratory problems.³ Indeed, in 2002 the World Health Organization's International Agency for Research on Cancer classified secondhand smoke as a carcinogen.² Given these health risks it is important that the NHS becomes smokefree to protect staff and patients from the dangers of exposure to secondhand smoke.¹¹

Evidence has also emerged of a greater risk of perioperative complications, delays in wound healing and increased rates of wound infection and postoperative pulmonary complications for smokers, resulting in delayed recovery, greater treatment costs and prolonged hospital stays.⁴ Stopping smoking reduces the risks of surgical complications for smokers and increases the availability of hospital beds. It is therefore important that hospitals should actively encourage and help smokers to stop.

Support for smokers who wish to stop is now widely available. Since 1998 a network of NHS Stop Smoking Services has been established across England, offering evidence-based advice and support for smokers wishing to stop. The services include the provision of proven medications – nicotine replacement therapy (NRT) or bupropion. The services also offer specialist intensive support that can quadruple the chances of a smoker's quit attempt succeeding.¹² Some of these services are based in hospitals; those that are not have formal links with hospitals in their area. All smokers, be they employees, patients or visitors to the NHS, anywhere in the country, can be referred to these services to receive the best help to stop smoking.

The recent public health white paper states clearly that the NHS should be smokefree by the end of 2006 (see Box 2).

Box 2 Selected excerpts from the white paper on public health⁵

'NHS organisations should take action to eliminate secondhand smoke from all their buildings and provide comprehensive support for smokers who want to give up'

'By the end of 2006 ... the NHS will be smokefree'

'The HDA will shortly publish guidance for NHS organisations on the provision of smokefree buildings to protect staff, patients and others from the health risks of secondhand smoke'

This is a measure which receives widespread public support. A recent survey (April/May 2004) of British adults conducted by MORI for Action on Smoking and Health (ASH) found that 96% of respondents were in favour of a law making NHS hospitals and clinics smokefree, with 84% strongly supporting this.⁸

A survey of hospitals carried out by the HDA at the end of 2003 found that there is still considerable and unacceptable exposure of staff, patients and visitors to secondhand smoke.¹ The survey also highlighted the difficulties encountered by some hospitals trying to implement smokefree policies (see also Annex 1). A more detailed rationale for why hospitals should become smokefree can be found in the HDA document, *The case for a completely smokefree NHS in England*.⁴

This document aims to support hospitals to become smokefree by providing guidance on how to overcome the difficulties involved. The guidance is based on the learning from the survey, three detailed case studies and consultations with individuals who have been involved in implementing smokefree policies.

What is meant by a smokefree NHS?

By smokefree it is meant that smoking is not permitted anywhere within the hospital, so smoking rooms are not allowed (see Box 1). There are no exceptions for staff or visitors although exceptions can be made for individual patients on a **case-by-case basis**. Exemptions are explained further on p8 and in the policy template on p16.

However, some NHS trusts have decided to include grounds as well as buildings in their smokefree policies and this may be considered the ultimate standard to which all trusts might aspire to in the near future. Smoking just outside the entrance to hospital buildings can give a very poor impression, as well as a cloud of smoke for patients, staff and visitors to walk through. Resources spent on clearing smoking litter, or building and maintaining smoking shelters, can be much better spent on providing treatment and support for smokers to stop. The reasons why some trusts may decide to opt for smokefree grounds as well as buildings are explained further in Annex 2.

The remainder of the guidance sets out the steps needed for NHS trusts to become smokefree as defined in Box 1, but it also refers to the small additional steps needed to achieve the 'gold standard' of smokefree grounds as well as buildings.

How to introduce a smokefree policy in hospitals

The five main steps needed to implement a smokefree policy in hospital trusts are set out in Box 3. The first four steps need not take long to implement given that it is now a requirement to go smokefree. However, gaining commitment to the policy from all those involved and engaging a working party to collaborate effectively can take more time. In addition, it will be essential to the success of the policy that when it is introduced cessation support is made widely accessible, including the need for smoking cessation medications to be put on the hospital formulary. Another key factor will be identifying clearly how the policy will be enforced and monitored. These steps are discussed in more detail in the following sections and draw on a survey,¹ case studies and interviews carried out by the Health Development Agency (HDA).

Box 3: Five steps to implementing smokefree trusts

STEP 1 – COMMIT TO THE POLICY

- Identify a champion who will be responsible for implementing the policy
- Secure visible senior commitment
- Set up a working party
- Identify financial and human resources
- Consider the pros and cons of including grounds as well as buildings in the policy

STEP 2 – CREATE THE POLICY

- Draft the policy
- Consult with all staff and representative patient groups
- Anticipate and deal with common challenges
- Finalise policy and seek board approval
- Ensure adequate timescale for implementing the policy with 'lead-in' period

STEP 3 – ENSURE CESSATION SUPPORT IS WIDELY AVAILABLE AND ACCESSIBLE

- Local NHS Stop Smoking Services should be widely advertised

STEP 1 – COMMIT TO THE POLICY

Identify a champion who will be responsible for implementing the policy

There is a need to identify a champion who will act as the driving force behind the smokefree policy. The key attributes are enthusiasm and commitment to the policy. The champion also needs to have sufficient seniority within the hospital or trust to ensure that the necessary time is put aside to discuss the policy at board meetings and ensure that the policy is promoted and acted on. The champion needs the authority to set up a working party with broad representation to steer the policy through implementation and must act decisively in the face of any

- Offer training in smoking cessation to healthcare staff
- Ensure smoking cessation medications are on the hospital formulary

STEP 4 – COMMUNICATE THE POLICY

- Adopt and advertise a firm date for implementing the policy
- Communicate policy requirements internally and externally
- Inform ancillary services
- Ensure employee ownership of policy, especially at management level

STEP 5 – CONSOLIDATE THE POLICY

- Introduce the policy
- Enforce the policy via written and verbal communication on a regular basis
- Deal with violent or abusive patients or visitors
- Ensure a rigorous monitoring protocol whereby all staff are responsible for implementation
- Review the policy regularly

problems. This cannot be done by an external person, who would not know the relevant people or systems to see that the policy is successfully implemented. This role will take up a significant amount of time.

