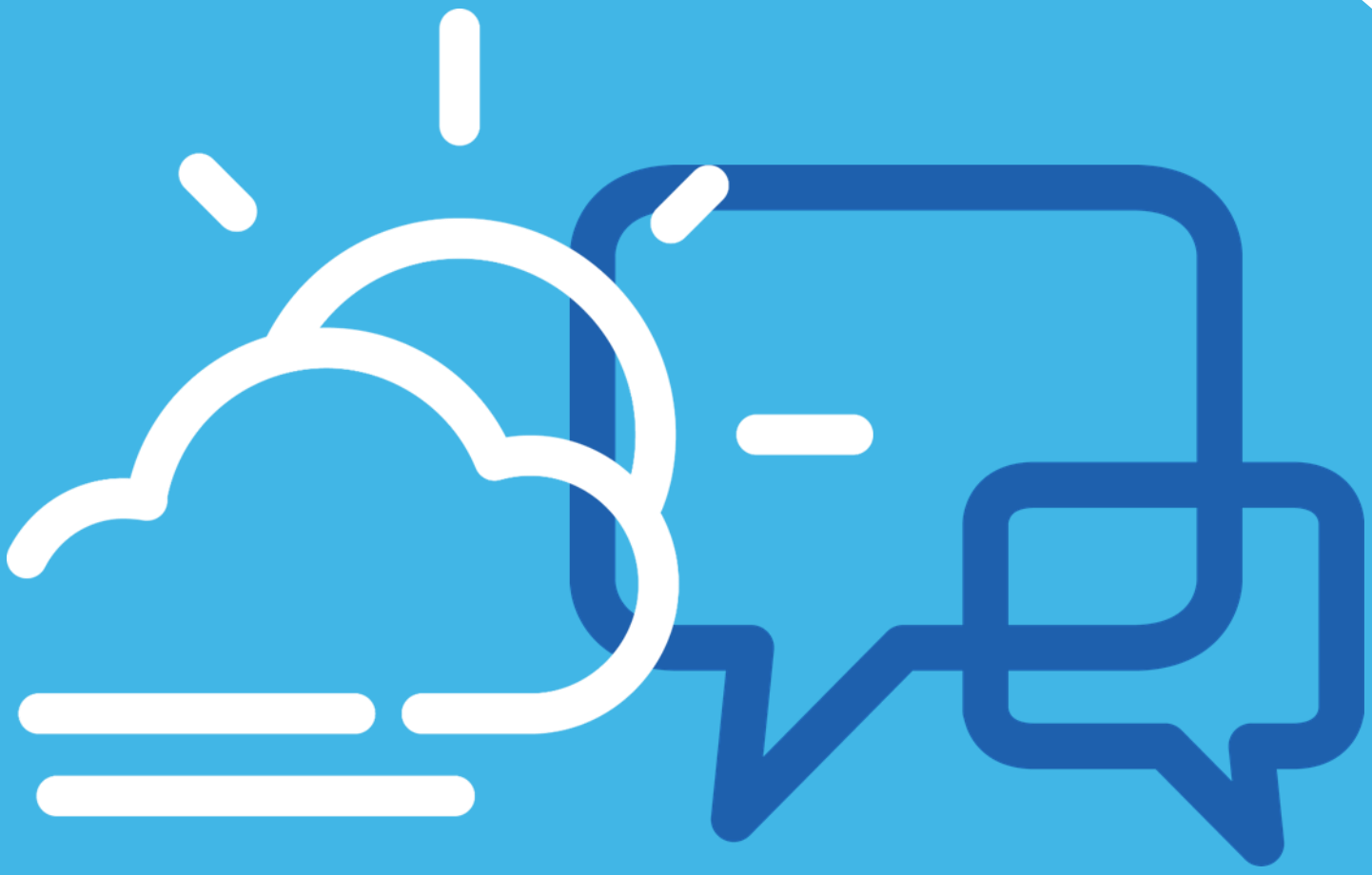
NHS
Greater Manchester Mental Health
NHS Foundation Trust

Smoke Free Policy

Greater Manchester Mental Health NHS Foundation Trust



Improving Lives

Document Name:	Smoke Free Policy
Executive Summary:	The Health Act (2006) made provision for the prohibition on smoking in enclosed or substantially enclosed premises from 1st July 2008. This policy provides staff with clear guidance on how the smoke free legislation should be applied in practice and is supported by National mandated NHS Service Delivery Improvement Plan and National CQUIN programme 2017/2019.
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Contents

1. Introduction

Greater Manchester Mental Health NHS Foundation Trust provides inpatient/residential care to service users in a wide range of care setting across the Trust as well as community services for outpatients receiving care from our Trust. Within GMMH footprint, Manchester has the highest rate of smoking related mortality rate with 458 per 100,000 population (Statistics on Smoking England, 2016).

The policy has been updated as part of the GMMH NHS Foundation Trust's commitment to national policy of achieving a non-smoking NHS and in supporting healthier communities. The policy seeks to support improved public health and to reduce the fire risks associated with smoking in NHS premises.

The Health Act 2006 made provision for the prohibition on smoking in enclosed or substantially enclosed premises from 1st July 2008. Mental Health NHS trusts put into to place arrangements to ensure that the smoke free legislation was complied with to avoid the risk of criminal prosecution. Individuals who do not abide by the smoke free legislation also face the risk of criminal prosecution.

Smoking is the largest single cause of death and disease in England. It is also the biggest preventable cause of death and disabling illness. Around half of all people who smoke over the long term will die as a result of their smoking losing on average about 10 years of life (ASH, April 2013). Smoking is also the leading cause of fatalities. Smoker' materials (such as cigarettes, cigars or pipe tobacco) were the source of ignition in 30% of fire related fatalities in accidental dwelling fires in 2016/17, and was by far the largest ignition category involved in accidental dwelling fire related fatalities. https://www.gove.uk/government/uploads/system/uploads/attachment_data/file/650926/detailed-analysis-fires-attended-fire-rescue-england-hosb1617.pdf

One of these groups is people with mental health problems. Up to 40-50% of people with diagnosed depressive illness or anxiety disorders smoke. The figure for people with schizophrenia has been estimated at around 70% (ASH, 2013). People who smoke in this population also smoke significantly more on average and have higher levels of nicotine dependence than the population as a whole (ASH ibid).

Predictably, this high prevalence of smoking and the large amounts of tobacco smoked results in much higher rates of certain illness and death amongst people with mental health problems including, cancer and respiratory and cardio-vascular disease. Smoking accounts for the largest population of health inequality between those with mental health problems and those without. Furthermore, people who smoke require higher doses of certain drugs that are regularly used in psychiatry; including anti-psychotics and benzodiazepines as tobacco smoke has the effect of breaking down these drugs. Smoking cessation in people taking these medications, often results in a lowering of level of drugs required.

