Birmingham and Solihull Mental Health NHS Foundation Trust

Smoke Free Policy

Policy number and category	**RS07**	**Risk and Safety**
Version number and date	**4**	**June 2025**
Ratifying committee or executive director	**Trust Clinical Governance Committee**	
Date ratified	**September 2025**	
Next anticipated review	**September 2028**	
Executive director	**Executive Director of Quality and Safety (Chief Nurse)**	
Policy lead	**Deputy Director of Nursing and Quality**	
Policy author *(if different from above)*	**Project Lead - Tobacco dependency**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

The purpose of this policy is to support the Trust by having a completely smoke free environment and is in line with NHS requirements (NICE NG 209, NICE QS82 and NICE QS 207).

Policy requirement (see Section 2)

- To protect and improve the health of staff, service users, contractors, and visitors by removing the dangers of second-hand smoke
- Follow Health and Safety Legislation and Employment Law (Health Act 2006, 2006)
- Provide staff with a healthy working environment and protect the current and future health of staff, service users, contractors, and visitors
- Support smokers to help them cope with increased restrictions
- Encourage and support those staff and service users who wish to stop
- Ensure compliance with NICE Guidance – Tobacco: preventing uptake, promoting quitting, and treating dependence [NG209] (NICE, 2021) and NICE Quality Standard – Smoking: Reducing Tobacco Use [QS82] (NICE, 2015)
  - Tobacco: Treating dependence [QS207] (NICE, 2022)

Change record

Date	Version	Author (Name & Role)	Reasons for review / Changes incorporated	Ratifying Committee
Aug-2025	5	Hanan Khan (Project lead for tobacco dependency service)	2 yearly review and rewrite	CGC

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1. Introduction

BSMHFT is committed to improving the health and wellbeing of service users, carers, staff, and visitors. The historic image of mental health services is strongly associated with smoking and other health and social inequalities. The Trust is dedicated to changing this to one that positively promotes health and wellbeing for all. (ASH. Action on smoking and health, 2025)

1.1. Rationale (why):

Smoking is the main cause of preventable illness and premature death. People with mental health problems smoke significantly more and are more dependent on nicotine than the wider population, and on average die 10 – 20 years younger than the general population (ASH, 2016, The Lancet Psychiatry, 2019) The high rates of smoking exacerbates the health inequalities already experienced by those with a serious mental illness and the largest positive impact on the health of people with mental health problems will come from increasing the focus on their smoking behavior and through the routine provision of smoking cessation support. (NICE, 2022) (West, Kock, Kale, & Brown, 2022)

The policy complies with Smokefree legislation (Health Act 2006, 2006) and NICE Guideline NG209 - Tobacco: preventing uptake, promoting quitting, and treating dependence (NICE, 2021)

The Smokefree legislation prohibits smoking in Trust premises i.e., buildings, grounds, and Trust vehicles this includes any staff wearing Trust uniform or lanyard.

The policy also aligns with the Tobacco and Vapes bill which if passed by the parliament will expand existing legislation.

The Trust will provide treatment to smokers who wish to quit, and support smokers who do not want to quit to temporarily abstain from smoking, whilst in Trust buildings or grounds.

We aim to provide a healthy environment to work in and create outside spaces that are conducive to nurturing wellbeing and also to tackle health inequalities (ASH, 2019)

1.2. Scope (when, where and who):

This policy applies to all Trust members (including Temporary Staffing Solution (TSS) workers and agency staff and those working in the Trust on a placement, work experience students, contractors and employees of other organizations that are on site and volunteers at the point of service delivery. This Policy applies to all service users. Service users who are distressed for any reason should be reassured, but the policy still stands.

For HMP Birmingham In-patient wards, please refer to the HMP policies.

1.3 Principles (beliefs):

1.3.1 This policy recognizes that smoking is a key factor in the poor physical health experienced

by people with diagnosed mental health problems and in their early death. As a health organization, the Trust acknowledges that it has a duty of care to service users to inform and support them in achieving the best possible health for themselves.

1.3.2 It also recognizes that secondhand smoke adversely affects the health of all service users, visitors, smoking and non-smoking colleagues and other members of the wider community.

1.3.3 It aims to address the use of cigarettes and rolled tobacco causing nicotine addiction as a chronic relapsing disease requiring treatment.

1.3.4 The Trust encourages employees to avoid smoking in general, to protect their health and uphold the Trust's role in promoting public health.

1.3.5 To support this policy, the trust will increase the opportunity for service users in our inpatient units to get involved in various activities. Activity workers, support staff, health instructors and Occupational therapists on the ward can contribute to these opportunities for service users. This may include access to gyms, walking groups, and exercises. Whether regularly timetabled or provided ad hoc for a positive smoke free environment.

1.3.6 We have clear NICE guidance to support with smoking cessation in mental health services and NICE quality standards which support this policy.

1.3.7 We also have clear CQC guidance for Smokefree policies in a mental health setting. (CQC, 2024)

1.3.8 The policy will support Health and Safety legislation and Employment law. (Health Act 2006, 2006)

1.3.9 This policy sets out the requirements for all staff employed by the Trust to promote healthy behavior. All clinical staff are specifically tasked with screening for smoking status and providing very brief advice – ASK, RECORD, ADVISE, ACT.

1.3.10 All clinical staff (i.e. HCA's, RMN's, AHP's and Medics) are expected to be familiar with the care pathway for those who are tobacco dependent and ensure referrals are completed as required (as soon as possible or within 24 hours of admission.

1.3.11 The principal requirements of this policy are to:

- Provide comprehensive screening, tobacco dependent service users are identified and offered evidence-based treatments
- Eliminate the health risks associated with passive smoking and improving the health and wellbeing of service users, staff, and visitors
- Protect non-smoking service users from second-hand smoke through being cared for in smokefree environments across the care pathway
- Support service users to quit, service users are potentially able to reduce some of the prescribed antipsychotic medications, and this will contribute to improved health status.
- Support smoking cessation which has proved to be associated with improvements in mental health compared with continuing to smoke, in particular improving mood, self-confidence, and reducing levels of

anxiety.

- Support smoking cessation for staff to provide opportunities for improved health status, good role modelling and improved attendance at work.
- Some clinicians will be responsible for assessment and treatment of tobacco dependence. The extent and the nature of the interventions delivered will be dependent on the staff's role and the service user's choice.

2. The Policy:

The review of this policy revokes the COVID addendum that allowed smoking in certain areas on Trust premises. Moving forward, there will be zero tolerance for smoking tobacco on any Trust premises. This policy aims to:

- Protect and improve the health of staff, service users, contractors, and visitors by eliminating second-hand smoke.
- Comply with Health and Safety Legislation and Employment Law.
- Provide a smoke-free environment and protect the health of all individuals on Trust sites.
- Support smokers in coping with increased restrictions, including the prohibition of tobacco and related items on Trust premises.
- Encourage and support staff and service users who wish to quit smoking.
- Ensure compliance with NICE Guidance and Quality Standards on tobacco use and dependence: Tobacco: preventing uptake, promoting quitting, and treating dependence NICE guideline [NG209**]** (NICE, 2021) and NICE Quality Standard – Smoking: Reducing Tobacco Use [QS82] and Tobacco: Treating dependence [QS207] (NICE, 2022)

3. The Procedure

3.1 Guidance for service users

A. <u>In-patients</u>

3.1.1 Admission teams are required to provide screening for smoking status and providing very brief advice – **ASK, RECORD, ADVISE, ACT.**

3.1.2 Service users should also be informed, preferably at pre-admission or on admission that this is a Trust Policy relating to health and safety and is based on legislation and on the same principles as policies relating to alcohol, toxic substances etc. The Trust has a duty to its service users and staff to protect them from the health hazard that smoking represents.

3.1.3 It is of utmost importance that while communicating the policy, trust values are upheld, and conversations are done in a compassionate, non-judgmental manner whilst offering options for support. It is to be recognized that nicotine dependence is a chronic relapsing condition and hence the difficulties in

managing this must be acknowledged.

3.1.4 On admission to an inpatient area, the service users will have their smoking status recorded on the Physical health assessment form and a comprehensive management and Nicotine intervention plan implemented.

