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Smoke-free Scotland

Guidance on smoking policies for the NHS, local authorities and care service providers

December 2005

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Those in the public services and in the caring professions have a vested interest in the smooth implementation of the smoke-free legislation and in making the law work.

Smoke-free Scotland: guidance on smoking policies for the NHS, local authorities and care service providers

This guidance is aimed at those in the NHS, local authorities and other care service providers in Scotland concerned with the development and implementation of smoking policies for staff, visitors and those who use their services.

Its purpose is two-fold:

- **to enable them to comply with the smoke-free provisions of The Smoking, Health and Social Care (Scotland) Act 2005, coming into force on 26 March 2006; including specific advice for those in control of premises exempted under the legislation; and**
- **to advise on the development of an approach to tobacco which will maximise the benefits of becoming smoke-free.**

The document builds on:

Helping to get your business or organisation ready for the new law on smoking: A guide for employers, managers and those in control of premises, published by the Scottish Executive (2005)[1];
Effective Tobacco policy in the Health Service: Guidelines for Action published by ASH Scotland (1998)[2];
Tobacco at work: guidance for local authorities. Achieving the best outcomes. A joint publication between NHS Health Scotland, ASH Scotland and the Convention of Scottish Local Authorities (2004)[3]; and
The Managing Health at Work Partnership Information Guideline, the Scottish Executive (2003)[4]
Available at http://www.scotland.gov.uk/Resource/Doc/47032/0013906.pdf.
It was also informed by the findings of the re-audit of tobacco control policies[5] in the NHS in Scotland commissioned by ASH Scotland in conjunction with the Scottish Executive and NHS Health Scotland (2005).

Further information on smoke-free public places is available at
www.clearingtheairscotland.com

This guidance is also available online at
www.clearingtheairscotland.com
www.ashscotland.org.uk

ashscotland NHS Health Scotland COSLA Healthy Working Lives healthier scotland

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Foreword:
Scottish Executive and Convention of Scottish Local Authorities

Reducing smoking and tobacco related harm is one of the main drivers to transforming Scotland's health. The action by the Scottish Executive in introducing the Smoking, Health and Social Care (Scotland) Bill, which was overwhelmingly endorsed by the Scottish Parliament and backed by the Convention of Scottish Local Authorities, is testament to the determination of politicians at both national and local level to make significant progress on this issue.

Passive smoking kills. The evidence is now irrefutable. The smoke-free legislation will significantly reduce exposure to second-hand smoke by prohibiting smoking in the majority of enclosed public places. But it also provides the opportunity for smokers to cut down or stop smoking; the opportunity for our children and grandchildren to grow up with less pressure to smoke, and less likelihood of dying early; and for Scotland, the opportunity to transform our national health and to reduce our health inequalities. We must all work together in our local communities to maximise the benefits which this opportunity brings.

Those in the public services and in the caring professions have a vested interest in the smooth implementation of the smoke-free legislation and in making the law work. But more than that, we have a clear obligation to provide leadership and standards for others to follow. This document sets out how we might strive to achieve these standards, whilst at the same time recognising and dealing with the very real practical and humanitarian challenges we face in doing so.

We commend this guidance to you for consideration and action.

Andy Kerr
Minister for Health and
Community Care

Cllr Eric Jackson
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Executive Summary

This guidance was commissioned by a working group comprising representatives of the Scottish Executive, ASH Scotland, the NHS, NHS Health Scotland, the Convention of Scottish Local Authorities (COSLA), the Care Commission and the Scottish Centre for Healthy Working Lives (now incorporating Scotland's Health at Work).

It provides guidance to the NHS, local authorities and care sector providers on how to comply with Scotland's smoke-free legislation, including specific advice for those premises which are permitted exemptions under the new law. It builds on '*Helping to get your business or organisation ready for the new law on smoking: A guide for employers, managers and those in control of premises'*[1], recognising the unique circumstances of these organisations and the challenges faced by staff and those who use their services.

In addition, it highlights the benefits of going further than the legislation and working towards completely smoke-free policies, maximising the health gain opportunity which the legislation presents in order to protect and improve the health of the people of Scotland and reduce health inequalities.

Introduction (Chapter 1)

From 26 March 2006, Scotland joins a number of other countries benefiting from comprehensive legislation to remove second-hand smoke from most public places and workplaces.

International research suggests that a number of benefits can be expected, including increased protection from the health risks of passive smoking; healthier communities as smokers use the opportunity to stop smoking or reduce the number of cigarettes they smoke; much reduced health care and treatment costs; a more efficient and equitably treated workforce and an improved environment for all members of society.

Those working in the NHS, local authorities and other care service providers are invited, where possible, to go further than the legislation, working towards comprehensive smoke-free policies with the provision of cessation advice and support to those who wish to quit smoking.

Scotland's smoke-free legislation and how to comply – the legal imperative (Chapter 2)

This section sets out the requirements placed on employers and managers of organisations in Scotland to comply with the smoking provisions of The Smoking, Health and Social Care (Scotland) Act 2005[6] and The Prohibition of Smoking in Certain Premises (Scotland) Regulations 2006[7]; the minimum recommended action for those in control of premises; enforcement arrangements and penalties for non-compliance.

From 26 March 2006, employees, patients, clients and visitors will not be able to smoke in 'wholly or substantially enclosed' areas of public premises, including workplaces and vehicles which are used primarily for business purposes (heavy and light goods vehicles, not cars). Included within the scope of the legislation are NHS and local authority premises.

In adult care homes and residential psychiatric hospitals and units designated smoking areas can be established as long as certain criteria are met. Adult hospices are also permitted exemptions. However, there is no legal obligation on the proprietors of these premises to provide designated areas for smoking, if they do not wish to do so.

Specific issues facing NHS organisations, local authorities and care service providers (Section 3)

It is recognised that there are a number of difficult and sensitive issues for NHS organisations, local authorities and care service providers in complying with the legislation. In addition, there is a health leadership role for these organisations that makes it desirable for them to be in the vanguard of smoke-free policy development.

These issues are examined in detail in this section, setting out good practice in terms of organisational responses to tobacco. The main issues are set out below.

- **The provision of external smoking areas**

  No requirement to provide external smoking areas to comply with the legislation and strong evidence to suggest that their provision undermines the potential health gain to staff and those who use their services. Shelters may be useful on a time-limited basis, combined with work to encourage and support smokers to stop smoking. Care needs to be taken to ensure that existing or new shelters comply with the new law, that they are not 'wholly or substantially enclosed' within the meaning of the legislation.

- **Workers on shift, on call etc.**

  Careful consideration needs to be given to the matter of staff leaving the site in order to smoke, particularly those working late into the evening or through the night. Above all else, the health and safety of the employee needs to be a major concern. This may lead to the need to discourage employees from this practice and instead encourage them to consider joining a smoking cessation programme.

- **Patient safety**

  The safety of patients is paramount to any agency with care or treatment responsibilities. Alternatives to allowing patients to exit the premises are explored, including the availability of cessation services whilst in hospital or care treatment centre and pharmacological aids to help them during their stay.

- **Adult residential care homes**

  Proprietors may designate rooms for smoking, although they are not obliged to do so. Any 'designated' rooms should be enclosed spaces with ventilation systems that do not ventilate into any other part of the building, and should be clearly marked as a room in which smoking is permitted. These rooms are designed for the use of residents, not staff or visitors. Staff exposure to second-hand smoke should be minimised.

- **Residential psychiatric hospitals and psychiatric units**

  The principles which apply to adult care homes also apply to residential psychiatric hospitals and units. The Scottish Executive has established a short-life working group to oversee the development of a national framework which will deal more clearly with the specific challenges faced by mental health services and their users, particularly in relation to smoking cessation.