One option is for a local respiratory physician to take on this role. They have direct experience of the damage smoking can do and will be aware of the help available for people wanting to stop. Another option is to have the human resources director as champion as he or she will have links with external contractors as well as easy communication with all internal staff. The HR director also has direct control of changes such as those needed to job descriptions, contracts, advertisements, disciplinary actions etc. Alternatively a senior member of the health and safety department could also act as champion.

In some cases the next step – ‘Secure visible senior commitment’ – may be needed before a suitably senior champion can be found. However, if a suitable champion exists this person can play an important role in securing the commitment of senior colleagues.

Secure visible senior commitment

It is vitally important to ensure board-level approval and prioritisation of the policy. This will help ensure that financial and human resources are devoted to the policy and that it is taken seriously by all employees. The clear commitment to a smokefree NHS by the end of 2006 in the public health white paper will mean that achieving the successful implementation of this policy should be a priority for all NHS boards. It helps if the chief executive and chair of the trust are seen to be taking an active interest in the successful implementation of the policy.

Set up a working party

A working party can help to draft the policy, ensure adequate consultation across various professional and patient groups, and help with troubleshooting prior to and during the early stages of implementation. It can also ensure the policy is equitable and that smoking cessation treatment is accessible to all who need it, and assist in the monitoring and review of the policy’s success.

The working party should have broad representation, including members from health and safety, clinical, nursing, pharmacy and smoking cessation staff, human resources, trade unions, service users/patient

representatives, operational services, buildings or estate managers and health promotion. It is useful to be able draw on the experiences of smokers when implementing the policy – they should be invited to join the working party. If they are reluctant, a union representative can bring the views of smokers to the group. Feedback from occupational health representatives about queries or concerns from smokers can also be informative.

It helps to have someone involved who has implemented a smoking policy before, perhaps from a primary care trust or neighbouring hospital. They can report on their experiences in the run-up to the implementation of the policy and this can help to allay fears. Although insuperable problems are often foreseen, they rarely become a reality. Annex 5 gives contact names of people willing to offer advice, support and further information.

The working party should meet on a regular basis both before and after implementation and it may be necessary to meet fortnightly in the month leading up to policy implementation. Sometimes, to avoid wasting people’s time on issues that are not of direct concern to them, subgroups of the working party can be set up – for example, a staff group, an estates group and a patient’s group – and these can meet more regularly and report back to the working party. Meetings should be kept short, avoid busy clinic times and planned well ahead to secure dates in people’s diaries. Email can also be used to communicate between meetings.

The working party will also need to ensure continuity of the policy if the champion leaves (see also ‘Identify a champion’).

Securing trade union representation

It is particularly important to include union representatives on the working party. Most national health professional trade unions are supportive of smokefree workplaces including, the TUC, Unison and the RCN.¹³ It helps if this fact can be brought to the attention of local trade union representatives as they are not always aware of or follow the line of their national organisations.

Securing clinician representation

One case study highlighted the difficulties of involving clinicians in the implementation of the smokefree policy as, despite repeated requests, no clinician attended working party meetings. This appeared to reflect the perception that this is a complex area and/or an

unpopular policy that could create extra work for them, or a lack of interest in the topic and its importance.

However, it is very difficult to make the policy work if clinicians do not engage with the process. In this particular case study members of the working party were asked to attend a clinicians' meeting and present the reasons for the policy and discuss issues concerning its implementation. Once the clinicians appreciated that the policy was going ahead (countdown signs displaying the date of implementation helped to bring this message home), more than one representative then became actively involved and helped to ensure the policy was promoted to medical staff and its implementation supported. Having a clinician as a champion for the policy can also motivate other medical staff to get involved.

Securing pharmacy representation

Pharmacy involvement is also crucial, especially for ensuring the accessibility of stop-smoking treatments. This is relevant particularly in a mental health institution where there are some important interactions between antipsychotic medication and stopping smoking. Pharmacists can lend specific expertise to this area.¹⁴

Given that smoking cessation treatment is being made more accessible, the pharmacy budget will need to cover greater demand for medication. However, the National Institute for Clinical Excellence (NICE) has concluded that both nicotine replacement therapy (NRT) and bupropion are extremely cost-effective drugs¹⁵ and therefore both should be made available on the hospital formulary. Pharmacists can assist with securing supplies with the support of the trust board.

Identify financial and human resources

Funding is needed for outlays such as designing and producing signage, posters, countdown signs, increased smoking cessation staffing and pharmacotherapy support, staff and patient consultation events, training costs and locum cover when attending training. There are also 'intangibles' that need to be taken into account such as the time needed to write to all contractors who share the site (such as ambulance drivers, taxi drivers etc), attendance at meetings to publicise the policy, troubleshooting and problem solving, and answering queries and comments concerning the policy. The funding involved need not be great – about £5,000, depending on the size of the trust or hospital.

The HDA's survey¹ indicated that just over half (53%) of hospital trusts felt that they did not have the capacity to devote resources and staff to the development and implementation of the policy and only just over one in 10 had a specific budget for policy development and implementation. Awareness and usage of external resources was relatively low, although just over a quarter were aware that they could get support from NHS Stop Smoking Services.

In one case study, funding was initially allocated but then withdrawn as the budget was diverted to other – apparently more pressing – needs. This jeopardised the implementation of the policy until funding could be secured from elsewhere. Although securing funds can be difficult, some money is essential for adequate policy implementation. When requesting resources it is important to highlight that any financial outlay to support the policy will easily be recouped by savings on accidental fires and cleaning within a very short time of implementation. Bed occupancy and other complications may be reduced if patients are not smoking. If staff stop smoking, there should also be a reduction in absenteeism.