This will include:

- An assessment of the level of nicotine dependence the service user has
- A discussion of previous use of NRT (if any)
- An explanation of the various products available
- An explanation of how to use NRT
- Provision of a supply of NRT for use during the in-patient period

3.1.5 Some service users will need to have their NRT administered under supervision initially to reduce the risks of misuse of the products. Certain products such as gum may not be permitted.

3.1.6 All clinical staff (i.e. HCA's, RMN's, AHP's and Medics) should familiarize themselves with the Trust Formulary and supporting guidance to ensure that NRT is administered effectively. Training will be made available to support staff, particularly prescribers in this role, please see Appendix 2.

3.1.7 If a service user becomes angry or violent, staff are encouraged to use de- escalation principles as they would in their normal working practices.

3.1.8 The approaches used to assess nicotine dependence and subsequent provision of NRT should be seen as part of the clinical pathway and be discussed by the clinician, the service user and/or appropriate relatives and subsequently documented in the service user's Rio record.

3.1.9 When service users are prohibited from smoking on-site, and do not have any leave the following will apply:

- First Line Support - It is recommended NRT be prescribed at the earliest opportunity, preferably within 30 minutes. To ensure this is feasible, Staff nurses and Nurse associates can dispense NRT under Patients Group Directive/Homely remedies for up to 3 days' worth until signed off by a medic.
- Second Line Support (driven by service user choice and acceptability) - Use of NRT for smoking cessation or to manage temporary abstinence, after discussion with a tobacco dependency advisor.
- A pre-loaded Electronic Nicotine Delivery Device [ENDS]) – Vaping Device

B. Service Users in the community:

- All service users should be provided with very brief advice when accessing community services.
- Smoking status of service users to be recorded on the Physical health

assessment form. 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 Vapes/E-cigarettes. There is limited research to validate harm from exposure to secondhand vapor of Vapes/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 advised they should not smoke one hour prior to or during the health staff visit.
- 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, staff should not be expected to go into a home where they are smoking. The service users' treatment hence 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.
- For service users interested in cutting down (harm reduction) or stopping smoking, clinical teams should refer them to the Community tobacco dependency service or signpost to local authority services as appropriate.
- The service will provide 12 weeks of:
    - A thorough assessment of nicotine dependence and treatment plan.
    - Nicotine replacement therapy: range of options available and the correct way of using these.
    - Arrange for another pharmacotherapy through their GP's
    - Behavioral support

3.2 Pharmacological Support - Nicotine Replacement Therapies (NRT)

3.2.1 Nicotine Replacement Therapy (NRT) is a way of getting nicotine into the bloodstream without smoking.

3.2.2 There is Nicotine replacement therapy (NRT) patches, inhalers, tablets, lozenges, and sprays stops, or reduces, the symptoms of nicotine withdrawal. (Intense craving, tingling in hands/feet, sweating, cough, insomnia, irritability, difficulty concentrating)

3.2.3 **Varenicline:**

Varenicline (Champix) was an important stop smoking aid until 2021 when it was withdrawn

after it was found to contain nitrosamines above the acceptable level.
A generic version of varenicline is now available in the UK which is nitrosamine-compliant, remains on the British National Formulary and has the same Summary of Product Characteristics as Champix. This drug is prescription by medics only and the prescribing regime can be found in Appendix 2

3.2.4 Bupropion:

Bupropion, although effective for smoking cessation, has certain additional cautions. Bupropion has been associated with seizures and is contraindicated in bipolar affective disorder and epilepsy; it has been associated with increased anxiety and depression and should not be prescribed to people with depression or suicidal thoughts; prescribing bupropion should be undertaken with caution for people receiving medications that are known to lower seizure thresholds (NCSCT, Fact sheet, 2020). Regardless, majority research evidence suggests that there is no significant difference in smoking cessation effectiveness among bupropion, varenicline, nicotine replacement therapy and their combination when used with behavioral support in clinical practice (DaliaA Abdelghany et al., 2022). Bupropion also has a list of drug interactions with most antipsychotic medications. (NICE CKS, 2025)

3.2.5 Cytisine:

Cytisine is a new addition to NICE guidance NG209 – stop smoking interventions.

Cytisine works in a similar way to varenicline (Champix), reducing urges to smoke by attaching to some of the same neuronal receptors in the brain that nicotine does. Its side effects (gastric symptoms and sleep disturbance) are like those found with varenicline, but less common. This drug is prescription by medics only and the prescribing regime can be found in Appendix 2

3.3 NRT Admission Prescribing Flow Chart

3.3.1 Additional guidance on the implications for and clinical management of mental health service users can be found in the Standard Operating Procedure for Prescribing Nicotine Replacement Therapy in Smoking Cessation (see Appendix 2)

3.4 Out of hours/crisis/urgent access

3.4.1 For service users admitted out of hours, in a crisis, with no means to personal finances or carer support, NRT will be provided by the nurse in charge in the absence of a duty doctor. Please refer to Appendix 2.

3.4.2 The protocol for administration of NRT products until review by a prescriber is up to a maximum of 24 hrs treatment**.**

3.5 Visitors and Outpatients

3.5.1 Visitors and service users attending outpatient premises will be advised

prior to attending that the sites are smokefree; non-English speakers will be addressed as needed using an interpreter. Information on support services to enable them to cope with restrictions will be included together with information regarding stop smoking services.

3.5.2 Details of local stop smoking services can be found in Appendix 6.

3.6 Electronic Nicotine Delivery Systems (ENDS) – Vaping Devices

3.6.1 Psychiatrists should advise patients who smoke that Vapes/E-cigarettes may help them to quit, particularly when used in conjunction with stop smoking treatments, and are a safer than continuing to smoke. They should be encouraged to avoid Vapes/E-cigarettes in the long term where possible, provided this does not lead to a return to smoking. We support the recommendation of the Parliamentary Science and Technology Committee (2018) that all mental health provider organizations should ensure they have policies in place that facilitate the use of Vapes/E-cigarettes safely and effectively (RCPsych, 2018).

3.6.2 We also have clear CQC guidance on Smoke free policies in a Mental health inpatient setting that states: Vapes/E-cigarettes should not routinely be treated in the same way as smoking. It is not appropriate to prohibit e-cigarette use in health services as part of smokefree policies. (CQC, 2024)

3.6.3 There are three main forms of ENDS products (see Appendix 8)

3.6.4 Flexibility to assess a service user's suitability for having a vaping device will be ascertained at an MDT meeting as necessary.

3.6.5 If there is a desire amongst service users to use vaping devices, the Trust will support the use of them to help them cut down or quit tobacco. Refer to Appendix 3 for further information.

3.6.6 The policy will only allow the use of Rechargeable closed pod devices. The use of vapes/ 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 Trust will review this stand in future owing to any changes needed to support clinical practice.

3.6.7 According to The Tobacco Products Directive (TPD), products which contain more than 20mg per ml of nicotine or which make smoking cessation claims will be prohibited unless they are medicines. Zero nicotine products are not included in the TPD. The TPD 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.

3.6.8 Clinical staff will have flexibility to assess a service user's suitability for having a vaping device.

3.7 Guidance for staff who smoke

3.7.1 Staff smoking on hospital grounds, in Trust premises including premises that are not owned directly by the Trust or in Trust vehicles is prohibited, this includes entrances and exits. Given the importance afforded to the public health aspects of smoking, together with the Trust's image in that respect, staff in uniform and/or displaying a staff ID badge or using a Trust lanyard, should not be seen smoking anywhere and will ensure that:

3.7.2 Staff can meet with their line manager if necessary to discuss and agree time off work to attend a smoking cessation clinic if they wish to. The Trust acknowledges smoking is an addiction and hence will offer staff 12 weeks of free In-house tobacco dependency support.

3.7.3 They understand that Trust disciplinary procedures for continued non-compliance with this policy may apply. The Managers will initially address the breach of policy with the employee where there are reasonable grounds for concern in a sensitive and supportive manner and encourage employees to seek support voluntarily.

3.7.4 Staff especially are required to refrain from smoking near entrances to the Trust site where boards are displaying the organization's commitment to Smoke free environments.

3.7.5 Staff who smoke outside the Trust premises and grounds must be mindful that they are obliged to be seen as supporting the health promotion benefits of the smoke free policy.