- **Adult hospices**

  Adult hospices have been permitted exemptions from the smoke-free legislation on humanitarian grounds, although there is no obligation on management to allow smoking on these premises. Smoking should be contained and tobacco smoke restricted to designated smoking rooms.

- **Domiciliary visits**

  Private residences are not covered by the legislation. Staff who visit or treat people in their own homes are at risk if the person being treated is a smoker. Advice is provided on how exposure and the subsequent health risks can be reduced.

- **Vehicles**

  Whilst only those heavy and light goods vehicles that are used primarily for work purposes come within the scope of the legislation, the ideal is that all vehicles used by employees as part of their work should become smoke-free. This is particularly relevant when a private vehicle is being used to convey passengers. The use of private vehicles as a 'smoking shelter' should be discouraged.

- **Premises which are used by children/families, e.g. nurseries, schools etc.**

  All such premises which are 'wholly or substantially enclosed' are required to be smoke-free under the legislation. However, local authorities will wish to consider the benefits of also introducing smoke-free policies in external areas frequented by children and young people, like playgrounds.

- **Parks, grounds and working outdoors**

  Outdoor areas are not covered by the legislation. However, employers will wish to consider whether having different approaches to smoking for those who work indoors or outdoors is equitable. Good practice indicates that a comprehensive, equitable approach is followed.

- **Sheltered housing**

  Local authorities are reminded that the communal areas of such accommodation are caught by the smoke-free legislation.

- **Offender accommodation**

  Offender accommodation in the community is caught by the smoke-free legislation. Smoking is prohibited in these premises except for those areas that are captured by the residential accommodation exemption. In all cases, staff exposure to second-hand smoke should be kept to a minimum.

Going Forward – The case for completely smoke-free (Section 4)

To maximise the health and economic benefits to the organisation, compliance with the legislation should be supported by the development of a comprehensive workplace tobacco policy. Wherever possible, consideration should be given to going beyond the legal requirements and moving towards the goal of being completely smoke-free. This should be undertaken in communication and consultation with staff and accompanied by work to support smokers to stop smoking.

The health and business case are outlined in brief in this section. They are set out in full in Appendix 2.

Overcoming likely challenges and obstacles (Section 5)

This section provides some of the counter measures that can be used to help people overcome resistance to the legislation or completely smoke-free workplace policies.

This work includes:

- keeping staff fully aware of and involved in the development of policy and the evidence behind the approach to tobacco control, which will better protect the workforce and wider society
- investing in good communication with service users
- communicating the evidence against the effectiveness of ventilation as a solution to the problem of second-hand smoke
- underlining the consequences of committing an offence under the legislation and
- underlining the growing public support for smoke-free public places.

Smoking cessation (Section 6)

Some of the most significant health benefits of the smoke-free legislation will only be realised if smokers use the opportunity to stop smoking. Responsible organisations should offer support to staff, patients, clients, residents and visitors, for example by publicising smoking cessation services and encouraging staff to access them.

Those responsible for cessation services need to gear up to the implementation of the legislation and ensure the availability of appropriate services, delivered where people need them.

This section highlights how smokers can be encouraged to stop whilst in hospital – in both in-patient and out-patient situations. It also provides advice on cessation methods.

Checklist for Action (Section 7)

Sets out a checklist for action for managers to ensure that all steps are being taken to comply with the law and the development of an appropriate smoking policy.

Appendix 1

Contains three sections dealing with the legal requirements, including some relevant legal definitions, lists those premises classified as no smoking under the law, and those which are exempt.

Appendix 2

Sets out the health and economic case for becoming smoke-free.

Appendix 3

Contains practical guidance on preparing to become smoke-free, including a step-by-step guide to the development of a comprehensive policy.

Appendix 4

References and further resources/information.

Up to date information about Scotland's smoke-free legislation, including case studies, can be found at the Clearing the Air Scotland website: http://www.clearingtheairscotland.com

1 Introduction

From 26th March 2006 Scotland joins a number of other countries benefiting from comprehensive legislation to remove second-hand smoke from most public places and workplaces.

This legislation offers an historic opportunity to improve levels of public health in Scotland and to reduce health inequalities, both now and for future generations. In turn this will lead to a range of other economic, societal and community benefits, from which everyone gains.

From research and the experience of other countries that have introduced such legislation, a number of benefits can be expected, including:

- Widespread protection from the disease risks associated with tobacco smoke
- Healthier communities as smokers take the opportunity provided by smoke-free workplaces and public places as an opportunity to stop smoking
- A more efficient workforce as sickness absence rates diminish over time as the prevalence of acute degenerative tobacco related disease falls, and a reduction in associated health care and treatment costs
- A workforce that is treated more equitably regardless of their working environment
- A wide range of organisational benefits, including a more productive workforce, improvements in staff morale and working relationships and an improved environment for clients, service users and patients.

To be successful such a move requires careful planning at all levels. This document aims to enable the NHS, local authorities and care service providers in Scotland to comply with the requirements of the legislation and, where possible, go further by developing an approach to tobacco that will maximise the benefits of becoming smoke-free to the organisation and the people associated with it.

The approach set out in this guidance is grounded in evidence-based good practice, informed by the experience and knowledge of the corporate authors. Following it will both ensure compliance with the law and suggest ways of extending good practice and enhancing the benefits.

We invite those working in the NHS, local authorities and other care services providers to commit themselves to the development and implementation of comprehensive organisational tobacco policies. Such a process may take a little time, but the benefits for the organisation, its employees, clients, patients and visitors will be considerable.

2 Scotland's smoke-free legislation and how to comply – the legal imperative

This section sets out the requirements which the legislation places on employers and managers of organisations in Scotland. The smoking provisions of The Smoking, Health and Social Care (Scotland) Act 2005[6] and The Prohibition of Smoking in Certain Premises (Scotland) Regulations 2006[7] come into effect at 6 a.m. on Sunday 26 March 2006.

You can access both pieces of legislation at www.clearingtheairscotland.com Some relevant definitions, as set out in the Act and Regulations, can be found in Appendix 1.

What the law means in practice

The law prohibits smoking in certain public places which are 'wholly or substantially enclosed', including the majority of workplaces. It will be an offence to smoke in no smoking premises or to knowingly permit smoking in no smoking premises.

Vehicles used for business purposes will also be affected by the law. These include light and heavy goods vehicles, and public transport such as taxis, buses, trains and ferries, but exclude cars (private or company-owned).

Premises affected by the smoke-free law

Those premises which are classed as no smoking premises under the law, if they are 'wholly or substantially enclosed', are set out in full in Appendix 1. In these premises, previously designated 'smoking' rooms will no longer be allowed.

The legal definition of 'wholly or substantially enclosed' is also set out in the Appendix. However, a simple explanation is that it is an area with a ceiling or roof that – except for doors, windows and passageways – is either wholly enclosed (whether permanently or temporarily); or is enclosed but for an opening which is less than half the area of its walls. If there is any doubt about whether particular premises comply with the smoke-free legislation, then independent legal advice should be sought.

How those in control of 'no-smoking' premises should comply with the smoke-free legislation

Detailed guidance[1] has been issued to all businesses and organisations in Scotland on how to comply with the smoke-free legislation. This can be accessed at www.clearingtheairscotland.com

From 6 a.m. on Sunday 26 March 2006, every business and organisation in Scotland, to which the law applies, will need to take all 'reasonable precautions' to ensure that employees, customers and other visitors do not smoke on their premises. This includes the display of appropriate no smoking signs on their premises.

The minimum recommended action, including for those no smoking premises within an NHS, local authority or other care setting is:

- To display the required no smoking signs (see page 12) in such a way to make staff, customers and visitors aware that the premises are no-smoking premises and that they must therefore comply with the law

- Remove all ashtrays
- Develop and implement a smoke-free policy with staff to ensure that infringements by employees, customers, members etc. are dealt with under agreed procedures
- Inform anyone smoking that he/she is committing an offence
- Ask anyone smoking to extinguish their smoking material immediately or leave
- Consider if it is appropriate to refuse service to individuals who are contravening the law, depending on the nature of the service being provided.