There are large gains to be made by routinely offering evidence-based support to quit. These include

- Improved physical health and life expectancy
- Improvements in mental well-being
- Lowered medication doses

- Reduced financial stress
- Reduction of health inequalities between those with mental health problems and the population as a whole.

Evidence from The National Centre for Smoking Cessation and Training (2014) emphasises this, ***it is important to ensure that staff are supported to access stop smoking services. Staff who have a positive experience of quitting with the help of services may be more likely to recommend these services to others".***

1.1 Purpose

This policy has been agreed following full and considered consultation with staff, service users, partner agencies and other stakeholders and reflects understanding of the implications of implementation of the policy and its consequences for service users, visitors, staff and others.

The policy has been developed to promote health and well-being of all, to encourage smoking cessation for staff and service users and to protect non-smokers from the harmful effects of second hand smoke. This policy will also outline the support for service users and staff to stop smoking if they wish to do so.

To provide clear guidance on the July 2008 smoke free legislation in relation to:

- The application of the legislation to NHS buildings and environments for providing care and treatment
- The responsibilities of staff in relation to compliance with smoke free legislation
- The specialist network trial of the use of electronic cigarettes (e-cigarettes)

1.2 Scope

This policy will apply to all buildings, grounds and vehicles owned or otherwise accessed by the Trust, and used by its staff in delivering services or support as part of their role within the Trust and/or its services.

This is to include all Trust owned premises and their grounds, and any building and grounds leased, loaned or otherwise occupied by Trust staff in delivering services or support as part of their official duties anywhere within the footprint of the Trust.

The policy will apply to all vehicles, owned or leased to the Trust or its staff as a condition of their duties and responsibilities and used by staff in the course of their duties.

This policy will also apply to staff using privately owned vehicles when accompanied by colleagues, service users/carers whilst going about their duties.

Services will have clear signage on entry to Trust sites, at entrances and throughout service buildings advising staff and visitors of the smoke free policy and routes to non-smoking supports.

2. Definitions

- **Smoke Free** – In the context of this policy this is in relation to the smoking of tobacco products.

- **Smoking cessation** – Support for individuals to stop smoking through: education, health improvement strategies and Nicotine Replacement

- **Nicotine Replacement -** A medically approved way to take nicotine by means other than tobacco.

- **Electronic Cigarettes (E-Cigs) -** A device used to simulate the experience of smoking, having a cartridge with a heater that vaporises liquid nicotine instead of burning tobacco.

3. Duties

This policy will apply to all members of staff, service users, all visitors and any other persons entering Trust premises or buildings used by the Trust to deliver clinical and support services. This includes contractors/sub-contractors, suppliers, external agents of the Trust (legal advisors etc.) and any other non-staff persons.

"Staff" will include all substantive employees, whether full-time or part-time, all persons seconded to the Trust's service/departments, students, volunteers, contractors, staff supplied through Agency, Bank or Locum services, and all persons with honorary contracts.

For the purpose of this policy "service users" will apply to all individuals accessing Community Mental Health Services, Drop-ins, Day Services, Substance Misuse Services, clinical and other non-residential services provided by the Trust as well as to all individuals receiving in-patient/residential services provided by the Trust. This will include persons receiving care and treatment in secure units and other receiving compulsory care and treatment.

For services on site within Acute hospital Trusts, it is important that staff adhere to local Policies in relation to smoking on Acute Hospital sites. Staff should not be leaving Trust boundaries to facilitate smoking (for staff, service users or visitors) on another hospital site to smoke.

3.1 Board/Lead Committee

This policy is ratified by the Risk Management Committee and developed with support of members of the Physical health committee.

3.2 Chief Executive

The Chief Executive is responsible for ensuring that services are provided in a smoke free environment as defined in the 2008 legislation.

3.3 Director of Human Resources & Learning Development

The Director of HR & LD is responsible for ensuring that smoke free legislation is incorporated into the Trust induction programme and that access to smoking cessation training is available.

3.4 Associate Director of Nursing and Governance

Responsible for the implementation of this policy throughout the Trust.

3.5 Lead Nurse for Integrated Healthcare and Infection Prevention

Responsible for advising and directing on health improvement activity in relation to smoking cessation and health and wellbeing for service users.

3.6 Director of Human Resources and Corporate Affairs

Responsible for ensuring that all contractors are made aware of the requirements of the Trust Smoke Free Policy

3.7 Head of Service

Responsible for ensuring that staff, service users and visitors comply with the requirements of the policy within the services they manage.

3.8 Managers

Responsibility for ensuring that staff, service users and visitors comply with the requirements of the policy within the services they manage.

3.9 Clinical staff

Screening

All services must screen service users for smoking status at the point of admission or within 48 hours. This information must be recorded on the electronic client recording system.

All service users to be provided with brief interventions at the point of contact when recording smoking status.

Referral to smoking cessation advisor (if available for inpatient services) or community smoking cessation services/GP if service users demonstrates desire to stop smoking.

For inpatient services, service users to be prescribed suitable nicotine replacement to support smoking cessation following consultation with a health care professional.

3.10 Staff

All staff of Greater Manchester Mental Health NHS Foundation Trust whilst undertaking their roles and responsibility during their hours of working on any Trust site or in any Trust vehicle will ensure that;

- They do not smoke in/on any Trust Building/grounds (this includes smoking in vehicles whilst on Trust grounds)
- The do not support smoking by other members of staff/visitors and other non-members of staff in Trust premises or grounds or premises/grounds used by the Trust in delivering clinical and support services.
- During the course of their duties, they never smoke in the presence of a service user, carer or relative, visiting professional or other Trust stakeholders.
- They advise visitors and all non-staff persons coming into premises used by the Trust in delivering clinical and support services, of the Trust policy preventing smoking in any building or site used by the Trust in delivering services.
- From 1st October 2015 it became illegal for persons to smoke in a private vehicle if the vehicle has passengers under the age of 18 and additionally for a driver (including a provisional driver) not to stop someone smoking in these circumstances.

4. Process and Procedures

4.1 Community and out-patient services

All non-residential service users attending Community Mental Health Centres, Drop-ins, Day Services and other non-residential Community Services of Greater Manchester Mental Health NHS Foundation Trust will be required to refrain from smoking in the NHS designated building and grounds were their care and staff of GMMH provide treatment.

In order to protect Trust staff, from second-hand smoke, service users should be asked to provide a smoke free room for home visits and asked to refrain from smoking throughout the visit (a smoke free room is described as a room which has been smoke free for at least 1 hour prior to the visit). Repeated failure to comply with this request may require an alternative venue for visits to be arranged. It is appreciated that a request to refrain from smoking for one hour prior to an emergency visit may be impractical.