3.7.6 Staff also need to be aware of the sensitivity of service users who are abstaining from smelling smoke on them.

3.8 Adjust to a Smokefree Trust:

3.8.1 Staff who are finding it difficult to adjust to the Policy should be invited to discuss the issues with their manager and be referred to the Staff Tobacco Dependency service or local stop smoking services (Appendix 6) or occupational health for support and, if they wish, advised to consult their GP or smoking cessation services for further help.

3.8.2 Reporting a Vapes/E-cigarettes related adverse reaction via Yellow Card

Side effects can be reported if someone feels unwell after using an e-cigarette product and other safety concerns with vapes/e-cigarettes or refill containers to the MHRA through the Yellow Card scheme. See Appendix 8 for more information.

3.9 Challenging managers on the right to smoke

3.9.1 If individual staff challenges their manager on their right to smoke, the

manager should refer to Appendix 7 – Summary of Human Rights Legislation & ethics, along with these points:

3.9.2 This is a Trust Policy relating to health and safety and is based on legislation and on the same principles as policies relating to dangerous machinery, toxic substances, Alcohol and substance misuse etc.

3.9.3 An employee should not challenge the employer's duty to comply with legislation or the right to introduce healthier and safer working practices.

3.9.4 The Policy is concerned with where someone smokes.

3.10 Staff breaks.

3.10.1 Staff need to ensure "Smoking breaks" (outside of their entitled breaks) are not being taken during their contractual hours of employment. If they choose to travel off-site during their normal breaks to smoke, this is their decision, but this could be detrimental to the therapeutic relationship with service users complying with the policy.

3.10.2 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 that leave the building on breaks for any reason. At night, the issues will include lower staffing levels. Staff should be aware of the potential effects of service users seeing them smoke off the grounds, whether in uniform or not, particularly when they have been offering cessation of smoking advice to service users.

3.11 Tobacco Dependency support for staff

3.11.1 The Staff Tobacco Dependency service will offer staff who smoke and wish to manage their addiction with 12 weeks of free support through NHS Smokefree App, In-house counselling and provision of Vapes. Details of local stop smoking services, training and resources are also available from the local Stop Smoking services which can be found at Appendix 6.

3.11.2 Alternatively, smokers can phone the NHS Smoking Helpline free on 0300 123 1044 for advice and information about stopping smoking**.**

3.12 Vehicles

3.12.1 Smoking is not permitted in any trust contracted vehicles. Ban on smoking in workplace and company vehicles came into force in July 2007. It is covered in CG15 Transport & Fleet Management policy

3.12.2 In addition, smoking is not allowed in vehicles whilst transporting service users. Staff who use their own vehicles for Trust business journeys should not smoke in them if a work colleague is a passenger.

3.13 Guidance for staff who wish to use vaping devices

3.13.1 Staff who smoke will be encouraged to make full use of smoking cessation services, full and flexible support will be offered to staff in attempts to cut down and quit

3.13.2 Staff who smoke and are dependent on tobacco will be encouraged to use NRT whilst at work. NRT is available for staff from local Stop Smoking services (Appendix 6) and will not be directly supplied by BSMHFT. Using vaping devices as part of their personal tobacco management plan should only do this in designated areas.

3.13.3 Staff are not permitted to use vaping devices with service users whilst at work.

3.13.4 Staff are expected to make considered and sensible judgments on their personal use of vaping devices. They should never be used indoors, never be in highly visible areas (e.g., front entrance of Trust buildings). If ever in doubt advice should be sought from the local manager/s

3.14 Communicating the Smokefree Policy

3.14.1 Clear signs will be on display to ensure that everyone entering Trust properties understands that smoking is not allowed on the premises. Furthermore, those with language needs will be addressed as needed using existing diverse communication strategies.

3.14.2 Tenders and contracts with the Trust will stipulate adherence to this Policy as a contractual condition. Existing contracts currently have a contractual element in relation to smoking.

3.14.3 Job advertisements will include reference to the Smokefree Policy of the Trust and indicate that adherence to the Policy is contractual.

3.14.4 Services will provide early information to all relevant parties of the Smokefree Policy in advance wherever possible.

3.14.5 For staff working in the community, the expectation is that our staff are afforded a smokefree environment and this needs to be explained to service users and carers with reference to the possible alternatives where necessary.

3.14.6 All contractors working with the Trust will be informed of the policy as part of the contractor's induction procedure for site attendance.

3.15 Managing breaches of the Smokefree Policy

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

3.15.2 Our expectation is to promote and develop a culture across all our buildings and sites that smoking is unacceptable on NHS sites and that everyone respects this. Shifts in culture and behaviors 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. We need to respond to situations when this does not happen, and view the intervention required as an opportunity rather than a failure of the project.

3.15.3 Breaches should be reported via the Trust Eclipse incident reporting system with a brief explanation of the circumstances and outcome.

3.16 Service user breaches of the Smokefree Policy

3.16.1 Prior to planned hospital admissions service users will be advised that smoking is not permitted in the hospital or grounds, and they will be offered support to temporarily abstain or quit. This will include nicotine replacement therapy and behavioral support. They will be asked not to bring tobacco, cigarettes, lighters or matches with them to hospital.

3.16.2 For unplanned admissions, carers or family members who accompany the service user to hospital will be asked to take the prohibited items home. If the service users are unaccompanied when they arrive at hospital or carers/family members are unwilling to take tobacco products home, staff will store the tobacco products and they will be returned at the point of discharge/unescorted leave.

3.16.3 Ward staff must see the point of Service User's leave as an opportunity to educate SU in continuing to abstain from smoking especially if/when they have managed to do this successfully over a period of time.

3.16.4 Should the service user become aggressive when the Smokefree Policy is being implemented, then the member of staff should summon assistance and the aggressive incident managed according to that person's care plan.

3.16.5 Should a service user be observed breaching the Smokefree Policy by smoking in the hospital, staff should ensure the area is safe and advise the service user of the Smokefree Policy and where they are able to access support. The policy is aimed at supporting service users to stop smoking and develop a Smokefree culture and not to introduce unnecessary conflict.

3.16.6 Service users who are struggling to follow the Smokefree Policy should have a review of their nicotine replacement therapy, and consideration given to increasing the amount of behavioral support that has been provided.

3.16.7 It should be noted that there are no exceptions to this policy in respect of service users. There are to be no designated areas inside or outside of buildings where the use of cigarettes is allowed.

3.17 Visitors and contractors' breaches

3.17.1 Visitors to the Trust will be made aware of the Smokefree Policy through signs, posters, leaflets as well as conversations with staff. Carers will be provided with a list of the prohibited tobacco items which includes tobacco, cigarettes, lighters, and matches.

3.17.2 Any visitor who is found to be supplying a service user in hospital with tobacco items will be reminded about the policy and asked to support the service user's

treatment plan. The rationale for the policy will be explained and carers will be offered support to learn more about the harmful effects of tobacco dependency.

3.17.3 If appropriate they will be directed towards their local stop smoking service. It is recommended that where staff choose to approach a service user or visitor to inform them of the trust policy, this approach is made only once. The information provided should be limited and along the lines of; 'Can I make you aware that this is a Smokefree Trust.'

3.17.4 Breaches can be reported via The Eclipse incident reporting system with a brief explanation of the circumstances and outcome. If staff observe a contractor smoking on Trust premises, they should make the contractor aware of the Trust's Smokefree Policy and ask them to stop smoking. If the contractor does not comply, they should report the contractor to the relevant supervising Trust manager and an Eclipse report completed.

3.17.5 Should the person become aggressive then the member of staff is to walk away from the situation and seek support from their line- manager.

3.18 Reporting of smoking related incidents

3.18.1 The Trust Eclipse system has been adapted to allow staff to specifically highlight a breach of the Smokefree Policy by adding to the subcategory list. This would be relevant if staff had seen smoking but did not feel confident to approach those concerned. The Trust will ensure that appropriate measures are taken to enhance the Smokefree Policy at the location concerned.

3.18.2 Analysis of all recorded incidents enables the Trust to be both proactive and reactive to reduce the impact and likelihood of future recurrence. The Trust will carefully monitor violence and aggression, fire, failure to return from leave and AWOL incidents that are linked to the Smokefree Policy.