No smoking signage for premises

Businesses and organisations are required by the law to display no smoking signs in or on any premises that are affected by the ban, so that they can be seen and read by people in the premises and approaching the premises. They must be obviously displayed and protected from tampering, damage, removal or concealment.

The minimum signage requirement for premises is a no smoking notice which:

- Is at least 230mm by 160mm in size
- States that the premises are no smoking premises and that it is an offence to smoke there or knowingly to permit smoking there
- Displays the international no smoking symbol, at least 85 mm in diameter
- Displays the name of the person to whom a complaint may be made by anyone who observes someone smoking.

It's up to the manager or person in control of the premises to decide on the number of notices required to make sure everybody on the premises is made aware that smoking is not allowed. If you decide that you need more than one no smoking notice, the additional notices need to:

- State that the premises are no smoking premises and that it is an offence to smoke there or knowingly to permit smoking there
- Display the international no smoking symbol, at least 85mm in diameter.

No smoking signage for vehicles

You are also required by the law to display no smoking signs in or on any vehicles that are affected by the ban in such a way that the signs can be seen and read by persons who are in the vehicle, as well as persons approaching the vehicle in question. There's no legal requirement on the size of these signs but they must still meet certain requirements, as follows.

The minimum signage requirement under the new law for any relevant vehicles is a no smoking notice which:

- states that the vehicle is no smoking and that it is an offence to smoke there or knowingly to permit smoking there
- displays the international no smoking symbol
- displays the holder of a particular post (e.g. the manager) to whom a complaint may be made by anyone who observes someone smoking

Copies of sample signage can be downloaded from www.clearingtheairscotland.com
You may, of course, develop your own signs, provided they comply with the above requirements.

Premises exempted under the legislation

There are few exemptions to the law. These are listed in Appendix 1 and include certain premises which may be the responsibility of the NHS, local authorities or care services providers, as follows:

- Designated rooms in adult care homes (an establishment providing a care home service exclusively for adults).
- Designated rooms in adult hospices (a hospice providing care exclusively for adults).
- Designated rooms in residential psychiatric hospitals and residential psychiatric units (a hospital, or hospital unit, the whole or main purpose of which is to treat persons with a mental disorder within the meaning of section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003)[8].

A 'designated room' means a room which:

a. has been designated by the person having the management or control of the no smoking premises in question as being a room in which smoking is permitted

b. has a ceiling and, except for doors and windows, is completely enclosed on all sides by solid floor-to-ceiling walls

c. has a ventilation system that does not ventilate into any other part of the no smoking premises in question (except any other designated rooms) and

d. is clearly marked as a room in which smoking is permitted.

It is important to note that there is no legal obligation on the proprietors of those premises, to which an exemption applies under the new law to provide designated areas for smoking if they do not wish to do so.

Rationale for health sector exemptions

There are a number of issues which make it desirable to exempt adult care homes and hospices from the scope of the legislation, not least that these are effectively the homes of their residents.

However, safety and other considerations mean that in many such establishments smoking is not permitted in residents' own rooms, the places which most closely equate to their private place of residence. For this reason, particular consideration must be given to the impact of second-hand smoke on non-smoking residents and on staff.

Advice on addressing this situation can be found in Section 3 (Specific issues facing NHS organisations, local authorities and care service providers).

It is important to note that only residential adult care home premises are exempt. Day care centres are covered by the legislation.

Similarly, the position of patients in psychiatric hospitals and units, whether they are there voluntarily or on the basis of a compulsory order, is different to general members of the public. They do not have private rooms and may have limited access to the outdoors. For those reasons, designated rooms within such establishments have been exempted under the current legislation.

However, the Scottish Executive recognises that the physical health profile of those with mental illness in Scotland is poor and smoking rates are traditionally high. It is committed to reducing the health inequalities experienced by this group of patients and will work with service providers to implement a programme of targeted cessation, which may allow the exemption for designated rooms to be reviewed in due course.

Penalties and enforcement

Failure to comply with the law is a criminal offence. Individuals may be fined a fixed penalty of £50 for smoking in no smoking premises. The manager or person in control of any no smoking premises could be fined a fixed penalty of £200 for either:

- Allowing others to smoke in no smoking premises
- Failing to display warning notices in no smoking premises.

Refusal to pay or failure to pay may result in prosecution and a fine of up to £2,500.

The law will be enforced by Environmental Health Officers, who will have the power to enter no smoking premises to determine whether the law is being upheld. They will also assess whether or not those in control of the premises have taken all reasonable precautions to avoid people smoking. Inspections carried out by enforcement officers will either be pro-active (to advise employers or managers, and to confirm compliance with the law), or re-active (in response to a complaint). Inspections may also be incorporated within other health and safety and food hygiene inspections. (Further information on enforcement can be found in Appendix 3).

3

Specific issues facing NHS organisations, local authorities and care service providers

a. **With respect to their obligations as an employer**

b. **With respect to their obligations to service users and clients**

c. **The importance of the health leadership role**

d. **The requirement to develop an appropriate organisational response, and the benefits of doing this in a timely and efficient manner**

e. **Whether or not to provide external smoking areas**

f. **Workers needs – shift / on call etc.**

g. **Patient safety**

h. **Adult care homes**

i **Psychiatric hospitals and psychiatric units**

j **Adult hospices**

k. **Domiciliary visits**

l. **Vehicles**

m. **Premises which are used by children / families e.g. nurseries, schools, youth clubs, leisure centres, parks and playgrounds etc.**

n. **Parks, grounds and working outdoors**

o. **Sheltered housing**

p. **Offender accommodation**

3 Specific issues facing NHS organisations, local authorities and care service providers

a. With respect to their obligations as an employer

The new smoke-free law makes clear that the presence of second-hand smoke within a working environment (and this includes rest and welfare facilities) is no longer acceptable. In order to comply with the law, it is essential that all employers ensure that their premises and other indoor environments, where work is carried out on their behalf, are smoke-free. It is important to note that this includes vehicles (light and heavy goods vehicles), where they are being used as part of the employees' work.

Although the new smoke-free law governs smoking at work, some employers with responsibility for exempted premises (or parts of premises) will still have responsibilities for ensuring that their employees are protected from the effects of second-hand smoke, under health and safety legislation.

Under the requirements of The Management of Health and Safety at Work Regulations 1999[9], employers should assess the risks to any employees who may be subjected to the effects of second-hand smoke, and take action as appropriate to control or minimise that risk.

Employers also have a specific requirement, under Regulation 25[3] of The Workplace (Health Safety and Welfare) Regulations 1992[10], to ensure that rest rooms and rest areas include suitable arrangements to protect non-smokers from discomfort caused by tobacco smoke

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b. With respect to their obligations to service users and clients

The 2005 Act and 2006 Regulations in Scotland require owners and managers of relevant premises, visited by the general public, including places of entertainment and where food and beverages are served, to ensure that the premises are smoke-free.

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c. The importance of the health leadership role

NHS organisations, local authorities and care service providers all provide services which protect, promote or treat people's health. In other words they have a vested interest in 'health'. It is very important, therefore, that as public places and workplaces in Scotland become smoke-free that these types of organisation are in the vanguard, setting the pace and providing an example and leadership for others to follow.

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d. The requirement to develop an appropriate organisational response, and the benefits of doing this in a timely and efficient manner

The implementation of the smoke-free law will result in many benefits for employers and service providers in Scotland. To maximise these benefits, organisations, their management teams, staff and client / patient groups need to be prepared, both for the changes in day to day practice and for the opportunities that will result.

e. Whether or not to provide external smoking areas

One of the most positive outcomes of the move to smoke-free status is that some smokers use the fact that they can no longer smoke at work as an incentive to quit smoking, while others reduce the number of cigarettes they smoke each day[11].