Services should provide community patients with the Trust approved leaflet explaining to them that we are smoke free and where possible utilise brief interventions and advice during visits. Advice and support for smoking cessation will be available for non-residential service users. (See appendix 1 – letter which can be sent out on behalf of the Trust with accompanying leaflet).

All non-residential service users should be advised of the Trust smoke free policy and the legislation with regard to smoke free buildings.

All clinical community staff will be expected to undertake NCSCT training, very brief advice in order to assess service users smoking status and signpost individuals to appropriate local stop smoking services.

4.2 In-patient services

This policy requires that all service users receiving in-patient care will be required to refrain from smoking in all and any service buildings where their care and treatment is provided by staff of GMMH.

The smoking status of all persons currently in or being admitted in the future should be recorded and the appropriate care plans drawn up in respect to promoting smoke free policy and achieving smoking reduction/cessation as appropriate and necessary.

Service users smoking status will be recorded on the PHIT Tool within PARIS (Bolton, Salford and Trafford) and LESTER tool within AMIGOS (Manchester Services) and reviewed as per CPA recommendations but 6 monthly as a minimum.

Smoking for residential service users will no longer be permitted on GMMH premises. Smoking is not permitted in any of the ground of GMMH hospital sites.

All clinical staff will be expected to undertake NCSCT training, very brief advice in order to assess service users smoking status and signpost individuals to appropriate local stop smoking services.

4.3 Support for Staff, Service Users and Visitors who smoke

The Trust will provide advice and information on smoking and how individuals can access smoking cessation support and guidance, including individual and group based support and a variety of NRT therapies from Clinical Commissioning Group (CCG) www.giveupsmoking.co.uk and other support agencies.

Advice and support for staff, service users and visitors who wish to give up smoking is available from the NHS Smoking helpline on 0800 169 0169

Deaf or hard of hearing staff, users and visitors should contact text-phone 0800 169 0171

Trust services will continue to develop effective local interfaces with CCG provided smoking cessation services. The Trust will ensure the availability to service users of advice and information on access to a variety of local services and other smoking cessation support. Such support to include access to information and guidance on smoking reduction and cessation, individual and group based support and a variety of NRT therapies.

Each service will agree and adopt a smoking cessation/reduction care pathway to ensure that smokers or ex-smokers at risk of re-commencing smoking have access to timely and appropriate advice in regards to accessing smoking cessation and conditions in which they may smoke and any limitation which may impact on the

frequency with which they may smoke and any limitations which may impact on the frequency with which they can access outdoor smoking areas (staffing resources, other service user needs, building lay-out, security/safety concerns etc.).

4.4 Breaches of Policy

It is a criminal offence to smoke in a public building from 1st July 2008 and can result in individual prosecution and receipt of a fine. Managers in charge of services who allow individuals to smoke indoors can also be subject to prosecution and fine. Actions to prevent smoking should be recorded in all patient records.

The Trust do not want anyone to feel that they need to engage in difficult or overly challenging situations and should not approach individuals (whether staff or patients) to ask them to stop smoking unless they are confident that it is safe to do so.

Our expectation is to promote and develop a culture across all our buildings and sites that smoking is unacceptable and that everyone respects this. Shifts in culture and behaviours can take time and will not be achieved simply by releasing policies and guidance. The required culture change will be achieved if we stay committed to Smoke free becoming a reality and respond to situations when this does not happen as a breach and an opportunity rather than a failure of the project.

4.5 Staff

Staff will be actively involved in the planning and the implementation of this policy. Full compliance with the policy will be expected of all staff.

Any breaches of this policy by individual members of staff will be viewed as a disciplinary offence, which may lead to formal management action including use of the disciplinary procedure. Smoking inside Trust premises is an offence and staff may be subject to prosecution in non-compliant with legislation.

Managers will ensure that staff have been given access to the Trust's and other NHS smoking cessation services and support and that any individual concerns of staff in relation to policy breach have been discussed in supervision. The Smoke Free Policy should be covered with all staff at local induction and brief interventions smoking cessation should also be covered.

4.6 Visitors

Carers and other interested partners will be actively involved by the service in planning for, and the implementation of this policy.

Staff who are aware of a visitor in breach of the policy are responsible for ensuring that the individual is directly advised of the policy and asked to stop smoking whilst on Trust premises or sites.

Any repeated and unreasonable refusal of a visitor to comply with the policy should lead to a request that they leave the site.

Staff should not place themselves at risk in asking visitors to comply with the policy. Any instance of threat, abuse or violence towards staff seeking to implement this policy will be formally reported as an untoward incident and security breach. Such incidents will be separately reported to the Police and NHS Counter Fraud and Security Management Service informed, with criminal or civil court action following as appropriate.

In circumstances where staff judge that the behaviour of a non-compliant visitor poses risks to staff or property, the local service manager will decide whether that visitor should no longer have access to the site. This decision should be made following consultation with the Multi-Disciplinary Team as the decision might have serious implications for patient care and treatment.

4.7 Contractors/other External Agents of the Trust

All Trust contracts will make explicit a requirement for all contractor staff to comply with the policy and a clear statement that non-compliance may have implications for continuance of the contract. Failure of contractor staff to comply will result in formal communication between Trust Estate Management and the Contractor with an agreed outcome.

4.8 Service Users

Trust staff and managers, in recognition of the challenge to some individuals in complying, will respond to any breaches of this policy by Patients/Service users sympathetically.

Any untoward incidents arising out of breach of this policy by service users will, as appropriate, be considered by the Multi-Disciplinary Team or other review process as directed by Trust. Staff should engage persons who are non-compliant with this policy in reasoned discussion to encourage future compliance. Service users should be informed that it is an offence to smoke in a public building and that action will be taken against individuals who do not comply with the policy.

Staff should not place themselves in a position of risk in order to manage non-compliance with this policy. Any instances of threat, abuse or violence towards staff seeking to implement this policy will be formally reported and managed as an untoward incident and security breach. Should a patient become aggressive when the smoke free policy is being implemented then staff should summon assistance and the incident managed according to that person's care plan. Such incidents will be separately reported to the Police and Local Security Management Specialist informed, with criminal or civil court action following as appropriate.

Should a patient be observed breaching the Smoke Free Policy by smoking in the hospital, staff should ensure the area is safe. If there is an imminent risk, then support should be enlisted immediately using the emergency response system. Where there is no immediate risk the staff should discuss the breach with his/her colleagues and agree the most appropriate time and place to meet with the patient to review the care

plan. Patients who are struggling to comply with the smoke free policy should have a review of their care plan, and consideration given to increasing the amount of treatment and behavioural support that has been provided.

It should be noted that there are no exceptions to this policy in respect of patients, there are to be no designated areas within buildings where the use of cigarettes is allowed (this includes 136 suites).

Community Service users

All service users should be provided with very brief advice when accessing community services. This contact may prompt a commitment from the service user to make an attempt to quit smoking or cut down which will ensure significant benefits.

