Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust Board	Date:	29 March 2017

Agenda item	Title	Executive Director lead and presenter	Report author
BD/16/269	**Smoke Free Hospitals**	**Andrew Dean**	**Paul Daniels (Head of Health & Safety and Operational Risk Management)**

This report is for:	
Decision	X
Discussion	X
To Note	

History

Follow up from August 2016 Executive Team paper and February 2017 Executive Team report

The following impacts have been identified and assessed within this report	
Equality	
Quality	X
Privacy	

Executive summary of key issues

This report summarised the health risks associated with smoking and in particular with those with mental health conditions.
The report outlines the requirements from NICE, CQUINS and Department of Health on smoking and mental health and the requirement of all MH Trusts to be smoke free by 2018.
This report notes the progress made so far with preparatory work to become smoke free, the risks to this being achievable and lessons learned from other MH Trusts.

The Board is asked to approve the proposed go live date of 31 July 2017 and making certain smoke free training a mandatory requirement for staff.

This report addresses these strategic priorities:	
We will deliver the best care	X
We will support and develop our staff	X
We will continually improve what we do	X
We will use our resources wisely	
We will be future focussed	X

1 Introduction

1.1 NICE Guidelines

NICE has issued two sets of public health (PH) guidance on smoking – PH 45 Tobacco Harm Reduction and PH 48 Smoking Cessation - Acute, Maternity and Mental Health Services. The main impact of the guidelines are to recommend all buildings and grounds are smoke free including inpatient services.

The guidance includes interventions to help professionals stop smoking, including brief interventions and referrals to specialist services to help people who smoke to stop. It also recommends commissioners commission smoke free services.

1.2 Smoking and Mental Health

Tobacco smoking is the main cause of preventable and premature deaths in the UK. 100,000 people die ever year from smoking related illness. People with mental illness are more likely to smoke heavily than the general population. Those with severe mental illness have a reduced life expectancy, and are at significantly greater risk of smoking-related illnesses.

Reducing smoking among mental health service users can make an important contribution to improving public health and can improve the longer-term health and wellbeing of people living with mental health problems.

Smoking prevalence among people with mental illness is substantially higher than the general population. Around 20 % of the English population in private households are regular smokers, smoking seven or more cigarettes a week. However, among people with mental health problems, the figure is 33% to 40 % among people with probable psychosis. The strength of association tends to increase with the severity of mental disorder. The highest prevalence of smoking is found among psychiatric inpatients. In mental health units, it is estimated that 70% of patients smoke, with 50% of patients described as heavy smokers.

Higher smoking rates among people with mental illness result in increased levels of morbidity and premature death. People with severe mental illness are estimated to live 16 to 25 years less than the general population. Higher rates of smoking are also believed to be a major factor in the ten-fold increase in deaths from respiratory disease for people with schizophrenia, compared to the general population. Smoking also contributes to a significant proportion of deaths caused by cancer and circulatory disease with people who smoke heavily being more prone to smoking related illnesses. This has lead to health inequalities for people with mental health disorders. Whilst smoking rates for the general population have dropped to half the levels seen 30 years ago, the rates for those with mental health disorders have remained static.

NICE guidelines endorse the use of harm reduction strategies, by which people who are otherwise unlikely to quit, or do not want to, are encouraged to substitute smoking tobacco with alternative sources of nicotine (such as e-cigarettes) for long-term use. Nicotine substitutes offer the potential to prevent harm from smoking, by directly reducing the amount of smoke inhaled. Harm reduction is recommended as a means to promote smoking cessation, and support smoke-free policies, in mental health settings.

Helping service users who smoke quit is the single most important factor in improving their physical health. Quitting also improves quality of life through financial benefits, helping reduce social isolation and improved mental health.

Mental Health Trusts are expected to become “Smoke Free” by 2018.

1.3 Learning from Other Trusts

Several mental health trusts have already gone smoke free. Learning from these has been gathered through a number of events across the country which AWP staff have participated in.

Key messages from the early implementers have indicated the following areas as vital components in a successful smoke-free strategy and that these need to be in place before the go date:

- Leadership, both organisational and within clinical areas, from the top of the organisation.
- Clear messages and policy
- Information for service users, staff and visitors
- Support for service users including NRT and counselling services
- Support for staff including NRT and counselling services
- Monitoring of performance through clinical audit
- Adequate training and ongoing support for staff

Interestingly, and perhaps contrary to the perception of many

- There is no associated increase in the level of violence and aggression
- There is no detrimental effect on the mental health of service users, indeed there is evidence to the contrary.

However in approaching a smoke free status, careful planning and communication is vital to provide service users and staff with the correct support.

1.4 CQUINS for 2017/18

The new CQUINS have been published and are undergoing negotiation with CCGs currently.