However there is equally strong evidence that the provision of any smoking area for staff - including external smoking shelters, undermines this potential health gain[12]. In terms of health and wellbeing a smoking area does little to benefit either the staff or the organisation in the short or the long term.

The major point to be noted here is that there is no requirement within the legislation for employers to provide an external smoking shelter. If one is already in existence, then the move to smoke-free could be used as an opportunity to review whether or not it should continue to be made available to staff. If it is continued then care must be taken to ensure that its physical structure complies with the requirements of the legislation. (See Appendix 1 Section 1). Liaison on this issue with the local environmental health service, who will be enforcing the law, is advisable.

Employers should therefore think very carefully before erecting new external smoking shelters for staff, patients, clients etc. because they minimise the health benefits of going smoke-free, as outlined above. If it is felt that this option should be pursued, then again care should be taken to ensure that local planning laws and guidelines are followed and that the proposal complies with the new law, i.e. is not 'wholly or substantially enclosed' within the meaning of the legislation .

There is one context in which smoking shelters might be appropriate, and that is on a time-limited basis i.e. they could be maintained immediately prior to going smoke-free, or for a limited time after going smoke-free. At the same time a considerable emphasis is placed on encouraging and supporting smokers to quit the habit. The smoking shelter could even be used as a place in which cessation advice and guidance could be provided.

If external smoking areas are being maintained, or if staff or patients, visitors or clients need to leave the premises to smoke, then consideration should be given to the provision of external stubbing-out bins at entrances or exits to keep litter to a minimum.

Time-limited shelters should, of course, still not be 'wholly or substantially enclosed' within the meaning of the legislation

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f. Workers needs – shift / on call etc.

The issue of risk that staff face on leaving the site in order to smoke a cigarette must be considered in relation to an employer's duty of care towards staff. In some circumstances this simply means stepping out of the building onto a busy public thoroughfare, for others it might entail a long walk to reach a lonely and isolated road. For members of staff who are working late into the evening or through the night, streets which are busy and safe during the day can become threatening at night.

Careful consideration needs to be given therefore to the matter of staff leaving the site in order to smoke. Some organisations insist that staff clock in and out when they do this – effectively they are smoking in their own time and at their own risk. Other organisations provide specific breaks or encourage staff to use existing breaks in order to smoke, but the issue of employees being away from their work for what could be many minutes at a time should be carefully considered. The European Working Time Directive[13] sets out expectations about workers' hours and break times and will be a factor in these considerations.

The health and safety of the employee needs to be a major concern. If they are putting themselves at risk by leaving the premises to smoke – be it in the middle of the day or the middle of the night, then the employee should be discouraged from this practice and instead encouraged to consider joining a smoking cessation programme.

Organisations may wish to consider outlining to staff appropriate approaches and support mechanisms should they be in a position of challenging someone who has refused a request to stop smoking in an enclosed and non-exempted area.

g. Patient safety

The safety of patients is of paramount importance to any agency with care or treatment responsibilities. The sight of patients clustered around an entrance to a hospital has been commonplace and everyone would acknowledge that it is not desirable practice.

The question is – what are the alternatives?

The best alternative is for patients to no longer need to exit the safety of the building to smoke a cigarette. Encouraging them to prepare for treatment by quitting the habit is the optimal solution, although less easy to achieve in the case of emergency admissions. This issue is addressed more fully in Section 6.

If they are admitted as smokers, then patients should be encouraged to make use of smoking cessation services while they are in hospital. A number of examples of good practice in terms of hospital based cessation services and the creation of good referral pathways from and to community based services are available and these demonstrate the potential positive impact that can be derived from the creation of such a service.

Finally, consideration should be given to providing patients who cannot or who choose not to stop smoking, with pharmacological aids to help them during their stay in hospital, so long as their use is not contra-indicated. Experiencing the effect that such aids have in reducing the symptoms of nicotine withdrawal might encourage them to consider trying to stop smoking at a later date.

h. Adult care homes

For organisations with residents for whom the premises are considered to be their home, an exemption applies under the legislation, such that arrangements can be made to designate specific rooms in which residents can smoke. See section 2 for the definition of ‘designated room’ used in the smoke-free legislation. These rooms must, under the terms of the exemption, be enclosed spaces i.e. not one end of a large room. They must also have some form of forced air ventilation that vents to the outside of the building (and not immediately beneath or next to a window). Ideally they would be separated from the corridor or connections to the rest of the building by a double door. Finally, they must be clearly marked as a room in which smoking is permitted. Ventilation systems may make the air appear cleaner, by diluting the larger particles found in tobacco smoke, but ventilation cannot protect people from the health risks associated with second-hand smoke.

Designated rooms where smoking is permitted are intended for the use of residents only, not for staff or visitors. The exemption for designated rooms in these premises was made in recognition that they are residential establishments.

Staff should not normally be required to work in these designated smoking rooms. If they have to enter them, then their time of exposure to second-hand smoke must be kept to a minimum. Staff with pre-existing conditions exacerbated by second-hand smoke e.g. asthma, should not be asked to enter them at all.

Effective tobacco and smoking policies, sensitively communicated, can help to encourage smokers to stop smoking, which brings health benefits at any age.

If it is not possible to provide a designated room for smoking in line with the legislation, then the building must be smoke-free. This ensures that residents and staff are protected from the dangers of second-hand smoke.

i. Psychiatric hospitals and psychiatric units

The principles which apply to adult care homes also apply to residential psychiatric hospitals and units (i.e. residential care) for circumstances where it is possible to permit patients to smoke in designated rooms. Smoking prevalence can be higher among people with mental health problems and consideration must be given to the wide range of issues faced when implementing smoke-free policies in both residential and non-residential facilities for this care group.

Scottish Ministers are commited to reducing the health inequalities experienced by people with mental health problems, as for all others, including through a programme of targeted cessation, which may allow the exemption for designated rooms to be reviewed in due course. A specific national framework for mental health services is currently being developed by the Scottish Executive to augment the advice contained in this guidance.

This framework will deal more clearly with the specific challenges faced by mental health services and their users, particularly in relation to smoking cessation. For example, the framework will tackle the myth that stopping smoking exacerbates mental health problems and address concerns about medication issues, particularly in relation to NRT. The Scottish Executive has established a short-life expert group, with representatives of key interests, to oversee the development of the guidance. It is proposed that draft proposals will be developed and consulted on in Spring 2006, to enable the new framework to be finalised and launched in October 2006.

j. Adult hospices

For humanitarian reasons, adult hospices have been exempted from the smoke-free legislation. However, it is recommended that, wherever possible, smoking should be contained and tobacco smoke restricted to designated smoking rooms, as outlined above for adult care homes. Every effort should be made to ensure that exposure to second-hand smoke is kept to a minimum. Again, however, there is no obligation on management to allow smoking on these premises, if they do not wish to do so.

k. Domiciliary visits

Staff who visit / treat people in their homes are at risk if the person being treated is a smoker. Private houses are not covered by the Act. Several factors, therefore, need to be taken into consideration.

First, does your organisation know which of the homes visited by its staff are occupied by smokers? If not, it would be advisable to develop such a list. Once the situation relating to individual properties is ascertained, steps can be taken to reduce the exposure the staff might face.

Measures that can be taken include writing to all those who will be visited to ask them and those who may be with them, not to smoke during the visit, and ideally not to smoke for an hour or so before the visit is scheduled to take place.

Second, it is important to identify members of staff who have a pre-existing condition that is made worse by exposure to tobacco smoke, such as asthma, COPD and cardiovascular disease or who face additional risks e.g. due to pregnancy. Members of staff who have such conditions are at higher risk and particular care should be taken to prevent or minimise their exposure to tobacco smoke.