Smoking status of service users to be recorded on the community PHIT tool and to be updated accordingly at CPA reviews.

If community staff undertake home visits as part of their role, consideration should be given to the potential adverse effects of passive smoking. This relates to tobacco products rather than e-cigarettes. There are no concerns regarding the exposure to vapour from e-cigarettes. This advice will be revised in light of any future research or evidence.

When undertaking pre-arranged routine home visits the service user should be informed they should not smoke one hour prior to or during the health staff visit. Other household members should also not smoke in the room where the treatment is taking place for the same period of time.

On occasions where an emergency home visit is necessary, it may not be possible to inform service users prior to the visit. However, on arrival occupants of the premises should be respectfully requested to refrain from smoking during the visit or asked to provide a suitable smoke free room where staff can carry out the visit.

However, if this is a routine visit and the service user fails to comply with providing a smoke free environment for the treatment session, their treatment needs should be reviewed by the care team with a view to alternative smokefree community venues considered.

If a service user continues to smoke during a visit there may be occasions that dictate the need to continue the visit so each case should be assessed individually.

In-patient admissions

Planned and Unplanned admissions:

Prior to a planned hospital admission, care co-ordinators/community staff must ensure the service users are fully informed about the Trust smoke free status including,

- This is an essential element of their therapeutic treatment to support their recovery
- The Trust is smoke free and therefore smoking is not permitted by anyone on Trust premises, within grounds or at site entrances.
- All service users are offered nicotine replacement therapy and/or use of own electronic e-cigarettes within 30 minutes of admission to support them to temporarily abstain or quit smoking during their inpatient stay.
- Smoking paraphernalia (tobacco, cigarettes, lighters or matches) should remain at home
- Service users who bring any smoking paraphernalia into hospital will be given the opportunity to send them home as these items are not stored on the ward, alternatively they will can be disposed of if agreed by the service users.
- Service user to be given very brief advice during initial assessment (or at earliest opportunity).

Informing service users and carers

It is essential service users, families and carers are fully informed on admission that smoking paraphernalia is not stored on the ward and returned on discharge or leave.

Ensure that they are aware that all items brought in on admission or obtained during their in-patient stay should be sent home with family members. Alternatively, smoking paraphernalia can be disposed of with consent of the service user

Removing/disposing of smoking paraphernalia

In order to support service users during their inpatient stay to become smoke free and to ensure becoming smoke free is an essential element of their therapeutic interventions and recovery, it is no longer acceptable practice across the Trust to routinely store smoking paraphernalia.

We would encourage service users to send home any smoking paraphernalia at the point of admission. To support the removal and disposal of smoking paraphernalia the following guidance has been issued.

> *After a clear explanation why, service users should be asked to hand over their smoking paraphernalia for returning to family members to take home.*
>
> *Restraint is not expected to be used unless there is an imminent fire risk.*
>
> ***Sending smoking paraphernalia home***
>
> *Assess on an individual basis whether it is more appropriate to ask the service user to pass the products onto their family member or if the products should be confiscated and handed over to family by ward staff.*

Disposing of smoking paraphernalia

Disposing of the smoking paraphernalia should be seen as a last resort in circumstances where the products have not been sent home following at least three attempts to do so. Future developments to prepare contracts of admission with service users should be considered individually at service level.

A record must be kept of any items disposed of that belong to the service user, signed by both staff and service user and recorded on the electronic patient record system.

Exceptions

Discretion need to be applied when disposing of items.

There may be occasions when service users have lighters of sentimental value or non-tobacco products of value. In these circumstances service users/family members should be informed again it is essential to send them home. If on occasions there is no option to send them home, i.e. they have no family members, then items brought in on admission can be stored and returned on discharge. However, any products purchased during an in-patient stay will be disposed of as service users have been previously fully informed.

Capacity assessment

In some cases, it may be necessary for services users to have an assessment of capacity to ensure the service user to understand the Smoke Free Policy, use of NRT products/e-cigarettes etc. When a service user lacks capacity to either understand why or repeatedly forget that they cannot smoke, it is important to recognise this group will need to be sensitively supported when assisted to stop smoking.

Informal admission

If a service user has capacity to consent to their informal admission, then he/she is consenting to the admission itself and the package of care that goes with it. In order to document the service users consent (or not) he/she must therefore be informed of the rules related to smoking prior to admission.

If the service user has the capacity and refuses to comply with the no smoking policy, then they may in effect refuse informal admission. At this point the service user needs to be assessed if on-going in-patient stay is needed and if so whether they need to be assessed under the Mental Health Act 1983 if appropriate. Refusal to stop smoking is **not** reason for detention under the Mental Health Act.

Formal admission under Mental Health Act/Deprivation of Liberty Safeguards (MHS/DOLS)

When a service user is detained under the MHA/DOLS and continues to smoke then the key principles of both the Mental Health Act/Mental Capacity Act (MHA/MCA) still apply in all cases i.e. they will be prevented from smoking, applying least restrictive

interventions along with necessary, appropriate and safe procedures in the service users best interest and proportionate to the outcomes.

Admission under Mental Capacity Act 2005 (MCA)

If a service user lacks capacity to make an informed decision about hospital in-patient admission but does neither try to leave nor objects to treatment, then he/she must be managed under MCA (a further assessment for admission under the DOLS is required at this point).

However, is a service user objects to being prevented from smoking then he/she is objecting to the treatment package and hence their hospital admission. In this case, the service user needs to be assessed under DOLS (if they are only objecting to stop smoking) and MHA (if they are refusing other aspects of their care/treatment/admission). The above also applies to service users admitted with learning disabilities or Dementia.

Emergency smoke free support within 30 minutes of arrival onto the ward.

Immediate support is required for service users, as they will start to experience nicotine withdrawal symptoms. Added to their poorly condition/reason for admission, this will add to their discomfort and should be addressed at the earliest opportunity.

Within 30 minutes of arriving on the ward, service users will be

- Informed/reminded that the site is smoke free
- Given information about immediate and long-term available support – NRT or use of electronic cigarettes – followed by full assessment within 48 hours of admission
- Advised that any smoking paraphernalia brought in on admission or found during their stay will not be stored on the ward. They will be given the opportunity to send it home otherwise it will be disposed of by the ward staff (see disposal of smoking paraphernalia section).
- Offered NRT according to local availability and agreed formularies.
- Ascertaining if the service users is choosing to abstain from smoking during their in-patient stay or if they would like to use this opportunity to quit smoking.

Note: It is essential that consideration is given to the effect of stopping smoking on a service users medication regime as the plasma levels of some drugs can alter significantly when there is a change in smoking status. This issue is caused by chemicals in smoke other than nicotine therefore the problem still arises even if the service user choses an NRT product or e-cigarette to support their abstinence. Key drugs are Clozapine, Theophylline but please refer to appendix 2 – effects of smoking or stopping smoking on drugs.