From April 2017 there will be national CQUINS on preventing ill health and smoking is one of the key areas to be applied in mental health Trusts, The CQUIN for 2017 may be 2.5% of annual budget (Source: Catherine Wevill– CCG (Mental Health Commissioner Lead, Bristol) of £172 million for all block funding (including Secure).

The indicators for the CQUIN are:

- In Quarter 1 (33% of CQUIN):
  - Complete an information systems audit
  - Train clinicians to deliver Very brief advice for Service Users (Ask, Advise, Act)
  - Collect baseline data
- Ask and record smoking status (5% of CQUIN
- Advise smokers on the best way of quitting (20% of CQUIN)
- Act by referring for support to stop and medication (25% of CQUIN)

1.5 NICE PH48 and Implications for Community Services

As well as providing stop smoking services within inpatient settings, NICE PH48 requires the Trust to continue to provide support in the form of weekly sessions to service users for 4 weeks after discharge or if it is not possible to provide this support after discharge, arrange a referral to a local stop smoking service.

This will be a contentious area with pressure on public health services being stretched and unable to provide the more intense support that is needed for service users with mental health issues who are often heavy dependant smokers.

The Trust will need to identify and develop pathways from inpatient to community care and into mainstream stop smoking services. There is an impact on training numbers and some clarity will be needed on if the CQUINS will cover community service users.

2 Consultation and Approval Process

Progress with this project has been managed by the Smoke Free Hospitals Group which is a multi-disciplinary group. We have not been able to maintain service user involvement at this group but we have worked with SU representatives in those areas piloting Smoke Free and contemplating being an early implementer (Sycamore, Juniper and Secure Services respectively) through local Smoke Free working groups. Draft policies and implementation plans have been drawn up and approved by the Executive Team and Quality and Standards. The Trust has also consulted with staff side throughout.

The Group is still working on adopting notable practice from across the NHS and building these into the implementation plan, training, leaflets and communications.

3 Progress to date

The Trust has been making progress towards being ready to become a Smoke Free Trust.

The Smoke Free group has developed a policy and strategy which has been approved. This lays down the foundation of becoming smoke free. We have run two pilots, the first in Sycamore Ward and followed shortly afterwards in Juniper Ward. This has given the group useful experience and helped steer progress.

The group has reviewed training standards and developed, with colleagues in public health, new training for Tobacco Treatment advisors, a new basic awareness e-learning course for all staff and a new e-learning course for clinicians.

To support staff, we have made free NRT over 3 months available as a one off benefit, where staff are able to claim back NRT costs through expenses.

The group has researched and piloted the use of e-cigarettes in the pilot site and Fromeside as part of harm reduction and a viable alternative to tobacco for service users, particularly those in crisis.

The group has developed new leaflets for service users, carers, staff and includes information on health risks and benefits and guidance on e-cigarettes. It also has developed an implementation plan, identifying risks to achieving smoke free status and recommended actions to mitigate these risks.

4 Recommendations

4.1 Go live Date

The Smoking Free Hospitals Group are currently recommending the Trust consider a go live date of 31 July 2017.

It was felt that a go live date in the midst of CQC inspections was too onerous for staff workloads and focus.

4.2 Change the Training Matrix to include Smoking Cessation as Mandatory

In order to meet the CQUIN staff will need to be trained and in order for smoking cessation interventions to occur (ASK, ADVISE, ACT) staff will need the necessary skills to do this appropriately.

The Board are asked to approve the following training as Mandatory:

Smoking Awareness (basic advice) - Mandatory

All staff should undergo the basic smoking awareness e-learning training on the MLE.

Basic Smoking Cessation Training (Level 1) - Mandatory

All clinical staff should undergo Level 1 e-learning training on the MLE incorporating Very Brief Advice (VBA) from the National Centre for Smoking Cessation and Training (NCSCT) syllabus.

Additional training is also available for Tobacco Treatment Advisors (this is not mandatory for all qualified staff).

Advanced Smoking Cessation Training (Level 2) – Based on Role

Sufficient registered staff should this course within wards and community teams to be able to support service users wishing to engage in a quit attempt or abstain from smoking. This is required for all staff expected to undertake PGD training.

4.3 Communications Strategy

Strong communication is essential to the run up to go live. Through April, May and June there will need to be intensive messages in support to going Smoke Free. This will be followed up in October to coincide with Stoptober. Communications before go live with service users and staff to prepare for this change will enable them to prepare for changes.

5 Decisions Required

The Board are asked to support and approve the recommendations outlined in this paper.

6 Risks

The Smoke Free Hospitals Group has a risk register and is following up actions to mitigate the risks identified.

The main risks to success of this project are:

- Sufficient Staff trained, particularly Tobacco Treatment Advisors
- Changes to Rio to record smoking status, VBA and interventions in a format that can produce data for CQUINS
- Providing ongoing support for wards and community teams in providing stop smoking interventions.
- Engagement from all wards and community teams