Consider pros and cons of including grounds as well as buildings in the policy

As mentioned in Annex 2, there are several reasons why NHS trusts should consider including grounds as well as buildings in the smokefree policy. For example, some sites consider it easier to extend the policy to grounds as well as buildings to avoid the problem of deciding where smokers can smoke outside. When only buildings are included in the policy, difficult questions arise such as whether smokers should be allowed to smoke just outside entrances or whether a smokefree zone should be designated outside the entrance, for example banning smoking within five metres of the entrance. In one case study patients complained about smoke drifting in through the windows of a cancer ward.

A decision also has to be made as to whether resources deployed on smoking shelters in the grounds or clearing smoking litter would be better spent ensuring treatment is readily available and accessible throughout the trust. In addition, allowing patients to smoke in the grounds means that their continued smoking will hinder and delay their recovery (see 'Why become smokefree?', p2).

STEP 2 – CREATE THE POLICY

Draft the policy

The smokefree policy should be framed within the context of health and safety regulations with the aim of protecting and improving the health of staff, patients, visitors and contractors. The policy should apply to all staff working within the trust regardless of their grade or professional background. It should be integrated with other relevant policies such as the Working Time Directive and disciplinary procedures for failing to comply with the policy. In some policies smoking at work after a smokefree policy has been implemented is treated the same as any other form of drug misuse at work and classified as gross professional misconduct. Tenders and contracts should stipulate adherence to the policy as a contractual condition. The policy should apply to anyone entering or using the buildings (and grounds, if applicable) and staff while on duty. Annex 4 provides a model smokefree policy that can be adapted according to the local situation.

The policy should be equitable and transparent throughout the hospital. It should not be concerned with *whether* people smoke but about *where* people smoke and the effect it has on others. It is concerned with the preventable presence of carcinogenic substances in the locality of health sites. However, because smoking damages health and delays recovery, every opportunity should be taken to advise smokers of the health risks of smoking and encourage them to make an attempt to stop. In addition, the policy should apply to staff entering homes with a smoking environment while on duty. Patients should be asked, in writing, not to smoke when staff are present and staff should not be forced to enter patients' homes where people are smoking. In one trust where this policy was implemented compliance was almost 100 per cent.

The policy should allow for flexibility in exceptional circumstances, such as a terminally ill patient or a patient with mental health problems in an acute psychiatric state. The nurse or doctor in charge of a ward or unit should be able to make an exception for a patient where this has been agreed as part of their care plan. For all exceptions there should be demonstrable evidence that smoking cessation has been fully considered as part of the patient pathway. For example, over time all patients in long-stay institutions should be offered an appointment with a specialist stop-smoking adviser who can offer support for

stopping or advice on how to manage withdrawal symptoms when abstaining.

Where exceptions are made, every effort should be made to minimise exposure of staff and other patients to smoke. Smoking in these circumstances should occur out of sight of other patients, staff and visitors and there should be an agreed protocol for risk management. In one case study, smoking was permitted in an enclosed courtyard that was mainly out of sight of others. All exemptions should be regularly reviewed by a senior member of staff. In addition, all members of staff should know where smokers can go to smoke, or, if the grounds are also to be made smokefree, the nearest exit from the hospital grounds.

It must be stated clearly in the draft policy how it will be enforced. Preferably, enforcement should be the responsibility of all staff – everyone should be aware of how to deal with infringements. Managers have a responsibility to deliver the organisation's policies irrespective of their personal views and to support their junior staff on the same basis. Specific training may be appropriate. Non-compliance with the policy by staff should result in the initiation of disciplinary procedures in a similar way to non-compliance with other hospital policies.

Giving responsibility to all staff can, however, mean that no-one is directly responsible for the enforcement of the policy. It can therefore be helpful to designate an overarching responsibility for enforcement to a particular staff group, which should report to the working party at regular intervals as part of the monitoring process of the policy. In one case study, security staff hold overall responsibility for ensuring the policy is enforced. If smokefree grounds are included in the policy security staff can be particularly helpful at entrances and exits to the trust, and car park attendants can also be responsible for ensuring smoking does not take place in the grounds. Wherever possible, enforcement of the policy should be educational and supportive. However, patients who persistently offend (three or more times) should be referred to a stop-smoking adviser.

Consult with all staff and representative patient groups

Once a draft of the policy has been agreed by the working party, it should be widely circulated to all employees, trade unions, contractors, staff and partner organisations for comment by an agreed date. It should

be made clear that the policy is a decision of the board but that consultation is helpful to identify potential problem areas and to assist with implementation. The draft policy should also be circulated to users and carers for comment by an agreed date. In addition, members of the working party can present the policy at various multi-disciplinary meetings and address any concerns arising about implementation.

Anticipate and deal with common challenges

Staff and patients' rights

The issue of staff and patients' rights to smoke comes up repeatedly when implementing a smokefree policy. It has been argued that banning smoking leads to inhumane treatment of smokers. This can be a particular issue when the health institution is the home for long-stay patients, but such patients should be reviewed on a case-by-case basis (see section on 'Empowering smokers with mental health problems...', p9). In relation to staff, under health and safety guidelines no organisation should be endangering its employees by allowing the inhalation of carcinogens.

Some staff report smoking on hospital premises to signal that they are taking a break but are unable to leave their station because of staffing shortages. One case study dealt with this by identifying the staffing shortages, taking steps to fill the gaps and ensuring staff had their entitled breaks. Night staff may also comment that they cannot go out of the buildings to smoke because of the dangers of doing so. Improved lighting and security systems have helped to allay concerns about safety. In one case study where the policy required the grounds to be smokefree as well as the buildings, staff were allowed to smoke in their own vehicles as a compromise. More importantly, however, night staff should be provided with appropriate leisure facilities for their breaks to promote alternatives to smoking.

The smokefree policy should be seen in the same light as policies on alcohol and illicit drugs. Those addicted to alcohol and illicit drugs are not allowed to bring them onto hospital premises but are instead offered treatment for their addictions. Most smokers are dependent on nicotine and support should be offered to both staff and patients. Nicotine replacement therapies can be kept as stock items on wards and used by those not interested in quitting to assist in the control of withdrawal symptoms.