Nicotine Replacement Therapy

A qualified member of staff (who has completed medicines training) should complete the emergency NRT initial assessment and review NRT available locally within the

service (note, this may be different across all our services due to pharmacy arrangement, prescribing guidelines and service specification).

Prescribing NRT for in-patients

A level 2 smoke free advisor will fully assess the service user as soon as possible, within 48 hours of admission. This includes ascertaining whether the service user is most suited to NRT or use of e-cigarette. The list of NRT products available may differ across services and will be considered when advising suitable products.

The products will be prescribed on GMMH prescription, signed, dated and administered as per prescription guidelines.

Self administration and in-possession of prescribed NRT

In line with the Trust Medicines Management Policy, a risk assessment must be undertaken to determine if a service user is capable of self administering (self medication) NRT or other medication safely.

The assessment must include;

- Capacity to understand the instruction for use of the NRT product
- Safe use of the NRT product(s)
- Ability to manage safe keeping of the product

Any NRT products issued to the service users for in-possession must be stored in a designated safe place according to Trust Policy. Patches will not be permitted as in-possession and will be administered by nursing staff.

NRT will be labelled with the name of the service user and available for the sole use of the named service user.

If there are any concerns they must be discussed with the prescriber as soon as possible

4.9 Electronic cigarettes

Electronic cigarettes are a battery operated device used to simulate the experience of smoking, having a cartridge with a heater that vapourises liquid nicotine instead of burning tobacco.

Around 2.8m adults in Great Britain use e-cigarettes. Almost all are smokers or ex-smokers. E-cigarettes have rapidly become the most popular stop smoking aid in England and a developing body of evidence shows that they can be effective. Public Health England's ambition is to secure a tobacco-free generation by 2025. We believe e-cigarettes have the potential to make a significant contribution to its achievement. Realising this potential depends on fostering an environment in which e-cigarettes can provide a route out of smoking for England's eight million smokers, without providing a route into smoking for children or non-smokers. The use of e-cigarettes is supported by the Royal College of Physicians and the British Medical Association (BMA). However, while accepting the potential benefits, the BMA nevertheless warns that the

risk of uptake and use of e-cigarettes must be minimised in children and young people, that the use of these is not seen as promoting smoking, and health risks to users and bystanders must be avoided https://bma.org.uk/collective-coive/policy-and-research/public-and-population-health/tobacco/e-cigarettes

The Tobacco Products Directive 2014/14/EU (TPD) introduced new rules for nicotine-containing electronic cigarettes and refill containers (Article 20) from May 2016. MHRA is the competent authority for the notification scheme for e-cigarettes and refill containers in the UK and is responsible for implementing the majority of provisions under Article 20.

The Tobacco Products Directive introduced new rules which ensure:

- minimum standards for the safety and quality of all e-cigarettes and refill containers (otherwise known as e-liquids)
- that information is provided to consumers so that they can make informed choices
- an environment that protects children from starting to use these products.

The new requirements:

- restrict e-cigarette tanks to a capacity of no more than 2ml
- restrict the maximum volume of e-liquid for sale in one refill container to 10ml
- restrict e-liquids to a nicotine strength of no more than 20mg/ml
- require nicotine-containing products or their packaging to be child-resistant and tamper evident
- ban certain ingredients including colourings, caffeine and taurine
- include new labelling requirements and warnings
- require all e-cigarettes and e-liquids be notified to MHRA before they can be sold

On 20th May 2016 new regulations concerning tobacco products, herbal products for smoking and electronic cigarettes came into effect. These regulations include;

- standardised plain packaging of tobacco products
- Regulations to implement the Revised Tobacco Directive (TDP). The TDP has been transcribed into British Law through the Tobacco and Related Products Regulations 2016 (TRPR), it is through these regulations that the TPD is implemented and enforced.

In relation to e-cigarettes the TPD is very clear. Electronic cigarettes which contain **up to 20mg per ml of nicotine** will be regulated as consumer products as is required by the TPD (See article 20 of the directive). Zero nicotine products are not included in the TPD. Products containing over 20mg per ml of nicotine will need to have a medicinal license.

The new product rules under the TPD for electronic cigarettes will:

- Introduce a size limit for e-liquids of 10ml for dedicated refill containers and 2ml for disposable electronic cigarettes, cartridges and tanks.
- Require products to be child and tamper proof.
- Require the pack to include a health warning covering 30% of the surface of the unit packet and any outside packaging stating "*This product contains nicotine which is a highly addictive substance".*
- Requires instructions for use, information on addictiveness and toxicity on the packaging and accompanying information leaflet.
- Ban certain promotional and misleading descriptors on packaging.
- Ensure that all substances contained in the produce and information on the product's nicotine content are declared on the label.
- Require manufacturers to inform Member States before placing new or modified products on the market and notify a range of product information concerning composition, emissions and sales/marketing data.
- Introduce a registration scheme for businesses engage in cross-border distance sales of electronic cigarette products.
- Prohibit the advertising or promotion, directly or indirectly, of electronic cigarettes and refill containers on a number of media platforms, including on television, radio, newspapers and magazines.

Products which contain more than 20mg per ml of nicotine or which make smoking cessation claims will be prohibited unless they are medicines. The products will require authorisation from the Medicines and Healthcare Products Regulatory Agency (MHRA) in the UK and this will be enforced by the MHRA.

International peer-reviewed evidence indicates that the risk to the health of bystanders from exposure to e-cigarette vapour is extremely low. This is in contrast to the conclusive evidence of harm from exposure to second-hand smoke, which provides the basis for UK smoke free laws. The evidence of harm from second-hand exposure to vapour is not sufficient to justify the prohibition of e-cigarettes. Managers of public places and workplaces should ensure that this evidence informs their risk assessments.

In light of emerging evidence, the Trust has decided to overturn previous ban on the use of e-cigarettes. The Trust have agreed that the use of e-cigarettes will be permissible in designated areas (most likely but not exclusively to be outside areas only) in line with locally agreed standard operating procedures and following thorough service risk assessment.

The greatest risks associated with the use of electronic cigarettes is associated with charging the equipment. Any rechargeable e-cigarettes must be PAT tested prior to use in our services and must NEVER be left unattended during charging process. The minimum standard for recharging of rechargeable devices is in the lockable cabinets which will be sited in locations approved by the fire safety officer. Furthermore, inpatient services will have operational procedures to manage the fire risk associated with charging e-cigarettes.