Third, no member of staff should be expected to make consecutive visits, or even a sequence of visits, to houses in which they are likely to be exposed to tobacco smoke. A better option is to alternate the visits, but this should not take the place of steps one and two.

l. Vehicles

As outlined in Appendix 1 Section 2, vehicles used primarily for business purposes fall within the scope of the smoke-free legislation. Cars are exempt under the legislation, as are other vehicles that are used primarily for private purposes. The ideal, however, is that all vehicles used by employees as part of their work should be considered to be an integral part of the workplace and therefore be smoke-free. This is particularly so when a private vehicle is being used to convey passengers on work related activity and the driver / owner, whether an employee or volunteer, is a smoker. The driver should not seek permission to smoke from the passenger(s), rather he or she must not smoke.

The use of private vehicles as a smoking 'shelter' while parked on land associated with the employer should be discouraged.

m. Premises which are used by children / families e.g. nurseries schools, youth clubs, leisure centres, parks and playgrounds etc.

Second-hand smoke is particularly harmful to the health of children and young people.[14] Under the legislation, typically all 'wholly or substantially enclosed' public premises used or visited by children either on their own (schools and youth clubs) or with their families or friends (leisure centres etc.) must be smoke-free.

Smoke-free policies may already be in place in these areas. However, local authorities and others will wish to consider the benefits of introducing smoke-free policies in external areas which children and young people frequent, like playgrounds and parks. This will help to de-normalise smoking further and discourage young people from being influenced by what they may see as an 'adult' activity. Scenes of parental smoking at the entrances to schools, for example, are to be discouraged.

n. Parks, grounds and working outdoors

In situations where work is undertaken outside buildings, for example outdoor areas such as gardens, parks, grounds, highways etc. the employer should give careful consideration to the appropriateness of having one set of requirements for those who work indoors and another for those who do not. In such circumstances, consideration should be given to the development of a comprehensive policy that covers tobacco use and extends to all employees, irrespective of their working environment.

In any workplace situation, the equitable treatment of employees is a matter of prime concern. Having different approaches for employees working within an office or manufacturing environment, which is different to those employed by the same organisation, but who are working outside, is inequitable. Good practice would indicate that a comprehensive, equitable approach is followed.

For the employee, those working outside may conclude that they are exempt from the organisation's tobacco policy, since their smoking isn't harming anyone else. Three points need to be made in response to that position.

First, they are doing themselves harm 'on the company time' as it were. Second, they may be seen by members of the public, other employees, patients or visitors, who will rightly ask why one group of individuals within an organisation are treated differently to others, and who might assume that the organisation has a lax approach to tobacco at work. Third, they may be in breach of the organisation's smoke-free policy.

o. Sheltered housing

There are many different types of sheltered housing accommodation. Local authorities are reminded that the communal areas of such accommodation are covered by the smoke-free legislation.

p. Offender accommodation

The situation in relation to offender accommodation in the community is perhaps slightly different to those other types of premises detailed above, primarily because, in most cases, residents of offender accommodation will be there under a court requirement and not voluntarily.

Nevertheless, offender accommodation is still covered by the smoke-free legislation and smoking is banned in these premises except for those areas that are captured by the residential / domestic accommodation exemption. In practice this means that in hostel accommodation, smoking will be prohibited in any public areas, but in private dorms smoking may be permitted. In the case of co-habited dorms, smoking should only be permitted if both or all residents are smokers. In all cases, staff exposure to second-hand smoke should be kept to a minimum

Other forms of offender accommodation such as supported flats are considered to be residential / domestic accommodation and are therefore exempt from the smoke-free legislation. Bed and breakfast type accommodation is covered by the rules relating to hotels and guest houses.

Consideration should be given to actively encouraging and supporting any residents who may wish to take the opportunity to try to stop smoking.

4 Going Forward – The Case for Completely Smoke-Free

Much of this document has been devoted to explaining the implications of the legal requirements created by the smoke-free legislation. Prior to the introduction of the law, NHS organisations, local authorities and care service providers should inform their staff, service users, patients, visitors and clients that as of the 26th March 2006, the organisation's enclosed premises will be smoke-free. In addition it needs to display signs, brief managers and ensure that 'all reasonable precautions' are taken to comply with the legislation.

To maximise the health and economic benefits to the organisation, compliance should be supported by the development of a comprehensive written workplace tobacco policy, which goes beyond the legal requirements and carries the organisation towards the goal of being completely smoke-free.

Such a policy has at its core the concept of supporting smokers to stop smoking, not by compulsion or under threat, but rather by providing information, advice and support, which enables and encourages them to appreciate the health and other benefits, which accrue when someone stops smoking.

The development of such policies is underpinned by an organisational commitment to effective communication and consultation. This in turn means that measures implemented have the support of the staff, and levels of compliance will be even higher.

The health and business cases for going completely smoke-free are set out in full in Appendix 2, but key points include:

The Health Case

- Second-hand smoke has been labelled carcinogenic to humans[15] it represents a substantial public health hazard and no infant, child or adult should be exposed to it[16]
- Every year up to 1000 lifelong non-smokers die in Scotland as a result of exposure to second-hand smoke[17]
- Exposure to second-hand smoke is a cause of lung cancer and heart disease[18]
- Reducing people's exposure to tobacco smoke will reduce the disease burden on adults and children. In addition the introduction of smoke-free public places has been linked with a reduction in smoking prevalence – people use the move to smoke-free as an opportunity to quit, and consequently derive all the benefits to health that quitting smoking brings[11]
- So far as the workplace is concerned, tobacco has an impact on employees health and fitness for work. Tobacco will cause the premature death of half of all regular smokers, and of these a half will die in mid life, that is between the ages of 45 and 69[19]. Of those smokers who are not killed by their habit, many will experience tobacco related disease. This means that organisations are at risk of losing valuable and experienced employees at a time when pressure on the labour market is increasing due to the ageing of the working population. Helping smokers quit the habit and becoming a truly 'smoke-free organisation', reduces this pressure on the labour force.

The Business Case

- At the macro economic level the introduction of a smoking ban in Scotland has been estimated over a thirty year period to be a positive, net present value gain of around £4620 million pounds (the mid point of a range from £55 million to £7395 million)[20]
- The economic impact of smoking on the workplace is well documented with factors influencing costs including time away from the workplace in order to smoke a cigarette, and increased costs due to higher levels of sickness absence and lost productivity[21]
- Having a comprehensive smoke-free policy which has been developed through consultation and in partnership with the workforce results in the employer being seen in the wider community as 'caring', and this is recognised as being important in terms of both recruitment and retention.

5 Overcoming Likely Challenges and Obstacles

The smoke-free legislation protects the health of employees, patients, residents, clients and visitors. It is comprehensive and mandatory. Yet there may still be those who are unhappy about its implementation. This section provides some of the counter measures that can used to help people overcome their opposition. If the introduction of the smoke-free law is being used as an opportunity to develop a comprehensive tobacco control policy then addressing the issues below should be an important element of the policy development process. It is important for policy development and implementation to be approached in a sensitive and supportive manner including, as covered in section 6, signposting support which is available for those who wish to quit as a result of the introduction of smoke-free policies.

The resistance of managers and employees

Despite widespread public support for smoke-free legislation [22], some employees and managers, may resist any restrictions on their ability to smoke during the working day.

Keeping them fully aware of the developmental process, providing opportunities during that process for consultation and involvement can all help. Of particular importance is that when an employee puts forward an opinion or point of view, this is acknowledged and followed up. The member of staff should be given feedback on what action has been taken in response or why their view has not been acted on, or if they were asking a question, an answer should be given.

Staff representatives should be fully involved in the developmental process, and equally involved in any consultation. Consultation should not only be through or with the staff representatives. It should include all staff, and communication channels, such as the intranet and staff newsletter, which can help greatly in this context.