3.18.3 Staff should also use the Eclipse reporting system when service users refuse admission or self-discharge against medical advice because of the Smokefree Policy**.**

3.19 Training Requirements

3.19.1 The Trust will provide a training pathway to enable service to provide a safe and appropriate skill mix to meet the tobacco dependence needs of service users. **(West, et al., 2018)**. There will be three levels of training for staff across the Trust:

- **Very Brief Advice Training, Level 1 (Delivered on wards/Teams)**- This course will cover, basic smoking prevalence in mental health settings, the impact of smoking and stopping smoking on wellbeing, evidence-based interventions for smoking cessation and how to ask, record, advise and refer a smoker for specialist support. This basic course is to be completed by all staff.
- **Level 2 training (1-day workshop)**- This course is to enable staff to provide evidence-based support to help service users manage their tobacco dependency.

This training builds on the Very Brief Advice training and includes referring service users through RiO, information on using carbon monoxide monitoring, NRT adherence and assessing severity of tobacco dependence. Staff will be awarded 1-hour CPD for completion. This training is relevant for staff interested in becoming Smoke free champions.

- Additional training will also be provided for all wards on the processes around out of hours NRT provision, incident reporting on Eclipse, De-escalation protocols and Exceptional leave to ensure enough support is always available for patients.
- Training for service users: Service user engagement will be facilitated through Experts by Experience participation leads to ensure they are informed of the policy and understand what it means for them. Group sessions will also be carried out by the Tobacco dependency team where a need has been identified.

3.20 Links to relevant legislation Health and Safety at Work Act 1974

3.20.1 Requires employers to ensure the health and safety of all employees and anyone who may be affected by their work, as far as is reasonably practicable. This includes taking all reasonably practical steps to prevent workplace accidents. Employees have a duty to take reasonable care for the health and safety of themselves and others who may be affected by their acts or omissions at work and to co-operate with their employer and others to enable them to fulfil their legal obligations. **(legislation.gov.uk, 1974)**

3.20.2 Links to Trust policies

C 17	Blanket Restriction Policy
C 57	Clinical Risk Assessment Policy
R&S 45	Clinical Searching of Service Users Policy
HR 01	Disciplinary Policy
R&S 15	Fire Safety Policy
R&S 13	Management of Contractors Policy
MHL 14	Mental Capacity Act Policy
MHL 01	Mental Health Act Policy
R&S 10	Prevention and Management of Violence Policy

4 Responsibilities

Post(s)	Responsibilities	Ref
Clinical Staff (i.e. HCA's, RMN's, AHP's and Medics)	To be aware of and adhere to this policy and have completed very brief advice (VBA) training.	
All staff that smoke	To be aware of and comply with the policy whilst at work and within trust sites/vehicles and when identifiable as a staff member (Uniform, lanyard)	
Community and inpatient staff	Ask and record each patients smoking status at first contact and provide very brief advice to all smokers. Review at MDT and CPA meetings Refer all people who wish to quit and/or temporarily abstain from smoking (to comply with the Smokefree Policy) to The Tobacco Dependency Team (In-patients and CMHT's) or relevant Local Authority Services. Manage any medications that may be impacted by the quit attempt.	
Ward managers	• Have a documented action plan in relation to the Trust's Smoke Free policy • Provide tobacco dependency resources such as carbon monoxide monitoring. • Promote the tobacco dependency pathways and choices for patients and staff. • Meet the Trust mandated training requirements for staff trained in tobacco dependency. • Ensure that staff use Rio to record all assessments and interventions delivered to support tobacco dependency activity and referral to stop smoking services. •There is safe and appropriate skill mix within teams to meet the tobacco dependence needs of service users (either to provide very brief advice or intensive behavioural support). • Staff do not facilitate patients to smoke (i.e., escort a patient off site to smoke, buy tobacco products, light cigarettes) • Staff are competent at identifying and recording the smoking status of every patient in their electronic record. • All staff with clinical contact provide very brief advice (VBA) to all smokers (ask, record, advise, act). • All smokers are offered support to stop smoking on	

	admission and at regular intervals throughout their admission. • Ward systems are in place so that 1) patients are supplied with an adequate amount of NRT during periods of leave and on discharge, 2) follow up plans are in place if the patient wishes to maintain their abstinence after discharge •Staff appraisals and personal development plans reflect an employee's training needs to deliver tobacco dependence treatment. • All staff who have clinical contact with patients have completed Very brief advice training •There are sufficient staff trained in Tobacco Dependence Treatment Advanced Skills training to meet the needs of smokers in each clinical area. • Tobacco dependency training is promoted, taken up and translated into practice •Staff do not take smoking breaks during work hours. •Staff who smoke are supported to access tobacco dependency sessions during work time as specified earlier i.e., through Tobacco dependency team in-house or OH or community services.	
Responsible Clinician	Has the responsibility for monitoring medication and therapeutic levels for the medications impacted by abstinence from smoking and promoting general physical health.	
Service, Clinical and Corporate Directors	Has accountability for ensuring their service areas are aware of this policy and have all the necessary implementation plans in place for its success	
Policy Lead	•Review the policy as necessary to ensure it reflects best practice and relevant legislation.	

Executive Director	•Ensure that arrangements are in place for staff, service users, visitors, and contractors to be made aware of the policy. •Provide resources to ensure effective implementation of this policy. •Monitor compliance via the Trust CGC. •Will have representation on local Tobacco Control Networks. •Ensure that all jobs advertised will state that Birmingham and Solihull Mental Health Foundation Trust is a smoke free Trust. •Ensure that all Service Level Agreements with other organisations must contain the following clause 'Birmingham and Solihull Mental Health Foundation Trust is a smoke free Trust. Smoking is banned in all Trust buildings, grounds, and all Trust vehicles.	
Tobacco dependency Advisors	Tobacco dependency Advisors will: •Support smokers who wish to make a planned quit attempt . •Support smokers who do not wish to quit during an inpatient stay, to manage temporary abstinence from tobacco. •Deliver one to one, drop in and group-based treatment to service users and staff who smoke. •Following a referral from ward/community staff, carry out a comprehensive assessment of a smoker's needs, including the severity of tobacco dependency, patient preference for treatment, assessment, and recommendation for the use of stop smoking pharmacotherapies. •If authorised to administer NRT, to facilitate access to pharmacotherapy in line with Trust protocols. •Liaise with prescriber (ward, community, primary care) re potential interactions of stopping (and restarting smoking) and antipsychotic medication. •Every smoker has a personal tobacco dependence treatment plan. •Ensure staff and patients are aware of the need to adjust medication if required •Information on tobacco smoke and medication interactions is available in all clinical areas. •Staff are fully supported in reminding other people of the no smoking policy.	

	•Comply fully with the policy and provide a suitable role model for staff and patients. •Ensure that welcome packs and promotional materials provided about the service describe the smoke free status. •Direct service users to specialist psychological services who will provide intensive psychological, behavioral, and social support to assist the smoker to: - 1. Understand the personal relevance of smoking. 2. Cope with cravings. 3. Maximize motivation and commitment. 4. Maintain abstinence. 5. Maximise mental health. 6. Maximize physical health. •In collaboration with the smoker and their inpatient/community team, formulate, document, and evaluate personal stop smoking plans. •For patients who have made a quit attempt whilst in hospital and who wish to maintain their abstinence, ensure a seamless handover to the local community NHS Stop Smoking Service (or a Trained Advisor in the CMHT) so that patients can receive follow up care for up to 4 weeks . •Attend annual refresher training.	
Pharmacy	Liaise with prescriber (ward, community, primary care) re potential interactions of stopping (and restarting smoking) and antipsychotic medication. •Information on tobacco smoke and medication interactions is available in all clinical areas. •Ensure NRT is available in all inpatient areas to manage tobacco withdrawal symptoms (either for planned abstinence or temporary abstinence).	