Fire Risks associated with e-cigarettes include:

- Overcharging / left in the charger after charging
- Left unattended whilst charging
- Charger plugged into a non-approved power source or transformer
- Damaged batteries (have been, dropped or struck)
- Not being charged in the original, manufacturer-approved charger, or are charged in a borrowed charger, or cheap replacement charger
- Using when wet
- Atomisers being over-tightened
- Charging on a USB hub plugged into a computer (and not supplied by the manufacturer)
- Are not compliant with British equipment marks such as the CE Mark
- Are left charging on flammable surfaces
- Switching themselves on within handbags and lockers
- Exploding and igniting other materials, such as bedding, oxygen supplies and aerosols

It is the responsibility of each service to ensure that the use of electronic cigarettes is assessed, taking the fire risks listed above into consideration and that appropriate control measures are taken accordingly.

Fire risks assessments and reviews must consider the safe use of e-cigarettes. The fire risk assessments will reference this policy and require services to declare in the assessments if they are compliant with the policy

Other risks associated with the use of e-cigarettes

Other risks associated with use of e-cigarettes included deliberate ingestion of lithium batteries or high volumes of liquid specifically for use in e-cigarettes. A further risk is associated with the use of illicit substances which has been dissolved within the nicotine liquid.

Ingestion of Lithium batteries.

Lithium batteries are classified as Articles under REACH and are not subject to the requirements for information in the supply chain (Safety Data Sheets and Labels). While batteries may release hazardous substances if damaged, this is not an intended release as defined under REACH. Batteries are not classified as hazardous under the CLP. The following information is provided to assist in the safe use of batteries.

Caution: *Battery can explode or leak if heated, disassembled, shorted, recharged, exposed to fire or high temperature or inserted incorrectly. Keep in original package until ready to use. Do not carry batteries loose in your pocket or purse. Keep batteries away from children. If swallowed, medical advice should be sought at once. Under certain misuse conditions and by abusively opening the battery, exposed lithium can react with water or moisture in the air causing potential thermal burns or fire.*

Swallowing e-liquid

Public Health England noted that the lethal dose estimation may be considerably lower than previous estimations (1 – 2mg per pound in an adult but far less in children) and note that “if the 10ml bottle of e-liquid was drunk, it would cause nausea and vomiting but would be unlikely to inflict serious harm”.

While some e-liquids contain no nicotine at all, those that do clearly display their nicotine strength and content on their packaging. E-liquids generally range from 0 nicotine content to 20 mg/ml concentration. In any event, if service users ingest e-liquid it is important to ascertain the dose of e-liquid and quantity consumed and to seek appropriate medical advice

5. Training Requirements

Part of local induction.

All clinical frontline staff to undertake National Centre for Smoking Cessation and Training – (NSCT) very brief interventions training

Very Brief Interventions Training

Slide 1. 30 seconds to save life	(4 minutes)
Slide 2. Introducing VBA (Very Brief Advice)	(3 minutes)
Slide 3. Ask, Advise, Act	(6 minutes)
Slide 4. Closing the consultation	(5 minutes)
Slide 5. Summary	(5 minutes)

Additional smoking cessation training to be provided by staff as identified by local training needs analysis through the NCSCT website http://www.ncsct.co.uk

Level 2 Bespoke Smoking Cessation Training for inpatient staff.

Type: Face to face Length**:** ½ day (3 hours approx.) **Availability:** Arranged as required

Delivered by: Smoke free lead and local stop smoking champions

Where: On site

Mandatory requirement: Training is not mandatory however each service will identify through training needs analysis number of staff required to undertake training in order to provide ongoing support of the Trust Smoke Free strategy.

To support **in-patients staff** in relation to enforces abstinence/nicotine withdrawal or during a quit attempt whilst in hospital

- Smoke free policy and procedures
- Harm reduction programme
- CQUIN and SDIP requirements
- Nicotine Dependency Assessment
- Provision of Nicotine Replacement therapy/use of e-cigarettes
- Behavioural support
- Record keeping
- Incident reporting
- Referral for ongoing support if required.

Level 2 Bespoke Smoking Cessation Training for community staff

Type: Face to face Length**:** ½ day (3 hours approx.) **Availability:** Arranged as required

Delivered by: Smoke free lead and local stop smoking champions

Where: On site

Mandatory requirement: Training is not mandatory however, each CMHT/Community service will identify through training needs analysis number of staff required to undertake training in order to provide ongoing support of the Trust Smoke Free strategy and to include preparation for future in-patient stay and on-going support after discharge. To cascade relevant information to team colleagues.

- Smoke free policy and procedures – education re smokefree sites
- Harm reduction/quit programme (pre quit, quit and post-quit)
- Nicotine dependency assessment
- Requesting and accessing stop smoking medications
- Behaviours support
- Record keeping
- Incident reporting.

6. Monitoring

Services will continue to be monitored through our current established processes, which will align across Districts with the transfer of Manchester Services from the current Amigos system to Paris electronic records.

Minimum Requirement	Frequency	Process for monitoring	Evidence	Responsible Individual(s)	Response Committee(s)
Incident reports relating to smoking	Bi monthly	Reports	Datix Reports	Risk Manager	Risk Management Strategy Group
Completion of the PHIT tool	Weekly reports on current position during CQUIN period	Reports	Business Intelligence reports	CQUIN lead Matrons	Physical Health Care Committee Community Physical Health care committee
CQUIN and Quality Measures Group	Quarterly updates	Reports	Reports by leads	CQUIN lead	As above

7. Resource/Implementation Issues

None identified

8. Risk Issues

None compliance with the policy would be unlawful and the Trust and individuals could be subject to prosecution.

9. Requirements, Supporting Documents and References

9.1 Requirements

The Health Act (2006)
The smoke free (premises and enforcement) regulations (2006)
The smoke free (signs) Regulations (2007)

9.2 Supporting Documents

- *Health Lives, Healthy People: Our strategy for public health in England (*HM government) White paper and associated documents: https://www.dh.gov.uk/en/punlichealth/healthyliveshealthypeople
- *Tobacco Products Directive 2014/14/EU (TPD)*

- *Use of e-cigarettes in public places and workplaces (Advice to inform evidence based policy making)* July 2016, Public Health England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/534586/PHE-advice-on-use-of-e-cigarettes-in-public-places-and-workplaces.PDF
- Ash (2013) ASH Factsheet: Smoking Statistics; illness and death (www.ash.org.uk)
- RCP/RCPsy (2013) **smoking and mental illness: A joint report by the Royal College of Physicians and the Royal College of Psychiatrists,** RCP, London.
- Tobacco and Related Products Regulations (2016)

9.3 References

- Mental Health Act (1983)
- Mental Capacity Act (2005)

10. Subject Expert and Feedback

Head of Fire Safety, members of the Physical healthcare committee and Risk Management Group.

Public Health England latest evidence and research findings.

North West Boroughs Healthcare, NHS Foundation Trust.

South London & Maudsley NHS Foundation Trust

11. Review

This document will be reviewed in five years or sooner in the light of organisational, legislative or other changes.