Nevertheless, it should also be acknowledged that smoking cessation is about disease prevention and that clinical institutions have a duty of care to staff and patients for both physical and mental health. Stop-smoking support must be brought to the attention of, and made accessible to, both staff and patients. The occupational health department should be on standby to provide advice and support to staff members who smoke.

Blanket exemptions

In one case study, during a consultation on a draft smokefree policy, clinicians requested blanket exemptions for whole wards and wings where there were long-stay patients. In this example, blanket exemptions were ruled out but the policy allowed for case-by-case assessments (as described in 'Draft the policy', p7) as part of the individual care plans of all patients. Where an exception is made, minimising staff exposure to smoke would normally mean that smoking is only permitted outdoors, where staff and other patients are not in close proximity to the smoker. Ideally, this would be out of sight of other patients, visitors and staff, who may be engaged in a cessation programme.

Hospital shops

Guidance issued by the NHS in 1992 indicated that hospitals should not sell cigarettes except to long-stay patients.¹⁶ Given the availability of nicotine replacement therapy (NRT), any sale of cigarettes is no longer appropriate. Shops should also not sell lighters or other tobacco products, but instead consider selling those NRT products that are available over the counter. In addition, they should promote NHS Stop Smoking Services and other effective routes to quitting. The HDA survey¹ indicated that only 8% of hospitals offered NRT products in the hospital shop and 11% were still selling cigarettes.

In one case study, it was discovered that the hospital shop was sustained by its cigarette sales. Initially, there was resistance to the proposal that the shop should stop selling tobacco. However, as continuing to sell tobacco would undermine the smokefree policy, options for the future of the shop were considered. These included a subsidy, allowing a chain to take over the shop (although there was concern that most chains sold tobacco), selling NRT over the counter, or closing the shop. In the event, the shop continued to remain viable even though it no longer sold tobacco and smoking paraphernalia.

Concerns raised about crossing busy roads to purchase cigarettes if they were no longer available from hospital shops can be addressed with the positioning of 'older people' signs on neighbouring roads. This was successfully achieved in one case study.

Jointly owned premises

Some of the buildings on hospital sites are managed by other organisations or jointly managed by a number of trusts. In one case study a social club was jointly owned, leading to discussions about whether it should be forced to come under the smokefree policy. There were also concerns that it was mostly frequented by smokers and it could be forced to close if it was made smokefree and people no longer used it. In this case the decision was made that it should go smokefree so as not to undermine the policy.

Empowering smokers with mental health problems to make quit attempts

The smokefree policy can be seen as supportive of patients with mental health problems in that both their physical and mental health are being addressed by health professionals.¹⁴ Many mental health patients who smoke say they have never received advice to stop from a health professional. A smokefree policy can support these patients if it is coupled with advice and support for stopping.

The introduction of a policy can highlight the lack of social activities that are available on hospital sites for patients, many of whom cite boredom as an important factor in their continued smoking. Leisure activities can then be created or publicised.

In one case study, nursing staff identified that smoking rooms were useful as they knew where their patients were – in this particular hospital they could check up on them as the smoking room had glass windows. This is a tacit encouragement to smoke on the premises and highlights a number of issues: a shortage of social activities, availability of 'social rooms' for patients, and potential staff shortages. The smoking room was closed and the other issues addressed by providing non-smoking social rooms, a wider range of leisure activities and rectifying staff shortages.

Case studies have demonstrated that it is possible for NHS mental health care trusts to go smokefree. One such trust maintained a few smoking rooms in long-stay

institutions as a short-term interim step towards going completely smokefree but made the smoking rooms unattractive by restricting them to two patients at any time, having no televisions or radios, and providing only basic seating.

Smoking shelters

Some hospitals have built shelters in the grounds where staff, patients and visitors are allowed to smoke. These can be costly (for one trust the cost was an alleged £60,000),¹⁷ unsightly and undermine policies designed to protect health. Rather than spend budgets on building shelters it is much more preferable to invest in advice and support for smokers and provide nicotine replacement therapy for those smokers unwilling or unable to stop and who need help with controlling withdrawal symptoms.

Finalise policy and seek board approval

Once the consultation period is complete the working party should discuss the comments and decide whether any changes are needed to the policy. Approval of the board should then be sought for the final policy. Once agreed, the final policy should be widely circulated in the same way as the draft.

Ensure adequate timescale for introducing the policy with 'lead-in' period

The timescale needed to implement a smokefree policy can take a few months because of the need for adequate consultation, informing the relevant people, changing contracts, preparing signage etc. In one case study the start of the policy was postponed for three months for these reasons. Time should also be allowed for the provision and display of 'countdown' signs for the three months leading to the date the policy becomes live, ensuring all staff, patients and visitors are made aware of the start of the smokefree measures.

Consideration should be given to an appropriate 'lead-in' period for the policy. This could be for the first three months after the policy becomes live, during which staff not complying with the policy are not formally disciplined but instead are interviewed by their line manager and referred to occupational health for support and advice as appropriate. If an individual continues to infringe the policy after the lead-in period then the manager should be able to invoke disciplinary procedures as a means of encouraging adherence to the policy.

STEP 3 – ENSURE NHS STOP SMOKING SUPPORT IS WIDELY AVAILABLE AND ACCESSIBLE

Local NHS Stop Smoking Services should be widely advertised

It is incumbent on those working within the NHS to recognise the importance of encouraging their patients who smoke to stop. A close relationship should be forged with the local NHS Stop Smoking Services and patients and staff should be made aware of these services. The services should be widely advertised through pre-admission literature as well as no smoking signs and posters throughout the hospital.

It is important to ensure that smoking status is recorded when patients register so that all smokers can be readily identifiable on admission and throughout their stay in the hospital. This is to ensure help and support can be offered.

Some NHS Stop Smoking Services are hospital based (39% of hospitals in the HDA's survey¹ indicated that this was the case), others have a stop-smoking adviser employed by the hospital (29% of hospitals in the survey). Sixty one per cent of hospitals referred people to primary care trust stop-smoking services. Patients can self-refer or be referred by health professionals, who therefore need only to raise the issue of smoking, advise their patients to stop and refer smokers to the services for support in doing so. Some provision of specialist support will need to be offered on-site as some staff may not be able and willing to travel to other sites for support.