5 Development and Consultation process:

Consultation summary	
Date policy issued for consultation	June 2025
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	Date(s)
STR and AOT CGC	Distributed via email 26th June
Acute care CGC	18th June 2025
Urgent care CGC	Distributed via email
Dementia and Frailty CGC	18th June 2025
Communities CGC	Distributed via email
Health and Wellbeing steering group	Distributed via email
Pharmacotherapies Committee	Distributed via email
JOSC	2nd July 2025
Physical Health Committee meeting	1st July 2025
OMT meeting	Distributed via email
Where received	**Summary of feedback**

JOSC	**Actions / Response**
	Comments mainly around the safety of advocating vaping devices, potential risks of charging, use of illegal vapes and regulating this on the wards. Committee was reassured around the NICE guidance and CQC guidance that allows legal vapes for smoking cessation and is in line with least restrictive practice. However, it has been acknowledged that it can be challenging to ensure only trust approved vapes are used on the wards. Therefore, support is needed from Health and Safety team and Matrons to implement stricter management.
Katherine Allen: Hope Action group	An ask from EBE's to include in the policy that policy communication is done with utmost compassion, whilst understanding the difficulties service users face. I have since added the below into the policy: 3.1.1 It is of utmost importance that while communicating the policy, trust values are upheld, and conversations are done in a compassionate, non-judgmental manner whilst offering options for support. It is to be recognized that nicotine dependence is a chronic

	relapsing condition and hence the difficulties in managing this must be acknowledged

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7 Bibliography:

A list of works that the author has used as a source of information evidence or inspiration but is not referred to directly in the text.
{Note if there are no documents to list this section should remain but state that there are no documents)

8 Glossary:

CO	Carbon Monoxide
VBA	Very Brief Advice
Tobacco Dependency	The use of tobacco, smoked or smokeless. This includes stopping use of tobacco and moving on to pharmacotherapies (including nicotine replacement therapy) or nicotine-containing e-cigarettes.
Pharmacotherapy	This covers medication licensed for smoking cessation such as varenicline or bupropion, as well as nicotine replacement therapy.
Smokefree	Air that is free of tobacco smoke.
Temporary abstinence	Stopping smoking with or without medication for a particular event or series of events, in a particular location, for specific time periods (for example, while at work, or during a hospital stay), or for the foreseeable future.
Second hand smoke	Another name for passive smoking: this is smoke breathed out into the environment which is inhaled by a non-smoker. There is evidence to show that it leads to a range of disease such as heart disease and cancer.
Withdrawal	A variety of behavioural, affective, cognitive, and physiological symptoms, usually transient, which occur after use of an addictive drug is reduced or stopped.

9 Audit and assurance:

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Number and % of adult patients admitted as inpatients (IP) with > 1 day stay that have smoking status recorded.	Project lead – tobacco dependency	Physical Health Assessment form	Quarterly	Physical Health Committee and then to Trust CGC
Number and % of smokers offered Very Brief Advice	Project lead – tobacco dependency	Physical Health Assessment form	Quarterly	Physical Health Committee and then to Trust CGC
Number and % of smokers that are given NRT within 24 hours of admission.	Project lead – tobacco dependency	Physical Health Assessment form, Insight report	Quarterly	Physical Health Committee and then to Trust CGC
Number of Referrals created for Smokers within 24 hours of admission.	Project lead – tobacco dependency	Rio, Tobacco dependency service mailbox.	Quarterly	Physical Health Committee and then to Trust CGC
NRT PRN recording on EPMA	Project lead – tobacco dependency and Lead pharmacists across sites	EPMA	Quarterly	Physical Health Committee and then to Trust CGC
Vapes service provisions across individual sites.	Project lead – tobacco dependency, and Operational managers across sites.	Eclipse incident reporting	Quarterly	Physical Health Committee and then to Trust CGC
Service user breaches of Smokefree policy	Project lead – tobacco dependency and Operational managers across sites.	Eclipse incident reporting	Quarterly	Physical Health Committee and then to Trust CGC

Staff breaches of smokefree policy	Project lead – tobacco dependency and Operational managers across sites.	Eclipse incident reporting	Quarterly	Physical Health Committee and then to Trust CGC
Visitors/contractors' breaches of Smokefree policy.	Project lead – tobacco dependency and Operational managers across sites.	Eclipse incident reporting	Quarterly	Physical Health Committee and then to Trust CGC

10 Appendices:

Appendix 1 - The equality analysis Screening assessment
Appendix 2 – Admission Prescribing Flowchart
Appendix 3 – Guidance for staff when facilitating e-cigarette/ Vaping Device use
Appendix 4 – Medicine that requires review on Smoking Cessation
Appendix 5 – Gold standard Training Requirements
Appendix 6 – Local Stop Smoking Services
Appendix 7- Summary of Human Rights Legislation and Ethics

10.1 Appendix 1 - Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	Smoke Free Policy		
Person Completing this proposal	Hanan Khan	**Role or title**	Project Lead – Tobacco Dependency service
Division	Corporate nursing	**Service Area**	Corporate
Date Started	May 2025	**Date completed**	June 2025
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
The Trust is committed to the health of its employees, contractors, sub-contractors, service users and visitors. The policy aims to: Promote and support health and well-being in staff and service users Protect smokers, and non-smokers, from risk to their health from exposure to tobacco smoke Comply with national smokefree legislation			
Who will benefit from the proposal?			
Employees, service users, contractors, sub-contractors, and visitors			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
The policy effects service users and employees by helping abstain from smoking while on a healthcare premises. Also protects the wider community by reducing the impact of second hand smoke/ passive smoking.			
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
The policy affects service delivery positively in that it incorporates health promotion. Business processes may have an effect when it is expected of externally contracted employees (eg: SSL) to not smoke on Trust grounds. However, this is already being mentioned in Job /descriptions to make them aware.			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			
Resources are only required in terms of manpower required to manage SU's and staff breaches of policy. However, this is to be seen as part of implementing any other policy.			

Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
No.				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box or leave blank if you feel there is no impact.				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	X			No impact
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			X	There will not be a detrimental impact due to disability but a positive impact will be achieved for those struggling with dependence
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers, and families?				
Gender	X			No impact
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	X			No impact
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity			X	There will be a positive impact for both the mum and the baby. The advisors are trained in delivering the service in a maternity setting to

				ensure the service users' dignity is upheld at all time and in a non-judgmental manner.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation into pregnancy and maternity?				
Race or Ethnicity	X			No impact
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	X			No impact
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	X			No impact
Including gay men, lesbians, and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	X			No impact
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights			X	Has a positive impact in terms of preventing exposure to tobacco smoke, hence reducing harm from second hand smoke.
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e., Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		

What do you consider the level of negative impact to be?	High Impact	Medium Impact	Low Impact	No Impact
				X

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.
If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.
If the proposal does not have a negative impact or the impact is considered low, reasonable, or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

Action Planning:

How could you minimise or remove any negative impact identified even if this is of low significance?

None identified

How will any impact or planned actions be monitored and reviewed?