Appendix 1 – Standard Letter

Greater Manchester Mental Health
NHS Foundation Trust

Trust Headquarters
The Curve
Bury New Road
Prestwich
Manchester
M25 3BL

Tel: 0161 773 9121
Web: www.gmmh.nhs.uk

Dear Service User

I am writing to you on behalf of Greater Manchester Mental Health Foundation Trust.

As you are aware smoking was banned in public buildings on 1st July 2008 and the Trust have used this as an opportunity to try and improve the health of everyone involved in our services. This includes providing advice about stopping smoking and ensuring that staff and service users are not exposed to passive smoking.

This means that staff, service users or visitors are not allowed to smoke in any of the Trust buildings or grounds. Staff are also not permitted to smoke in service user's homes when they visit.

In order to protect staff from second hand smoke we must ask that you do not smoke whilst staff are visiting you. It would be helpful if you could provide a room that you do not usually smoke in, or where this is not possible you refrain from smoking for at least one hour prior to the visit. This will help the room to become smoke free.

The Trust appreciates that giving up smoking can be difficult especially if you have smoked for many years. The NHS is offering lots of support to help people stop smoking and your community worker or GP will be able to advice how you can receive help.

Thank you for supporting us to improve the health of others.

Yours sincerely

Executive Director
GMMH

The Trust is committed to safeguarding children, young people and vulnerable adults and requires all staff and volunteers to share this commitment.

Greater Manchester mental Health NHS Foundation Trust, Trust HQ, Bury New Road, Prestwich, Manchester, M25 3BL Tel 0161 773 9121

Chair: Rupert Nichols **Chief Executive: Neil Thwaite**

APPENDIX 2 – Effects of smoking or stopping smoking on drugs

Cigarette smoking can interact with some medicines. This is mainly due to polycyclic aromatic hydrocarbons in cigarette smoke that stimulate the live cytochrome P450 enzymes, particularly CYP1A2. The process speeds up the metabolism and clearance of some medicines.

In order to have the desired therapeutic effect, one needs to prescribe higher doses of some psychotropic medicines for smokers compared to non-smokers. When people stop smoking, enzyme activity reduces over a week or so. This is particularly the case for Clozapine. One benefit of stopping smoking is the dose of some medicines can possibly be reduced.

The level of medication in the blood can vary if a person starts, stops or changes the way they smoke (such as being temporarily abstaining from smoking). Some service users may need the dose of their medication altering when reducing or stopping smoking or when resuming smoking following a period of temporary abstinence in a smoke free environment.

Since the majority of interactions are due to components of cigarette smoke other than nicotine, these interactions are not expected to occur with Nicotine Replacement Therapy (NRT). Drugs affected by smoking status are given in tables below. This is not exhaustive list and new interactions are continually being discovered. It is important to liaise closely with the service user's prescriber in hospital and when in the community, when changes to psychotropic medication are made and also when their smoking status changes.

Clozapine – Plasma level monitoring is indicated where Clozapine is prescribed. Clozapine plasma levels should be repeated one to two weeks after stopping smoking unless treatment emergent side effects indicate earlier monitoring is required. Levels can then be compared with those taken prior to smoking cessation.

If the service user resumes smoking after discharge and the dose of Clozapine was reduced in response to smoking cessation, then the dose will likely need to be increased again. **This needs to be considered as part of the discharge planning process.** Clozapine levels should be repeated one to two weeks after smoking resumes.

Action recommended on admission/assessment for all Interacting Medications.

- Ascertain pre-admission smoking status, current medication regime and recent medication compliance.
- Determine effects of smoking cessation on the drug from the table below
- Consider adjustment of dose, based also on age, hepatic function, and the time delay for drug plasma level changes to occur.
- Continue to monitor for emergence of adverse effects.
- Ascertain and monitor smoking status on leave/discharge. Readjust dose if indicated.

The following criteria have been considered in grading the clinical relevance of interactions:

High: Documented interaction with clinically important effects in a number of patients and/or drugs metabolised principally by CYP1A2 and with a narrow therapeutic range.

Moderate: Documented pharmacokinetic interaction with no or minor clinical effects, or isolated reports of clinically important effects and/or Drugs metabolised partly by CYP1A2 and with a wide therapeutic range.

Antidepressants

Drug	Effects of smoking	Clinical Relevance	Action to be taken when Stopping/Re starting smoking
Duloxetine	Plasma levels may be reduced up to 50%	**High**	Stopping – Monitor closely. Consider reducing dose by up to 25% over 1 week. Re-starting – Monitor closely. Consider restarting "normal" smoking dose.
Fluvoxamine	Plasma levels decrease by around a third.	**High**	Stopping – Monitor closely. Dose may need to be reduced. Re-starting – Dose may need to be increase to previous level.
Tricyclic antidepressants	Plasma levels reduced by 25-50%	**High**	Stopping – monitor closely. Consider reducing dose by 10–25% over 1 week. Consider further dose reductions. Re-starting – monitor closely. Consider restarting previous smoking dose.
Mirtazapine	Unclear, but effect probably minimal	**Moderate**	Stopping – monitor Re-starting - Monitor

Antipsychotics

Drug	Effect of smoking	Clinical relevance	Action to be taken when stopping/re-starting smoking
Clozapine	Reduces plasma levels by up to 50%. Plasma level reduction may be	**High**	Please refer to ***Clozapine plasma levels: a guide for clinicians*** on Trust intranet

	greater in those taking valproate.		Stopping smoking, even while using nicotine replacement therapy, can increase clozapine plasma levels by up to 50% resulting in toxic levels (the hydrocarbons in cigarette smoke are responsible for increased metabolism in smokers, not the nicotine). Ideally, take a level before stopping. On stopping, reduce the dose gradually (over a week) by approx. 25% and then check serum level one week later (**allow one week for steady state before repeat sample).** Consider smoking status post discharge (i.e. smoke free during admission but restart post discharge): the dose will need to be increased back to previous dose if nothing else has altered. Starting smoking is a less urgent problem because the risk of toxicity is low. However, assessment is required as clozapine could become ineffective and symptoms of psychosis return.
Fluphenazine	Reduces plasma levels by up to 50%	**High**	Stopping – Reduce dose by 25%. Monitor for up to 8 weeks. Restarting – Increase dose to previous level.
Olanzapine	Reduces plasma levels by up to 50%	**High**	Stopping – Try and take plasma levels before stopping. On stopping, reduce dose by 25%. After 1 week, repeat plasma level. Consider further reductions. Re-starting – Take plasma level before resuming smoking (anticipate this may happen soon after discharge). Increase dose to previous dose (prior to stopping smoking).
Haloperidol	Reduces plasma levels by around 20%	**Moderate**	Stopping – reduce dose by around 10% and continue to monitor Re-starting – monitor closely. Consider restarting previous smoking dose.
Chlorpromazine	Plasma levels reduced. Varied	**Moderate**	Stopping – Monitor closely. Consider dose reduction.

	estimates of exact effect.		Re-starting- monitor closely. Consider restarting previous smoking dose.
Zuclopentixol	Unclear but effect probably minimal	**Moderate**	Stopping – Monitor Re-starting - Monitor

Other Psychotropic Medication

Drug	Effect of smoking	Clinical Relevance	Action to be taken when stopping/re starting smoking
Benzodiazepines	Plasma levels reduced by 0 – 50% (depends on drug and smoking status	**Moderate**	Stopping – Monitor closely. Consider reducing dose by up to 25% over 1 week. Re-starting – Monitor closely. Consider restarting normal smoking dose
Carbamazepine	Unclear but smoking may reduce Carbamazepine plasma levels to a small extent	**Moderate**	Stopping – Monitor for changes in severity of adverse effects. Re-starting – Monitor plasma levels.