Ultimately all staff must accept that the organisation is adopting this new approach to tobacco because it has a statutory responsibility to do so, and that in going beyond the legal requirements it is seeking to protect and promote the health and wellbeing of people associated with it.

The resistance of service users / clients / patients

So far as these groups are concerned the key to overcoming any resistance is communication, communication, communication.

Investing in good communication practice with these groups during the development phase, prior to and following the launch of the new approach, is central to its success.

While posters and signs have an important role to play, it is better to correspond and engage directly with these groups. The key opinion formers need to be approached, briefed and asked to support the move to smoke-free. Once their support has been gained it should be given a high profile.

The appropriateness of ventilation as a way of keeping designated smoking areas functioning in the longer term?

Second-hand smoke, and the substances it contains, including more than forty carcinogens, **cannot** be controlled by ventilation, air cleaning, or by positioning smokers as far away as possible from non-smokers. Ventilation is a solution promoted by the tobacco industry but there are many studies which show that ventilation does not remove the harmful substances... as one expert states, ventilation would need to achieve "tornado like levels of air flow" to achieve a minimal risk[23].

Ventilation is not the solution so far as second-hand smoke is concerned. It does remove the smell and the colour of the smoke; it does not fully remove the harmful substances it contains[24]. So while the air in a ventilated room may look and smell good, in reality it isn't harmless.

Given the evidence, which indicates that harmful substances remain in a ventilated room, does ventilation have any role to play? The answer is a cautious 'Yes'. In residential care settings, ventilation can be used in a completely independent smoking area, properly separated by air tight doors to 'pull' air through the room and then to the exterior. As has been indicated previously, the external vent needs to be carefully positioned to ensure that the air containing smoke is not able to drift into other rooms in the building through open windows or doors. Under no circumstances should air containing smoke be allowed to enter common ventilation ducts i.e. ducts which are used to circulate or carry air to other rooms in the building. It must be remembered that even though the air passing through the room is colourless and to a large extent odourless, it is not safe.

Better that people smoke where we can see them?

People will be committing an offence if they are smoking in no smoking premises, and those in control of the premises will also be committing an offence of allowing that person to smoke. It is important that the consequences of breaking the law are clearly communicated and understood.

Smokers in breach of the law will be subject to a fixed penalty notice and those permitting smoking on their premises may be subject to prosecution. There will be a national compliance phone line to support the legislation, to which complaints may be made about people smoking in no smoking premises and all complaints will be investigated.

The smokers' rights lobby

There is public support for the move to greater smoking restriction in the workplace and in public places. Trades unions are supportive and in surveys undertaken among workers and the general public, support remains consistently high.

It is important to be clear with people that the legislation and associated workplace and public place restrictions on smoking do not call into question an adult's right to buy and smoke tobacco. Instead, in line with policies about drug and alcohol use, they make clear the circumstances in which tobacco may not be used.

Restricting the times and places where smoking is permitted is necessary because smoking produces a toxic substance, which is damaging to health. The key issue is not whether a person smokes, but when and where they do so and the impact this has on other people.

6 Smoking Cessation

The legislation does not require the provision of support to smokers who want to stop smoking. The provision of such support is however recognised good practice and as such is an essential component of the Scotland's Health At Work bronze award. Some of the most significant health benefits to be gained when premises become smoke-free will only be realised if smokers see the move to smoke-free status as an opportunity or trigger to stop smoking, and are provided with support and encouragement to help them do so.

Encouraging people to quit the habit, by raising awareness of the health and other benefits linked to cessation, is something that all employers and service providers can do. They can also raise awareness of the cessation services available in their locality and encourage people to access them. Employers may consider offering cessation services. The benefits of stopping smoking include a direct benefit to the health of the individual, as their risk of developing tobacco related disease reduces.

The following table indicates the reduction in risk once someone has quit smoking:[25]

Prevents continued steep decline in lung function	Almost immediately
Reduces risk of low birth weight in infants and complications in pregnancy	Within weeks
Reduces risk of sudden death from cardiac event	Within months
Reduces incidence of respiratory infections	Within months
Reduces severity of asthma attacks	Within months
Reduces risk of cardiovascular disease	Within a year
Prevents continued steep rise in risk of lung cancer	After several years
Reduces risk of other cancers	After several years

This reduction in risk should result over time with a fall in sickness rates, and in these days of an ageing workforce should reduce the impact of tobacco related disease on the workforce, especially when measured in terms of the premature retirement and the premature death of experienced and valuable workers.

Responsible organisations can offer valuable support to staff, patients, clients, residents and visitors by publicising smoking cessation services and encouraging staff to access them.

Managers should contact the local NHS providers of cessation services and information on the benefits of stopping and how to stop should be made widely available.

Similarly the 0800 84 84 84 Smokeline number should be widely publicised.

Smoking cessation and hospitals – in-patients

In September 2004 new guidelines for smoking cessation services were published by NHS Health Scotland and ASH Scotland. The guidelines highlight the importance of hospital patients being given the opportunity to quit smoking, as well as the importance of cessation services being available to workplaces. "All health professionals should have access to information on the smoking status of their patients and should ensure that smokers have been advised to stop. All smokers making an attempt to stop should be strongly encouraged to use specialist smoking cessation services (which offer group or individual counselling with Nicotine Replacement Therapy - NRT). Patient groups such as hospital in-patients and pregnant smokers should be offered smoking cessation treatment appropriate to their circumstances at locations and schedules to suit them. Where practicable, smoking cessation services should offer outreach services to non-NHS locations such as workplaces and prisons"[26].

In preparing prospective in-patients for their stay in hospital, the best option is to encourage smokers to give up the habit. Steps can be taken to help them give up the habit before, during and after their stay in hospital. Patients being admitted for elective procedures should be advised that the hospital operates a smoke-free policy and should be provided with information about the benefits of stopping smoking as far in advance of their stay as possible. They should be given the contact details for the local NHS cessation services and the Smokeline number (freephone 0800 84 84 84) or encouraged to see their GP for help.

Where possible all hospitals should be able to offer a cessation service to in-patients.

On discharge patients, who have either tried to stop smoking during their stay in hospital or have expressed an interest in quitting the habit should be referred on to the community based cessation services

Out-patients. Out-patient departments should promote smoking cessation via signs, notice boards and the referral of patients to smoking cessation programmes either in the hospital or via the NHS cessation services.

Adolescent smokers (under the age of 16). Adolescents who are regular smokers should be encouraged to quit the habit either via their outpatient clinic or prior to or during their stay in hospital. The NHS cessation services and the Smokeline are able to provide tailored advice for this age group.

Cessation issues for local authorities and care service providers

So far as staff is concerned, anyone who wishes to stop smoking should be encouraged to do so. Some employers, recognising the benefit which cessation brings, offer to support the individuals by giving them time off to attend a cessation group – as an example, employees may give fifty percent of their own time to attend a cessation group and this contribution is matched by the employer.

It is important to promote local NHS services and they may be able to come into the organisation, if demand is sufficient and a group would be of a viable size.

For residential client groups, including young people, cessation is very important. Young people should be put in contact with the NHS cessation service. Older people may feel that as they have smoked for many years, the health benefits of quitting will be lost to them. However smoking later in life has been associated with higher rates of physical disability, poorer self-perceived health status, higher levels of depressive symptoms and lower levels of physical function, bone mineral density, pulmonary function and muscle strength[27]. Consequently smoking cessation for older people can bring about major improvements in their general health and wellbeing.

A note on cessation methods – traditional or alternative?

Our understanding of what works so far as smoking cessation is concerned is based on many years of experience and a wide variety of studies. The move towards evidence-based practice is particularly pertinent for smoking cessation where many purprted remedies are available – often expensive and with little evidence to support their efficacy.