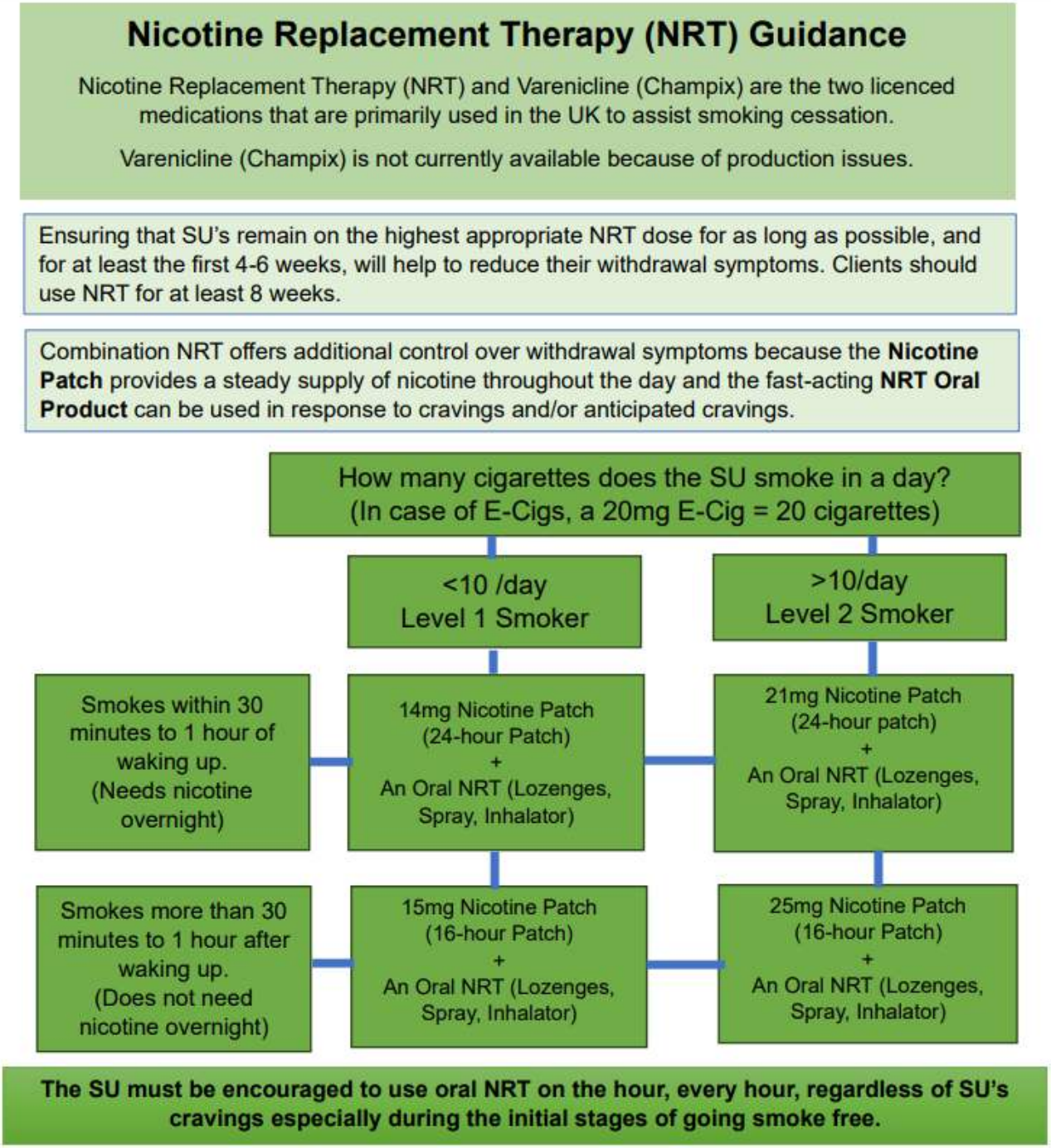
The criteria alongside which the policy will be monitored has been mentioned above. This will be done collaboratively with the relevant teams involved.

How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic?

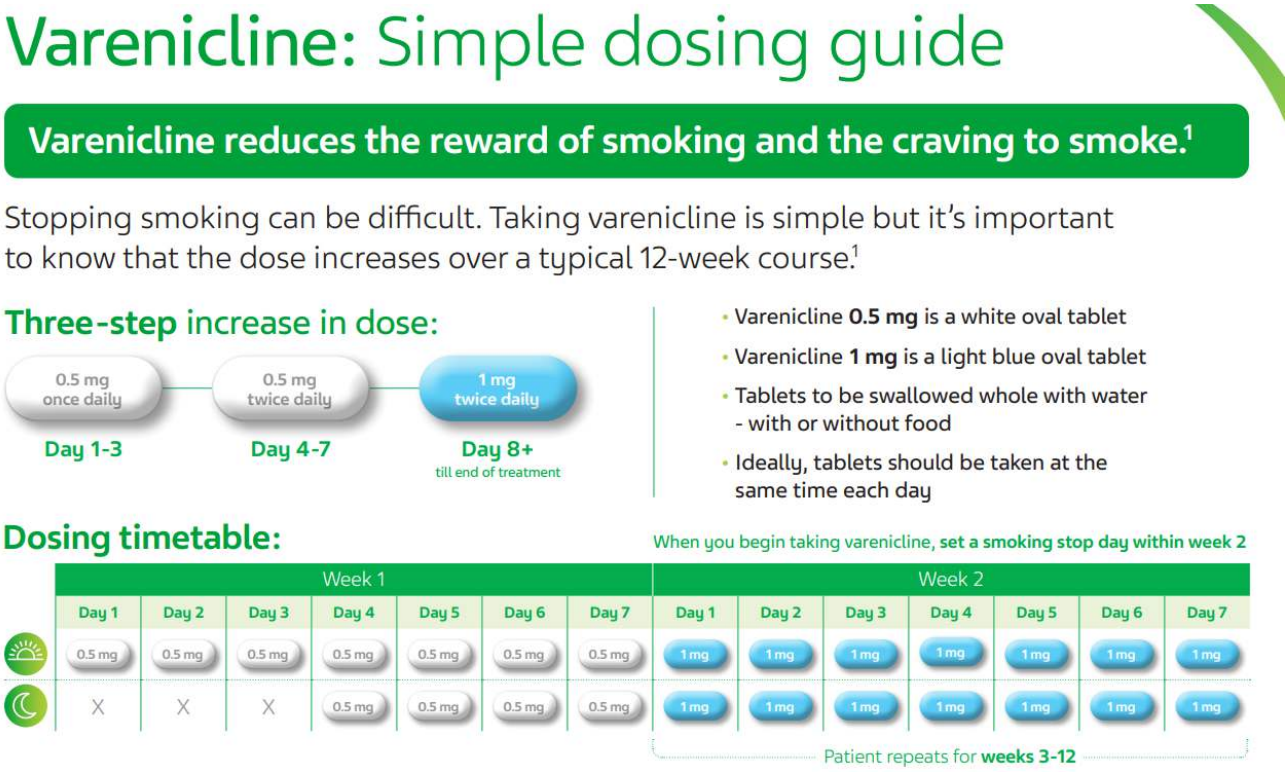
The policy applies to all irrespective of their personal characteristics and provides equal support and opportunities to whoever wishes to abstain/stop smoking whilst on Trust's grounds.

Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net**
The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

10.2 Appendix 2 – Prescribing Flowcharts



Varenicline prescribing guidance:



Varenicline: Simple dosing guide

Varenicline reduces the reward of smoking and the craving to smoke.[1]

Stopping smoking can be difficult. Taking varenicline is simple but it's important to know that the dose increases over a typical 12-week course.[1]

Three-step increase in dose:

0.5 mg once daily	0.5 mg twice daily	1 mg twice daily
Day 1-3	Day 4-7	Day 8+ till end of treatment

- Varenicline **0.5 mg** is a white oval tablet
- Varenicline **1 mg** is a light blue oval tablet
- Tablets to be swallowed whole with water - with or without food
- Ideally, tablets should be taken at the same time each day

Dosing timetable:

When you begin taking varenicline, **set a smoking stop day within week 2**

	Week 1							Week 2						
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
☀	0.5 mg	0.5 mg	0.5 mg	0.5 mg	0.5 mg	0.5 mg	0.5 mg	1 mg	1 mg	1 mg	1 mg	1 mg	1 mg	1 mg
☾	X	X	X	0.5 mg	0.5 mg	0.5 mg	0.5 mg	1 mg	1 mg	1 mg	1 mg	1 mg	1 mg	1 mg

Patient repeats for **weeks 3-12**

Cytisine prescribing guidance:

Each tablet contains **1.5 mg of cytisine**. One pack of Cytisine contains 100 tablets which is a complete treatment course (25 days).