Some hospitals in the US that have implemented smokefree environments in the grounds as well as the buildings offer all patients and family members a pack that contains an explanation of the policy, a map showing where they can smoke, a brief summary of treatment options. They also offer a small pack of nicotine replacement therapy to aid withdrawal and educational materials about smoking.¹⁸

Demand for stop-smoking services can be high when a smokefree policy is implemented – planning ahead helps to ensure demand can be met.

Offer training in smoking cessation to healthcare staff

Training should be provided for all health professionals on how to give opportunistic stop-smoking advice to smokers. This training will also ensure that they are made aware of the support available to smokers from the local NHS Stop Smoking Services. The coordinator of these services should be able to provide the training.

In one case study, stop-smoking training was deemed to be a low priority by the clinical staff, who did not believe it should be made mandatory for all staff. Given that stopping smoking is the most important step most smokers can take to improve their health, encouraging smokers to stop should be a priority for all health professionals. Training in opportunistic advice to stop smoking takes half a day. A database of training courses can be found on the HDA website.¹⁹

Ensure smoking cessation medications are on the hospital formulary

As proven smoking cessation treatments, nicotine replacement therapy (NRT) and bupropion should also be made widely accessible throughout the hospital – so both need to be available on the hospital formulary. In addition to supplying patients who are receiving intensive support through the hospital system, patients unwilling or unable to receive such support can be prescribed NRT or bupropion. The National Institute for Clinical Excellence (NICE) has identified both these treatments as very cost effective.¹⁵ NRT, in particular, can be supplied to smokers who do not wish to stop, to help them with withdrawal symptoms during their stay in hospital.

The HDA survey¹ found that although 40% had NRT on the hospital formulary, NRT was available on prescription in only 10% of hospitals and in only 8% were patients offered NRT. Only 6% of the hospitals surveyed stocked NRT on their wards.

STEP 4 – COMMUNICATE THE POLICY

Adopt and advertise a firm date for implementing the policy

The date the policy will take effect should be widely advertised. Countdown signs advertising the date of implementation of the smokefree policy should be placed prominently near the hospital entrances and will help to ensure that people are made aware of the forthcoming policy. The date should be chosen carefully. Dates such as New Year's Day or No Smoking Day (the second Wednesday of March) will find many smokers making attempts to quit at the same time. When advertising the policy it can be helpful to briefly explain again the key reasons and the benefits for staff, patients and the trust.

Communicate policy requirements internally and externally

It is important to ensure that all staff, patients, visitors and contractors are made aware of the implementation date and reminded of the policy when on trust premises. In addition to countdown signs, no smoking signs should be placed in every ward, corridor and stairwell around the hospital premises to advertise the policy. The size of signage needs careful consideration: if too small, the policy could be deemed insignificant and not important; too large and it comes across like an order or 'shouting'. Signage also needs to be appropriate to the environment in which it is to be used. Both countdown and no smoking signs should give contact details for the local NHS Stop Smoking Service.

The policy on smoking should also be advertised on hospital intranet systems and in all correspondence with patients. Letters sent out in advance of hospital treatment should highlight the policy on smoking but also advise patients to stop, giving details of local NHS Stop Smoking Services.

All job advertisements, job descriptions, contracts etc should mention the smokefree policy. Briefing sessions should also be held for patients and staff when the policy is being introduced. In one case study information about the forthcoming policy was put on payslips.

It can be a good idea for board members, in particular the chair and chief executive of the trust, to tour smoking rooms and talk to staff and patients. This helps to inform

people that the smokefree policy will be taken seriously and emphasises the reasons for introducing it.

Where grounds are included in the policy, all ashtrays and bins for extinguishing cigarettes at entrances and exits to trust buildings should be removed.

Inform ancillary services

It is important to ensure that all staff are made aware of the policy, including ancillary staff such as ambulance drivers or volunteer car drivers.

Ensure employee ownership of policy, especially at management level

Communications around the policy should make it clear that the policy is the responsibility of all staff, not just the board. In other words, all managers should be made aware that it is their responsibility to ensure that their staff adhere to the policy and be made aware how to deal with infringements (see Step 5).

STEP 5 – CONSOLIDATE THE POLICY

Introduce the policy

When the policy is launched, publicity should be obtained in the local press.

Enforce the policy via written and verbal communication on a regular basis

It is important that the policy has teeth and is enforced from day one. All staff should observe the policy and ensure that others (staff, patients and visitors) also adhere to it. However, overall enforcement, particularly for patients and visitors, should be designated to one staff group, such as security staff. This staff group should nominate a representative who should report to the working party at regular intervals on the success of the policy.

Deal with violent and abusive patients or visitors

If a patient or visitor becomes angry or violent, the standard NHS procedures and policies for aggressive behaviour should be invoked. A 'zero tolerance' policy applies to the NHS for violence and abuse and this area should not be an exception. However, most smokers do appreciate that smoking in hospitals is inappropriate.

Ensure a rigorous monitoring protocol whereby all staff are responsible for implementation

A monitoring protocol should be drawn up to identify problems and suggest improvements. Monitoring should involve identifying breaches of the policy as well as positive outcomes such as the number of staff trained in smoking cessation, staff and patient numbers seeking support with stopping etc. Monitoring should be assigned to ward managers or hospital matrons, as well as those assigned overall responsibility for enforcement. They should collect information on a monthly basis.

Review the policy regularly

It is suggested that the working party meets quarterly for the first year to examine the implementation of the policy and then on an annual basis. A formal review of the policy should be carried out by the champion of the policy after six months, with support from the working party, and yearly thereafter.