We know that the cold turkey approach will result in around 5 in 100 quitters being successful, and advice from a health professional, plus the use of pharmacological products, could see more than 20% of quit attempts being successful[26]. Research by the Cochrane collaboration is recognised as being an excellent, up to date source of reliable information on treatment outcomes. Reviewing the evidence reveals that, “Hypnotherapy is recognized as being popular but has not been found to have a specific effect above simple counselling. Acupuncture has been studied and found not to have any specific effect. St John’s Wort – there are no published trials showing a benefit in aiding permanent smoking cessation.” [25]

In essence organisations wanting to help staff or clients quit smoking should be wary of purchasing alternative sources of treatment.

Two key questions which might be asked before purchasing a smoking cessation product or service are therefore:

- How much will this cost? NHS cessation services are free and if they recommend the use of NRT or other pharmacological cessation aids then these are available on prescription
- Is there clear, objective evidence to support any claims made by the potential supplier that their service / product is effective, and if claims are being made, have they been reviewed independently? NHS cessation services have been evaluated and have been shown to be effective in increasing the chances of successfully stopping smoking.

7 Checklist for Action

Action	Required for compliance	Evidence of good practice
Are all reasonable steps being taken to ensure that all staff, visitors and customers are not smoking on the premises, including the removal of ashtrays?	✓	✓
Is signage of the correct size and positioned correctly?	✓	✓
Has the organisation developed a comprehensive tobacco control policy?		✓
Has the organisation developed and implemented a policy with staff to ensure that infringements by employees, customers, members etc. are dealt with under agreed procedures?		✓
Does the organisation promote smoking cessation to staff, patients, clients and visitors?		✓
Have links been established with local NHS cessation services?		✓
Are the tobacco policy and smoke-free status of the buildings regularly monitored, reviewed and evaluated?		✓

Appendix
1 Further detail on the legislation

There are three sections to this Appendix. Section 1 deals with the legal requirements, Section 2 is a list of those premises classified as no smoking premises under the law and Section 3 is a list of the exemptions to the law.

Section 1
The legal requirements

The Smoking, Health and Social Care (Scotland) Act 2005 & The Prohibition of Smoking in Certain Premises (Scotland) Regulations 2006

Part 1 of the Smoking, Health and Social Care (Scotland) Act 2005 prohibits smoking in certain 'wholly or substantially enclosed' places. It sets out the offences relevant to the Act, the penalties for non-compliance, the requirements for display of no smoking notices and gives powers to authorised officers of the appropriate council to enforce the law.

The Prohibition of Smoking in Certain Premises (Scotland) Regulations 2006, made under the Act, set out the premises prescribed as no smoking and those premises (or parts of premises) which are exempt. They also make further provision in relation to the display of no smoking notices.

A copy of the Act and the Regulations can be obtained from www.clearingtheairscotland.com, or by contacting the Scottish Executive's Tobacco Control Team at St Andrew's House, Edinburgh EH1 3DG, tel 0131 244 5660 or e-mail info@clearingtheairscotland.com

Frequently asked questions from businesses and responses can also be found on the web site and you can e-mail for further information if your query is not shown.

Some relevant definitions, as set out in the Act or Regulations, are given below:

'No smoking premises' – these are premises which are 'wholly or substantially enclosed' and which are set out in Schedule 1 to the Smoking Regulations (listed at Section 2), subject to any exemptions set out in Schedule 2 (listed at Section 3).

The kinds of premises which can be defined within the regulations as no-smoking premises are limited under the Act to one of 4 categories of premises, namely:

- Premises to which the public or a section of the public has access
- Premises which are being used wholly or mainly as a place of work
- Premises which are being used by and for the purposes of a club or other unincorporated association; or
- Premises which are being used wholly or mainly for the provision of education or of health or care services.

'Smoke' means smoke tobacco, any substance or mixture which includes it or any other substance or mixture; and a person is to be taken as smoking if the person is holding or otherwise in possession or control of lit tobacco, of any lit substance or mixture which includes tobacco or of any other lit substance or mixture which is in a form or in a receptacle in which it can be smoked.

a. **'Premises'** includes -
(i) any building or part of a building;
(ii) any structure or part of a structure, whether moveable or otherwise;
(iii) any installation on land or offshore;
(iv) any tent, marquee or stall; and
(v) any vehicle.

b. **'Wholly enclosed'** means-
(i) for premises other than a vehicle or part of a vehicle, having a ceiling or roof and, except for doors, windows and passageways, wholly enclosed, whether permanently or temporarily; or
(ii) for premises that are a vehicle, or part of a vehicle, having a top or roof and, except for doors, windows and passageways, wholly enclosed, whether permanently or temporarily.

c. **'Substantially enclosed'** means –
(i) for premises other than a vehicle or part of a vehicle, having a ceiling or roof and, except for doors, windows and passageways, substantially enclosed, whether permanently or temporarily; or
(ii) for premises that are a vehicle, or part of a vehicle, having a top or roof and, except for doors, windows or exits, substantially enclosed, whether permanently or temporarily,
and in determining whether premises are 'substantially enclosed', no account is to be taken of openings in which there are doors, windows or other fittings that can be opened or shut;

d. Premises shall be taken to be **'substantially enclosed'** if –
(i) the opening in the premises has an area; or
(ii) if there is more than one, both or all those openings have an aggregate area,
which is less than half of the area of the walls, including any other structures serving the purpose of walls, which constitute the perimeter of the premises.

e. Where an opening is in, or consists of the absence of, such walls or other structures or a part of them, their area shall be measured for the purposes of paragraph (d) as if it included the area of the opening; and

f. **'Has access'** means has access whether on payment or otherwise, and whether as of right or by virtue of express or implied permission.

In relation to exempted premises (see Section 3 of this appendix), the Regulations also provide the following definitions:

'Designated room' means a room which –

(a) has been designated by the person having the management or control of the no smoking premises in question as being a room in which smoking is permitted;
(b) has a ceiling and, except for doors and windows, is completely enclosed on all sides by solid floor-to-ceiling walls;
(c) has a ventilation system that does not ventilate into any other part of the no smoking premises in question (except any other designated rooms); and
(d) is clearly marked as a room in which smoking is permitted.

'Designated hotel bedroom' means a room which –

(a) is set apart exclusively for the sleeping accommodation of travellers;
(b) has been designated by the person having the management or control of the hotel as being a room in which smoking is permitted;
(c) has a ceiling and, except for doors and windows, is completely enclosed on all sides by solid floor-to-ceiling walls;
(d) has a ventilation system that does not ventilate into any other part of the hotel (except any other designated hotel bedrooms); and
(e) is clearly marked as a bedroom in which smoking is permitted.

Appendix 1

Section 2
"NO SMOKING PREMISES"
(as listed in Schedule 1 to the Regulations)

Those premises which fall within the scope of the legislation, having been classed as "no smoking premises", are

1. Restaurants.
2. Bars and public houses.
3. Shops and shopping centres.
4. Hotels.
5. Libraries, archives, museums and galleries.
6. Cinemas, concert halls, theatres, bingo halls, gaming and amusement arcades, casinos, dance halls, discotheques and other premises used for the entertainment of members of the public.
7. Premises used as a broadcasting studio or film studio or for the recording of a performance with a view to its use in a programme service or in a film intended for public exhibition.
8. Halls and any other premises used for the assembly of members of the public for social or recreational purposes.
9. Conference centres, public halls and exhibition halls.
10. Public toilets.
11. Club premises.
12. Offices, factories and other premises that are non-domestic premises in which one or more persons work.
13. Offshore installations.
14. Educational institution premises.
15. Premises providing care home services, sheltered housing or secure accommodation services and premises that are non-domestic premises which provide offender accommodation services.
16. Hospitals, hospices, psychiatric hospitals, psychiatric units and health care premises.
17. Crèches, day nurseries, day centres and other premises used for the day care of children or adults.
18. Premises used for, or in connection with, public worship or religious instruction, or the social or recreational activities of a religious body.
19. Sports centres.
20. Airport passenger terminals and any other public transportation facilities.
21. Public transportation vehicles.
22. Vehicles which one or more persons use for work.
23. Public telephone kiosks.