Physical Health Medicines

Drug	Effect of smoking	Clinical Relevance	Action to be taken when stopping-starting smoking
Theophylline Aminophylline (N.B. Aminophylline is a prodrug form of theophylline and so same effects and actions apply).	Theophylline is metabolised principally via CYP1A2. Smokers need higher dose than non-smokers due to theophylline's shortened half- life and increased elimination. Some reports suggest smokers may need twice the dose of non-smokers.	**High**	Monitor plasma theophylline concentrations and adjust the dose of theophylline accordingly. The dose of theophylline may need to be reduced by about ¼ to one third one week after withdrawal. However, it may take several weeks for enzyme induction to dissipate. Monitor theophylline concentration periodically. Advise the patient to seek help if they develop signs of theophylline toxicity such as palpitations or nausea.
Warfarin	Warfarin is partly metabolised via CYP1A2. An interaction with smoking is not clinically relevant in most patients. The dose of warfarin is adjusted according	**Moderate**	If a patient taking warfarin stops smoking, their INR might increase so monitor the INR more closely. Advise patients to tell physicians managing their anticoagulant control that they are stopping smoking. Similarly if a patient restarts smoking then INR levels require monitoring.

	to a patient's INR (Internationalised Normalised Ratio).		
Methadone	Methadone is metabolised via isoenzymes including CYP1A2. There has been a case report of respiratory insufficiency and altered mental status when a patient taking methadone for analgesia stopped smoking	**Moderate**	Be alert for signs of opioid toxicity and reduce the methadone dose accordingly.
Insulin	Smoking is associated with poor glycaemic control in patient with diabetes. Smokers require higher doses of insulin but the mechanism of any interaction is unclear.	**Moderate**	If a patient with insulin-dependent diabetes stops smoking, their dose of insulin may need to be reduced. Advise the patient to be alert for signs of hypoglycaemia and to test their blood glucose more frequently.
Erlotinib	Erlotinib is metabolised primarily by CYP3A4 and to a lesser extent CYP1A2. Smokers have an increased rate of erlotinib clearance leading to decreased drug exposure. Smokers gain less benefit than non-smokers in clinical studies.	**High**	Current smokers should be advised to stop smoking prior to starting treatment. When given to patients who smoke, dose adjustments may be necessary. This will be managed by the specialist. If there are changes in smoking status, advice should be sought from the specialist.
Riociguat	Riociguat is metabolised by CYP1A1, CYP3A4, CYP3A5 and CYP2J2. In cigarette smoking, riociguat exposure is reduced by 50-60%.	**High**	Current smokers should be advised to stop smoking prior to starting treatment. When given to patients who smoke, dose adjustments may be necessary. This will be managed by the specialist. If there are changes in smoking status, advice should be sought from the specialist.

Supporting safe use of refillable and rechargeable e-cigarettes in GMMH inpatient services

The impact of adverse effects from rechargeable and refillable e-cigarettes can be significant therefore, the following precautions are required to ensure known risks are well managed. The Trust is committed to support smokers to quit for good. In line with current evidence it believes that e-cigarettes may help many smokers achieve this goal. Since e-cigarettes do not contain tobacco and are not burnt, they do not result in inhalation of cigarette smoke which contains approximately 4000 constituents, of which 69 are known to cause cancer. They are therefore regarded by experts as a safe delivery device for nicotine. This does not mean they are completely safe, but they are thought to be much less harmful than cigarettes. The Royal College of Psychiatrists recently indicated that the hazard to health arising from e-cigarettes was unlikely to exceed 5% of the harm from smoking tobacco. **E-cigarettes are not recommended as a first line treatment option, and cannot be used by pregnant women or those under 18.** They should be considered after smokers have rejected all other options set out in the Smoke Free Policy has been exhausted. All e-cigarettes users must have a current risk assessment and care plan that details how the smoker will be supported to use his/her device safely.

The following risks must be considered as part of the risk assessment.

FIRE: Similar to other devices that require charging (such as mobile phones), there is a potential fire risk if an incorrect charger is used or if the device is left charging for longer than recommended. In some confined spaces vapour produced by some e-cigarettes can activate smoke detectors.
MANAGEMENT: All re-chargeable e-cigarettes will be PAT tested. They will be charged in the metal charging cupboards provided in line with the manufacturer's instructions, including only using batteries/chargers that came with the e-cigarette, disconnecting when the charge is complete, and storing batteries safely. E-cigarette use will be facilitated in designated areas only according to local procedure.
BATTERY INGESTION: Self-injurious behaviour involving battery ingestion can be fatal.
MANAGEMENT: Service users presenting with current high risk of self-injurious behaviour who wish to use an e-cigarette should be considered suitable for a disposable e-cigarette until their risk rating is reduced. During the initial stages of recovery, they may require within arm's length observations whilst using the re-chargeable or re-fillable device.
SUBSTANCE MISUSE: New Psychoactive substance (NPS) have recently been linked to a number of deaths and hospital admissions. Illegal substances are linked with deterioration in mental state and impede recovery. Both NPS and illegal substances can be added to e-cigarettes.
MANAGEMENT: Service users with a recent history of using NPS or illicit substances should only be considered suitable for using e-cigarettes following assessment of level of engagement and risk of relapse or using substances has been reduced. Consider using e-cigarettes supervised until risk is low.
PLASMA LEVEL CHANGES: If a service user switches from smoking cigarettes to using e-cigarettes this may affect metabolism of some prescribed medication.
MANAGEMENT: Plasma levels must be monitored as per effects of smoking on prescribed drugs document (appendix 2). This is especially important for those prescribed Clozapine.
IRRITATING TO NON USERS: Vapour produced by e-cigarettes can be irritating to other and especially challenging for those who are trying to stop smoking.
MANAGEMENT: The use of e-cigarettes will be permitted in designated areas only according to local operating procedures.
HAZARDOUS WASTE: Used e-cigarettes are considered hazardous waste.
MANAGEMENT: Used e-cigarettes must be disposed of in a hazardous waste bin.