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Annex 1 – Previous guidance and implementation

In 1992, the government indicated that the NHS should create a virtually smokefree environment for staff, patients and visitors.^{16,20} In particular, the sale of tobacco on NHS premises, except for long-stay patients who smoked, was to cease by 31 December 1992, and by 31 May 1993 the NHS was to be smokefree 'except for limited necessary provision of separate smoking rooms'. By 1998, it appeared that although virtually all hospitals had policies on smoking, not all were properly in operation.²¹

A survey carried out by the Health Development Agency (HDA) in November/December 2003 of a random sample of 80 hospitals* confirmed that the vast majority of NHS hospitals had policies on smoking, with 10% reporting to be *completely* smokefree.¹ The definition used in this survey for a completely smokefree policy was that no exceptions were allowed whatsoever and smoking was not permitted anywhere on hospital premises, including buildings and grounds. However, further research of a sub-sample of the hospitals claiming to be completely smokefree found that this was not the case. Respondents in this sub-sample either reported that their hospitals had endeavoured to implement a completely smokefree policy but that the policy had lapsed due to inadequate implementation and enforcement, or that smoking was allowed either in shelters or outside the buildings.

The remaining 90% of the hospitals sampled were operating *partial* bans. For these hospitals, smoking was most frequently allowed in dedicated smoking rooms (63%), and/or in dedicated smoking shelters (61%), and/or outside the hospital entrance (60%). The most common location for smoking rooms was on the wards (22%), or in or near the canteen/restaurant (19%), although 8% located them in theatre, 4% in A&E and

4% in maternity. Partial bans frequently granted exceptions, the most common being for bereaved relatives (65%), long-stay patients (51%) and mental health patients (42%). In addition, 32% allowed smoking by theatre staff, 26% by nursing staff and 24% by consultants.

The survey indicated that of hospitals currently operating a partial ban, 10% had tried implementing a complete ban. The survey and further research indicated that the two main reasons for failure of these bans were inability to enforce the policy and a need to control smokers and where they smoked.

Twenty nine per cent of the hospitals with partial bans were planning to introduce a complete ban on smoking. Overall, although 70% of the hospitals thought the NHS should be totally smokefree in the next two years, only 11% thought this a very realistic prospect.

* 138 people were interviewed across a random sample of 80 hospitals stratified to include a spread of hospitals across the country. Nine further in-depth interviews were conducted covering hospitals with different policy programmes and different levels of implementation. All interviews were carried out between 6 November and 10 December 2003.

Annex 2 – Rationale for smokefree grounds as well as buildings

RATIONALE FOR SMOKEFREE GROUNDS AS WELL AS BUILDINGS

A strong message is communicated about the dangers of smoking

Having smokefree grounds as well as buildings means a strong message is communicated about the established dangers of smoking and secondhand smoke.

Duty of care

People smoking at the entrance to NHS trusts gives a very poor impression and also means that those entering and leaving the buildings have to pass through tobacco smoke. Smoking cessation is about disease prevention and clinical institutions have a duty of care to staff and patients for both physical and mental health.

Allowing patients to smoke while in hospital puts them at increased risk of complications and delays their recovery.

Support for smokers to quit

Completely smokefree hospitals and grounds create a smokefree environment for people trying to stop smoking and remove triggers that cause many to smoke or relapse to smoking. The availability of a national network of specialist NHS Stop Smoking Services means that support is easily accessible for patients and staff wishing to stop smoking.

Resources can be better spent elsewhere

Building and maintaining smoking shelters and clearing smoking litter uses considerable resources. Money spent on these is much better spent on profiling and providing treatment and support for smokers wanting to stop.

Smoke travels

If smoking is allowed at entrances and outside buildings, the smoke will drift in through doors and windows thereby continuing to be a health hazard. In addition, patients dislike the smell of cigarette smoke on staff if employee smoking is allowed on-site, and this can weaken patients' attempts to stop as well as undermining the smoking policy.

Fire risks

When smoking is allowed anywhere on the premises an additional risk of fires breaking out remains.

Annex 3 – Policy template*

SMOKEFREE POLICY

Introduction

The public health white paper, *Choosing Health*, makes a clear commitment to a smokefree NHS by the end of 2006.

Section 2(2) of the Health and Safety at Work Act 1974 places a duty on employers to:

'...provide and maintain a safe working environment which is, so far as is reasonably practical, safe, without risks to health and adequate as regards facilities and arrangements for their welfare at work.'

Several EU directives relating to health and safety in the workplace have come into force since 1 January 1993. These include the Management of Health and Safety at Work Regulations 1999 which, under General Principles of Prevention, include:

- Avoiding risks
- Combating risks at source
- Replacing the dangerous by the non-dangerous or the less dangerous
- Giving collective protective measures priority over individual protective measures.

Secondhand smoke – breathing other people's tobacco smoke – has now been shown to cause lung cancer and heart disease in non-smokers, as well as many other illnesses and minor conditions.

The employer acknowledges that breathing other people's smoke is both a public health hazard and a welfare issue. Therefore, the following Policy has been

* Adapted from smokefree policies implemented at Norwich Primary Care Trust and Norfolk Mental Health Care Trust (NMFCT). This policy can be adapted for Trusts implementing either smokefree buildings policies or smokefree buildings and grounds with additional wording required for grounds being provided in italics.

adopted concerning smoking at all [name] NHS Trust premises (*buildings and grounds*).

General principles and scope

The aim of this Policy is to:

- Protect and improve the health of staff
- Protect and improve the health of patients, visitors and contractors
- Protect both smokers and non-smokers from the danger to their health of exposure to secondhand smoke
- Set an example to other employers and workforces, particularly in health-related locations.

...by arranging for Trust buildings (*properties and vehicles*) to be 'smokefree' and by requiring staff not to smoke while on duty.

This Policy is part of a range of policies that together comprise the [NAME] Trust Health and Safety Policy.

Work areas

This Policy will apply to all staff, patients, visitors, contractors and other persons, who enter the [name] Trust owned or rented buildings (*or grounds*) for any purpose whatsoever. (*Although the Policy extends to cars leased from the [NAME] Trust during business usage, it does not apply to the interior of cars owned privately and not being used for business purposes or during business hours.*)

(The policy can be extended to protect staff from exposure to smoke when making home visits.)

Introduction and implementation of the Policy

The Policy was agreed by the Trust Board at its meeting on [date]. Its formal adoption will commence on [date]. From that date, staff will not be permitted to smoke

while they are on duty, (*irrespective of their location*), except in accordance with the previous paragraph.