Cytisine should be taken with water according to the following schedule with **the quit date no later than the fifth day of treatment:**

Days of treatment	Recommended dosing	Maximum daily dose
From the 1st to the 3rd day	1 tablet every 2 hours	6 tablets
From the 4th to the 12th day	1 tablet every 2.5 hours	5 tablets
From the 13th to the 16th day	1 tablet every 3 hours	4 tablets
From the 17th to the 20th day	1 tablet every 5 hours	3 tablets
From the 21st to the 25th day	1–2 tablets a day	2 tablets

Below is an easier to follow version of the schedule which can also be found in the NCSCT document *Cytisine summary and dosing guidance:* www.ncsct.co.uk/publications/Cytisine-SPC

10.3 Appendix 3 – Guidance for staff when facilitating e-cigarette/ Vaping Device use

The following principles will be followed when staff facilitate the use of vaping devices with service users:

- Staff will explain to service users and carers that Vapes and E cigarettes are similar to nicotine replacement therapies (NRT) and other licensed stop smoking medicines such as nicotine patches, lozenges and inhalators when given together with intensive behavioral support, are the most safe and effective way to stop smoking.
- Information leaflets on vapes for service users should be used to develop a collaborative plan for any use of vaping device, as they would with NRT or any other stop smoking medication.
- A risk assessment and care plan will need to be in place for service users who use e- cigarettes/vapes noting any risks with the devices chosen by the service user, and potential for harm e.g., access to batteries and liquids
- Charging should only take place in designated ward areas.
- Vaping devices use is only allowed by service users in designated areas (e.g., hospital grounds, ward gardens but not any indoor areas).
- Vaping devices use should not be included as part of therapeutic interventions or recreational conversations.
- E-cigarette/ vaping devices users will be required to plan their use of these devices with their care team as part of their care plan (as they would with NRT) and allow staff to check the products that they are using.
- E-cigarette/ vaping devices use is not permitted to persons under the age of 18 years.
- If a service user switches from smoking cigarettes to vaping devices this will affect the metabolism of some prescribed medication. Blood plasma levels will need to be monitored and medication regimes adjusted accordingly. This is especially important for service users taking theophylline, olanzapine, clozapine, caffeine, and warfarin. See Appendix 4 and refer to NRT guidelines.
- E-cigarette/ vaping devices users will be required to store their e-cigarette/ vaping devices safely and securely. They should not share products with others for infection control reasons and should not use them near oxygen/naked flames.
- E-cigarette vaping devices users are expected to be considerate to those around them and always use the e-cigarette/vapes when in an allocated area.
- Vaping devices must be disposed off in a designated bin so that the battery and plastic can be recycled in line with European Union regulations.
- All vape liquids should be stored in a secure, cool, dry place until required for refill.

Birmingham and Solihull Mental Health NHS Foundation Trust

Management of Medication During Tobacco Smoking Consumption Change

Aim of Guideline

The aim of this guideline is to support the safe and effective use of medication when service users change their tobacco smoking consumption, by guiding clinicians on the appropriate and evidence-based actions to take when a person changes their tobacco smoking consumption. This may be in the context of a planned quit attempt, or an environmentally-imposed decrease in (e.g. admission on to a ward with specified smoke breaks) or abstinence from (e.g. being placed in seclusion) tobacco smoking.

Who it applies to:

All clinical staff, particularly prescribers, who work with service users who take relevant medication and whose tobacco smoking consumption changes.

Process for Review/Feedback

This guideline will be reviewed in response to any significant change in national or local guidance, practice or service provision pertinent to the subject matter and according to the organisational process of policy/guideline review. Local practice will be audited against the content of this guideline according to the PTC work plan.

Introduction

Smoke from tobacco cigarettes contains around 3000 different substances. These include polycyclic aromatic hydrocarbons (PAHs), which are thought to account for most of the interactions that cigarette smoke has with medication[1].

Cigarette smoke increases the metabolism of some medications, sometimes significantly, via inducing hepatic cytochrome enzymes (especially CYP1A2). The increased metabolism of these medications increases the elimination of medication and reduces circulating levels in serum and other tissues[2]. This can mean smokers may require more medication to achieve a given therapeutic effect or target serum level. When smoking decreases or ceases, the effect on the hepatic enzymes decreases, metabolism of the medication slows, and serum levels can rise. It should be remembered that the majority of interactions between medicines and smoking are not clinically significant[3]. Tobacco smoking generally takes between one and four weeks to have an effect on medication serum levels, although this differs from person to person[2].

The opposite happens when smoking starts or increases; serum levels can drop and result in mental state deterioration. Mental state and other relevant clinical parameters (e.g. serum levels) should be monitored closely. Waning of the effect of tobacco smoke on hepatic enzymes is often quicker and reaches equilibrium after only one week[5].

As e-cigarettes or electronic nicotine delivery systems do not contain tobacco cigarette smoke[4], their use or change in use would not be expected to interact with medication. The same applies to nicotine replacement therapy[3].

The extent of the effect on hepatic enzymes depends on several factors and is related to the amount of PAH exposure. Heavy smoking, smoking of unfiltered cigarettes and inhaling more all confer an increased risk of interactions occurring[2]. It has been found that daily consumption of 7-12 cigarettes is likely to be sufficient for maximum induction of the hepatic enzymes responsible for metabolism of clozapine and olanzapine[6]. This will be relevant if a cutting down strategy is being employed rather than complete and immediate cessation of to

General Principles of Management

If the service user's smoking status changes, either decreases, ceases or they start tobacco smoking, the following general principles should be followed[7]:

1. Elucidate details regarding baseline smoking status, including quantity and type (filtered or unfiltered) of cigarettes smoked.
2. Identify any possible interactions with current medication.
3. Consider measuring plasma levels of relevant medication.
4. Consider adjusting the dose depending on age (older adults show less enzyme induction), pre-existing liver dysfunction, timeframe of the interaction, current dose/serum level, tolerability and any previous history of adverse drug reactions.

5. Continue to monitor and make changes as indicated for several weeks after the change in tobacco smoking has occurred. Successive changes (e.g. if the service user is cutting down their tobacco smoking gradually) will need extended monitoring. Adverse effects to medication when cutting down or stopping smoking should be monitored closely.
6. For clozapine, wherever possible, take a baseline level for comparison purposes prior to smoking cessation
    - Consider making an adjustment (reduction) in clozapine dose where an enzyme inhibitor is added or smoking is reduced or stopped. Review progress weekly for at least four weeks
    - Where an enzyme inducer is added or smoking starts or increases, review weekly for at least four weeks. Dose adjustment (increase) may be needed after two to three weeks when enzyme induction has increased significantly.
7. On admission to non-smoking inpatient units also consider the following
    - Ascertain pre-admission smoking status
    - Monitor for change in smoking status, e.g. S17 leave, extended leave periods and on discharge.

The clinical guideline on Monitoring and Management of Common Adverse Reactions to Clozapine and Therapeutic Drug Monitoring may also be useful in adjusting clozapine doses following change in smoking status.

Summary of Interactions

See table 1 below for a summary of interactions.

Contact pharmacy if there are queries regarding other medications and for advice on best management of individual service users.

The following criteria have been considered in grading the clinical relevance of interactions[3]

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 narrow therapeutic range and/or
	Drugs metabolised principally by CYP1A2 and with a wide therapeutic range

Table 1: Summary of Interactions

Drug Name (Alphabetical by Generic Name)	Nature of Interaction	Clinical Relevance	Action to Take When Stopping Smoking
Clozapine	Clozapine is metabolised principally via CYP1A2 and clearance is increased in smokers. Serum clozapine levels are reduced in smokers compared with non-smokers; smokers may need higher doses. There have been case reports of adverse effects in patients taking clozapine when they have stopped smoking.	***High***	Monitor serum drug levels before stopping smoking and one or two weeks after stopping smoking. Be alert for increased adverse effects of clozapine. If adverse effects occur, reduce the dose as necessary.
Olanzapine	Olanzapine is metabolised principally via CYP1A2 and clearance is increased in smokers. Serum olanzapine levels are reduced in smokers compared with non-smokers; smokers may need higher doses. There have been case reports of adverse effects in patients taking olanzapine when they have stopped smoking.	***High***	Be alert for increased adverse effects of olanzapine (e.g. dizziness, sedation, hypotension). If adverse effects occur, reduce the dose as necessary.
Chlorpromazine	Chlorpromazine is metabolized principally via CYP1A2. Smokers have lower serum levels of chlorpromazine compared with non-smokers. A case report describes a 25 year old patient with schizophrenia who experienced increased adverse effects of chlorpromazine (sedation and dizziness) and increased plasma chlorpromazine levels after abruptly stopping smoking.	***Moderate***	Be alert for increased adverse effects of chlorpromazine (e.g. dizziness, sedation, extra-pyramidal symptoms). If adverse effects occur, reduce the dose as necessary.
Insulin	Smoking is associated with	***Moderate***	If a patient with insulin

	poor glycaemic control in patients with diabetes. Smokers may require higher doses of insulin but the mechanism of any interaction is unclear.		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.
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.
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 to a patient's INR (International Normalised Ratio).	***Moderate***	If a patient taking warfarin stops smoking, their INR might increase so monitor the INR more closely. Advise patients to tell the physician managing their anticoagulant control that they are stopping smoking.

Acknowledgements

The developers would like to thank Lancashire Care NHS Foundation Trust and Oxford Health NHS Foundation Trust for sharing their documents.