There will be a 'lead-in' period between [DATE] and [DATE]. During this period, staff who do not comply with the Policy will be interviewed by their line manager and referred to occupational health, for support and advice as appropriate. Should an individual or group of individuals continue to infringe this Policy **after** the lead-in period the manager may invoke disciplinary procedures as a means of encouraging adherence to the Policy.

Responsibility for implementing this Policy rests with the chief executive. Day-to-day responsibility for implementation lies with directors and managers.

The occupational health department will provide advice and support for staff. Those who wish to stop smoking will be helped to access individual or group support and nicotine replacement therapies as appropriate.

To ensure that everyone entering [name] Trust sites understands that smoking is not allowed in the buildings (*and grounds*), clear signs will be on display. Staff will be reminded of how the Policy relates to their use of vehicles. (*Smoking at entrances and exits by staff, patients or visitors will not be tolerated.*)

Tenders and contracts with the [NAME] Trust will stipulate adherence to this Policy as a contractual condition. Existing contracts will be modified as soon as possible. Patients will be advised of the new Policy on admission to [NAME] Trust premises. GP practices will also be informed of the Policy. Existing patients will also be addressed through a series of information sessions, with the support of stop-smoking specialists and counselling as appropriate.

Job advertisements will include reference to the non-smoking policy and indicate that the adherence will be contractual.

Training will be offered to staff in advising patients, visitors etc of the policy, as requested.

Secondhand smoke

This policy recognises that secondhand smoke adversely affects the health of all employees. It is not concerned with **whether** anyone smokes but with **where** they

smoke and the effect this has on patients, visitors, smoking and non-smoking colleagues and other members of the wider health community. It is also concerned with the presence of preventable carcinogenic substances in the locality of health sites.

[NAME] Trust sincerely encourages its employees to refrain from smoking outside the times and circumstances set out in this policy, both in their own interests and as representatives of a major public body, whose purpose is to improve health. However, this falls outside the scope of this Policy.

Exceptions

The Trust Board recognises that some patients have circumstances that will require staff to make an assessment as to whether special arrangements need to be made so that the patient will be permitted to smoke on a Trust site. Such circumstance might include detention under the Mental Health Act or the inability of a patient to give informed consent for help with smoking cessation. Permission to grant an exception will rest with the nurse in charge of the ward or unit and be formally recorded.

In all cases where an exception has been made there should be demonstrable evidence that smoking cessation has been fully considered as part of the patient pathway, in conjunction with the patient and/or their relatives. Where an exception is made, every effort must be made to minimise staff exposure to smoke. This would normally mean that smoking would only be permitted outdoors where staff and other patients would not be in close proximity to the smoker. Ideally, this would also be out of sight of other patients, visitors and staff, who may be engaged in a stop-smoking programme.

Annex 4 – Guidance to staff template*

SMOKEFREE POLICY

GUIDANCE TO STAFF

The Smokefree Policy applies to staff, patients, residents, visitors and contractors. The following guidance points are intended to give all staff key phrases and references to enable them to implement the Policy effectively.

General

- 1 Smoking is the biggest single cause of ill health and premature death in the country. The Trust is doing everything it can to promote the no smoking message.
- 2 As an NHS employer, the Trust has a duty to its staff and patients to protect them from the health hazard that smoking represents.

Staff

- 1 The Policy applies to all staff, without exception. It has been drawn up following staff and patient consultation, and has been endorsed by the Trust Board.
- 2 Staff cannot smoke in buildings (*or grounds*) owned by the Trust, (*or in leased cars belonging to the Trust*) or when they are on Trust duty. During the lead-in period, from [DATE] to [DATE], if you see a member of staff smoking, in contravention of the Policy, it is suggested that you:
 - Remind the person of the Policy
 - Make a simple diary note
 - Report the incident to the person's line manager.

- 3 Staff who are finding it difficult to adjust to the Policy should be a) invited to discuss the issues with their manager, and b) referred to occupational health for support and, if they wish, referral to medications.
- 4 After [DATE] staff will be expected to comply with the Policy. Failure to do so will result in disciplinary procedures. Managers will need to establish their own monitoring arrangements to see that the Policy is being followed. Evaluation will be carried out during, and at the end of, the first six months.
- 5 If individual staff challenge their manager on their right to smoke, the manager should refer to these points:
 - This is a Trust Policy relating to health and safety and is based on the same principles as policies relating to dangerous machinery, toxic substances etc
 - An employee cannot challenge the employer's right to introduce healthier and safer working practices
 - The Policy is concerned with where someone smokes. (*A smoker may use their break to go off-site or to their private vehicle to smoke.*)
- 6 *If staff need to go 'off-site' to smoke during their break, the following applies:*

- *Under the Working Time Directive, where staff work for longer than six hours they are entitled to a break of a minimum of 20 minutes. Within the Trust all staff should be encouraged to take a break*
- *In most health and social care workplaces, breaks are taken in a manner consistent with maintaining minimum staffing levels. Managers need to plan effectively for staff who leave the premises on breaks for any reason. In relation to smoking 'off-site', managers will need to liaise with their human resources manager/adviser to assess the impact on staffing levels and the expected/required availability of staff.*

* Adapted from smokefree policies implemented at Norwich Primary Care Trust and Norfolk Mental Health Care Trust (NMFCT). This policy can be adapted for Trusts implementing either smokefree buildings policies or smokefree buildings and grounds with additional wording required for grounds being provided in italics.

7 Under no circumstances should a confrontational attitude be adopted or allowed to develop. All staff who experience difficulties with the application of the Policy should seek support from their line manager in the first instance.

Patients

- 1 This Policy applies to all patients, but there may be some exceptions. (See Smokefree Policy and paragraph 3 below)
- 2 Polite signage and reminders are usually sufficient to deter smoking, but patients should also be informed at pre-admission or on admission.

A similar rationale applies as for staff:

- This is a Trust Policy relating to health and safety and is based on the same principles as policies relating to dangerous machinery, toxic substances etc.
- The Trust has a duty to its patients to protect them from the health hazard that smoking represents
- Nicotine replacement therapy (NRT) is available on prescription and over the counter.

(Patients who are not detained under the Mental Health Act and who choose to discharge themselves because of the Policy may do so.)

If a patient becomes angry or violent, the standard Trust policy for aggressive behaviour is to be invoked.

- 3 Where there is an exception, permission to smoke in a designated outdoor area away from others can only be given by the relevant ward or unit nurse, clinician or senior manager. Permission to smoke should be seen as part of the clinical pathway and be discussed by the clinician, the patient/client and appropriate relatives in that light and documented. This allowance should not be extended to staff who work with those patients/clients.

Visitors and contractors

- 1 This Policy applies to all visitors and contractors, irrespective of their circumstances.

2 Visitors who are distressed for any reason should be comforted, but the Policy still stands.

3 Contractors who contravene the Policy should be reported to the person responsible for monitoring the conduct of contractors on site.

4 Visitors and Contractors may wish for advice on stopping smoking and should be given the local NHS Stop Smoking Service [NAME] on [TEL].

You have the full support of your Trust in the delivery of this Policy. We would like you to feel confident about your role and the contribution you are making to improve the health of staff and patients. If you would like further guidance or support, please contact your line manager or the Trust's physical health nurse on [TEL].

Annex 5 – Contacts

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NO SMOKING DAY (INFORMATION AND TIPS ON QUITTING)

www.nosmokingday.org.uk

ROY CASTLE LUNG CANCER FOUNDATION/THE NATIONAL CLEAN AIR AWARD

www.roycastle.org

www.cleanairaward.org.uk/business_levels.htm

SMOKING HELPLINES

NHS Smoking helplines:

England and Wales – 0800 169 0169

Scotland and Northern Ireland – 0800 848484

NHS Pregnancy Smoking Helpline – 0800 169 9169

Quitline – 0800 002200

Support is also available in the following languages:

| | Quitline | NHS |
|-----------------|-------------|---------------|
| Bengali | 0800 002244 | 0800 169 0885 |
| Gujarati | 0800 002255 | 0800 169 0884 |
| Hindi | 0800 002266 | 0800 169 0883 |
| Punjabi | 0800 002277 | 0800 169 0882 |
| Urdu | 0800 002288 | 0800 169 0881 |
| Turkish/Kurdish | 0800 002299 | |

Annex 6 – Resources

ACHIEVING SMOKE FREEDOM TOOLKIT

www.cieh.org/research/smokefree

HOMELESSNESS, SMOKING AND HEALTH

www.hda.nhs.uk/documents/homelessness_smoking.pdf

MEETING DEPARTMENT OF HEALTH SMOKING CESSATION TARGETS: RECOMMENDATIONS FOR PRIMARY CARE TRUSTS

www.hda.nhs.uk/documents/smoking_cessation_targets_part1.pdf

MEETING DEPARTMENT OF HEALTH SMOKING CESSATION TARGETS: RECOMMENDATIONS FOR SERVICE PROVIDERS

www.hda.nhs.uk/documents/smoking_cessation_targets_part2.pdf

PERCEPTIONS OF SMOKING CESSATION PRODUCTS AND SERVICES AMONG LOW INCOME SMOKERS

www.hda.nhs.uk/documents/perceptions_smoking_cessation.pdf

PREVENTION OF LOW BIRTH WEIGHT: ASSESSING THE EFFECTIVENESS OF SMOKING CESSATION AND NUTRITIONAL INTERVENTIONS (EVIDENCE BRIEFING)

www.hda.nhs.uk/documents/low_birth_weight_evidence_briefing.pdf

PREVENTION OF LOW BIRTH WEIGHT: ASSESSING THE EFFECTIVENESS OF SMOKING CESSATION AND NUTRITIONAL INTERVENTIONS (EVIDENCE BRIEFING SUMMARY)

www.hda.nhs.uk/documents/low_birth_weight_summary.pdf

SMOKING AND PATIENTS WITH MENTAL HEALTH PROBLEMS

www.hda.nhs.uk/documents/smoking_mentalhealth.pdf

SMOKING AND PUBLIC HEALTH: A REVIEW OF REVIEWS OF INTERVENTIONS TO INCREASE SMOKING CESSATION, REDUCE SMOKING INITIATION AND PREVENT FURTHER UPTAKE OF SMOKING (EVIDENCE BRIEFING)

www.hda.nhs.uk/documents/smoking_evidence_briefing.pdf

SMOKING AND PUBLIC HEALTH: A REVIEW OF REVIEWS OF INTERVENTIONS TO INCREASE SMOKING CESSATION, REDUCE SMOKING INITIATION AND PREVENT FURTHER UPTAKE OF SMOKING (EVIDENCE BRIEFING SUMMARY)

www.hda.nhs.uk/documents/smoking_eb_summary.pdf

STANDARD FOR TRAINING IN SMOKING CESSATION TREATMENTS

www.hda.nhs.uk/documents/smoking_cessation_treatments.pdf

STATISTICAL BULLETIN: STATISTICS ON NHS STOP SMOKING SERVICES IN ENGLAND, APRIL TO JUNE 2004

www.publications.doh.gov.uk/public/smokingcessationaprjun04.htm

THE CASE FOR A COMPLETELY SMOKEFREE NHS IN ENGLAND

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Notes

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Guidance for smokefree hospital trusts

The recent white paper, *Choosing health: making healthy choices easier*, announced that the NHS will be smokefree by the end of 2006. This guidance document provides the rationale for why the NHS should become smokefree, defines what is meant by smokefree and sets out the steps needed for NHS trusts to become smokefree. It is based on the learning from a survey of hospitals carried out by the HDA at the end of 2003, three detailed case studies and consultations with individuals who have been involved in implementing smokefree policies.

The document should be read in conjunction with the HDA briefing paper, *The case for a completely smokefree NHS in England*. This briefing paper sets out the case for a completely smokefree policy across the NHS and counters objections from those who say it cannot be done.