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10.5 Appendix 5 – Gold standard Training Requirements

The Stop Smoking Services provides a combination of behavioral support and medication. Research shows that smokers are three times more likely to stop smoking with this support

Stop Smoking Services should be staffed with:

- A service lead with up-to-date knowledge and experience of providing specialist behavioral support for smoking cessation
- Tobacco dependency advisors trained to an appropriate standard (NCSCT – all modules) and working from evidence-based treatment manuals

Support offer:

- Both group-based and individual face-to-face behavioral support; telephone-based support may also be offered in addition
- All medications approved by the National Institute for Health and Clinical Evidence (NICE) as first-line treatment,

Data collection and reporting: (Department of Health, 2011) (Department of Health & Social Care, 2018)

- Collect data on 4-week quit rates in accordance with the Russell Standard (clinical) (Bauld, et al., 2016), being careful only to count smokers who have set a quit date with a Stop Smoking Practitioner and been offered multi-session behavioural support.
- Successes are those who report not having smoked at all for the previous two weeks with at least 85% of these claimed quits being confirmed by an expired air-carbon monoxide concentration of less than 10ppm.

Knowledge Base Requirements

Learning resources and training course content should result in Stop Smoking Practitioners being able to do the following:

Smoking in the population

- describe prevalence and patterns of smoking and smoking cessation as functions of demographic characteristics such as gender, age, ethnicity, and socio-economic status
- describe prevalence and patterns of smoking and smoking cessation in special groups, such as pregnant smokers and those with mental health problems
- describe changes in smoking and smoking cessation patterns over time and across different demographic groups

Smoking and Health

- list the major life-threatening and non-life-threatening diseases to which smoking contributes
- describe the health benefits of cessation
- quantify the increased risk of premature death from smoking and the benefits of cessation at different ages
- Describe the harmful effects of smoking during pregnancy and breast feeding
- give an accurate and balanced indication of any potential beneficial effects of smoking
- describe the harmful effects of second-hand smoke
- describe any effects of stopping smoking on dosages of drugs used to treat conditions such as psychotic disorders

Why stopping smoking can be difficult

- accurately describe the process of stopping smoking in a way that reflects that attempts to stop can be arrived at suddenly or gradually, the importance of avoiding 'lapses', the factors that promote and deter quit attempts and factors that protect against and promote relapse
- explain what is meant by tobacco addiction and nicotine dependence and how these develop
- list known nicotine withdrawal symptoms and their natural time course
- describe the common reasons smokers give for why they smoke and how far these reflect the true effects of smoking
- describe environmental, socio-demographic, and psychological factors associated with cigarette addiction

Smoking cessation treatments

- describe the principles, and long-term and short-term effectiveness, of behavioral support (individual and group-based)
- identify potential difficulties associated with providing group-based support, such as patient recruitment and organizational logistic demands, and how these can be addressed
- describe the full range of evidence-based medications available to aid smoking cessation, including their efficacy; correct use; contra-indications and cautions, drug interactions, side-effects; and relevant clinical guidelines
- explain why complementary therapies and unproven commercial treatment programs for smoking cessation should not be made available
- show understanding of the principles and methodology of measurement of biomarkers of smoking, such as carbon monoxide (CO) and cotinine

The wider context

- show awareness of the contribution of smoking cessation to public health and to reducing health inequalities

- demonstrate understanding of the role of smoking cessation plays in wider tobacco control strategies
- describe the cost effectiveness of smoking cessation interventions compared with other life-saving clinical intervention

Training availability

BSMHFT learning Zone
Alcohol and Tobacco Brief Interventions as on Traffic lights

Funded by Public Health England - NCSCT (NCSCT , 2022)

Online Training Resources available to read on the website (or download) free of charge

NCSCT Practitioners Certification
- Core competences in helping people stop smoking
- Very brief Advice on Smoking (VBA+)
- Stop smoking medication
- Vaping: a guide for healthcare professionals
- Very brief advice on Smoking for Pregnant Women
- Very Brief Advice on Second-hand Smoke: promoting smoke free homes and cars

Specialty courses for practitioners who have NCSCT Practitioners Certification
- Mental Health and smoking cessation
- Pregnancy and smoking cessation

In-house Training will also be delivered by the Tobacco Dependency team.

10.6 Appendix 6 – Local Stop Smoking Services

The following are stopping smoking services available to staff and service users:

In person

- Visit your local pharmacy
- Speak to your own GP

Online

- Go online, visit NHS stop smoking services help you quit - NHS (www.nhs.uk) Call a local stop smoking service All services | Birmingham City Council
- Free NHS Quit Smoking app https://www.nhs.uk/better-health/quit-smoking/
- **ABL – Solihull: 0121 740 1212 Email: ablh.solihull@nhs.net www.smokefreesolihull.co.uk**

Telephone

- NHS Smoking Helpline free on 0300 123 1044

10.7 Appendix 7- Summary of Human Rights Legislation and Ethics

- Article 1 of the UK Human Rights Act of 1998 states that: “Everyone’s right to life shall be protected by law.” (Equality and Human Rights Commission, 2019)
- The Charter of Fundamental Rights of the European Union, signed in 2000, states that: “Every worker has the right to working conditions which respect his or her health, safety and dignity.” (The European Parliament, 2000)
- Article 8 of the Universal Declaration of Human Rights provides for the right to a private life. This is a referred to as a ‘qualified right’, meaning it does not override the protection of the health and freedom of others. Tobacco smoke is a Class as a carcinogen and exposure to second-hand smoke causes direct harm to non-smokers. Therefore, under the legislation the right to work or be treated in a hospital (or community centre) that has not been polluted by a Class A carcinogen outweighs any perceived right to smoke. (Equality and Human Rights Commission, 2019)
- Under the Health Act 2006 the vast majority of the British public has legal protection from exposure to second-hand smoke in public places. Failing to afford people with a mental illness the same level of protection from exposure to second-hand smoke or encouragement to quit smoking because of the introduction of smoke-free places is discriminatory against this group.
- During a 2008 legal challenge to a total smoke-free policy in Nottinghamshire NHS trust, legal precedence relating to the implementation of fully smoke-free mental health units was established by the High Court:
  Rejecting the notion of an absolute right to smoke wherever one is living.
  Rejecting the argument that those responsible for care of detained people are obliged to make arrangements to enable them to smoke.
  Concluding that in the interests of public health, strict restrictions on smoking and a complete ban in appropriate circumstances are justified. The Court also noted that none of the various disturbing consequences of a smoke-free policy feared by the claimants, such as an increase in the prescription of sedative drugs, had materialised. (BBC new report, 2008)

10.8 Appendix 8: Vapes/E-cigarettes

- The 2022 Cochrane review of e-cigarettes for quitting smoking shows that nicotine e-cigarettes help more people quit smoking at six months or longer than nicotine replacement therapy. While e-cigarettes are not risk free, the Cochrane Review found no evidence of serious harm from using e-cigarettes for stopping smoking. However, concerns about the safety of long-term e-cigarette use must be weighed against the relative harm that would be caused by continuing to smoke. (**Cochrane Review of e-cigarettes, 2022)**
- 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 minimized 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.

  There are three main forms of ENDS product
  - Disposables are single use products with a non-rechargeable self-contained battery, and the liquid non-refillable. These have been banned nationally on 1st June 2025 and hence they will not be allowed on trust premises.
  - Rechargeables are multiple use products with rechargeable batteries.

Reporting adverse effects from vaping devices:

Side effects can be reported if someone feels unwell after using an e-cigarette product and other safety concerns with vapes/e-cigarettes or refill containers to the MHRA through the Yellow Card scheme. Yellow Card reports submitted to the MHRA are added to our vigilance database where reports are looked at by our specialist team of assessors. Reports are assessed for potential patterns of concern by our team of scientists, doctors and pharmacists. Should any potential safety concerns be identified the MHRA is able to take regulatory action to safeguard the public.

Data from Yellow Card reports received relating to suspected side effects to nicotine- containing e-cigarettes can be viewed on the **e-cigarette Analysis Print**. It is important to note that inclusion of a report of the Analysis Print does not necessarily mean that the effect was caused by the e-cigarette just that there was a suspicion it might have been.
Please see the **accompanying guidance document** explaining how this data should be interpreted.