Appendix 1

Section 3
Exemptions
(as listed in Schedule 2 to the Regulations)

Those premises (or parts of premises) which are exempt from the legislation are:

1. Residential accommodation.
2. Designated rooms in adult care homes.
3. Adult hospices.
4. Designated rooms in psychiatric hospitals and psychiatric units.
5. Designated hotel bedrooms
6. Detention or interview rooms which are designated rooms.
7. Designated rooms in offshore installations.
8. Private vehicles.

Appendix

2 The health and economic case for becoming smoke-free

The risks to health associated with smoking and tobacco smoke are clear and irrefutable. The Scottish smoke-free legislation addresses these risks in a direct and beneficial way. There is also, however, a strong economic case for going smoke-free, particularly for those involved in the care and treatment of those who are affected by tobacco-related diseases.

This section provides an overview of the health and economic case for going smoke-free.

What is passive smoking?

Passive smoking means breathing in other people's tobacco smoke. This smoke is often called environmental tobacco smoke (ETS) or second-hand smoke (SHS). It is made up of 'sidestream' and 'mainstream' smoke. Sidestream smoke comes from the burning tip of the cigarette and is the major component of SHS. Mainstream smoke is the smoke that is exhaled by the smoker.

What's in tobacco smoke?

Tobacco smoke contains over 4000 chemicals either in the form of particles or gases. Particles include tar, nicotine, benzene and benzo(a)pyrene. Some of these chemicals have marked irritant properties and 60 of them are known or suspected carcinogens (cancer causing substances). The gases include carbon monoxide, ammonia, dimethylnitrosamine, formaldehyde, hydrogen cyanide and acrolein[28].

There is no safe level of exposure to second-hand smoke.

Health risks from passive smoking

SHS has been labelled 'carcinogenic to humans' by the World Health Organisation's International Agency for Research on Cancer [15]. It has also been labelled a 'class A human carcinogen' by the US Environmental Protection Agency, along with asbestos, arsenic, benzene and radon gas [29]. The Scientific Committee on Tobacco and Health (SCOTH) reviewed the evidence on passive smoking in 2004 and confirmed that second-hand smoke represents a substantial public health hazard and that no infant, child or adult should be exposed to it [16].

Every year up to 1,000 lifelong non-smokers die in Scotland, as a result of exposure to second-hand smoke. Taking ex-smokers into account, it is estimated that this figure rises to between 1,500 and 2,000 deaths and represents a significant public health hazard [17].

SCOTH also reported that exposure to second-hand smoke is a cause of lung cancer and, in those non-smokers facing long-term exposure, there is an increased risk of 20-30% and that exposure to second-hand smoke is a cause of heart disease, with an increased risk for non-smokers of about 25%[30][16].

Exposure can also reduce lung function and coronary blood flow, irritate eyes, and cause headaches, coughs, sore throats, dizziness and nausea, as well as many other illnesses. It can trigger asthma attacks and cause serious respiratory illnesses, asthma and ear infections in children[14].

Exposure to second-hand smoke in pregnancy can lead to poor gestational growth, and low birth weight. Low birth weight is linked to neonatal mortality and complications in the health and future development of the child[31][32][33].

The health and economic impact of going smoke-free

The major reference for this section is the International Review of the Health and Economic Impact of the Regulation of Smoking in Public Places, which was carried out by the Health Economic Research Unit (HERU), Department of Public Health, University of Aberdeen, in 2004[20].

This Scottish Executive funded study was commissioned by NHS Health Scotland to provide a review of the latest evidence of the impact of smoke-free legislation and restrictions. The study combined a literature review with a modelling exercise to determine the likely impacts of regulation on smoking in public places in a Scottish context. As the study was not intended to be a full cost-benefit analysis, it did not look at implementation costs, compliance costs or the costs of any legislative process.

Based on the available literature, the study considered a range of impacts from restrictions on smoking:

- Reduced exposure to SHS in the workplace
- Reduction in smoking/increase in quit attempts by active smokers
- Reduction in number of deaths from major disease types
- Reduced costs of treating smoking related diseases
- Economic impacts on the hospitality sector.

The HERU study found strong evidence that exposure to SHS increases mortality and morbidity from lung cancer and coronary heart disease. There is also weaker evidence of an effect in relation to stroke and respiratory diseases. These results were found to hold true even after taking account of possible confounding factors and other potential sources of bias.

The HERU study reported on a US review that identified 17 studies of the effect of smoking restrictions / bans on exposure to SHS. These studies showed a reduction in exposure to SHS from both restrictions and bans, but an important distinction could be made, namely that the greatest reductions in exposure resulted from complete bans rather than partial restrictions. Though the studies covered a narrow range of workplaces, this was not expected to bias the results.

The study reviewed a large number of studies on the impact of smoking restrictions on cigarette consumption and smoking prevalence. Studies of the impact on smoking prevalence provided a wide range of estimates. This range may in part be due to the fact that smoking restrictions studied were in many cases accompanied by other smoking cessation interventions. The HERU study used a conservative central estimate (2% reduction) of the impact on smoking prevalence of smoke-free policies.

As with reduction in exposure, the HERU study found that while bans and restrictions were associated with reductions in smoking and increases in quit attempts by smokers, greater reductions in active smoking were associated with smoke-free policies than with partial restrictions. The study concluded that health gains in Scotland from reductions in active smoking may be at least as great as those from reduced passive smoking.

On the basis of available estimates, the HERU study forecast that a complete ban in Scotland would result in 219 deaths per year being averted from reduced incidence of lung cancer and CHD associated with exposure to SHS. Based on 13,000 deaths from smoking related diseases in Scotland per annum, reductions in active smoking were estimated to lead to a further 260 deaths per year being averted due to reduced incidence of lung cancer and CHD. These figures represent the best central estimate of lives saved after 20 years, with lives saved increasing in a straight line from zero to 219/260 over this period. Over the 30 year forecast period chosen by HERU, 4,490 lives would be saved from reduced exposure to SHS and 5,330 lives would be

saved through reductions in active smoking. Furthermore, these figures represent a conservative estimate, as only reduced deaths from lung cancer and CHD were included, and not reduced deaths from a variety of other disease types.

The HERU study converted lives saved into an economic impact based on studies of the value of life produced by the Department of Transport. The latest estimate provided by the Department of Transport for the value of a life is £1,249,150 (2002 prices). HERU adjusted this figure to account for the fact that deaths from smoking-related illnesses typically occur at a later age than road traffic accident fatalities. This gave a value per life saved of between £300k and £500k depending on disease type.

The economic impacts of restrictions on smoking in public places were considered. The literature considered by the HERU study suggested that overall there would be productivity gains from reduced smoking breaks, though whether any individual business gained or lost from the introduction of a complete ban would depend on the extant smoking policy for those premises. The study also derived estimated cost savings from reduced absenteeism due to reduced passive and active smoking, reduced fire hazards associated with a ban on smoking and reduced cleaning and decorating costs.

The HERU study gave separate consideration to the effect of smoking restrictions on the hospitality sector. Hospitality sector impacts were considered in terms of the impact on trade and split into impacts on restaurants, bars and hotels/tourism. Evidence from studies on the impact on hospitality sector was not as robust as the evidence available on health effects. In general it was found that studies had failed to find any statistically significant results. However, where evidence was available the results of the studies were reasonably consistent. The impact on the hospitality sector was calculated with reference to these studies and this figure was adjusted to account for expected offsetting expenditure elsewhere in the economy. This gave a net annual impact on the hospitality sector which was used in estimating the overall economic impact of a smoking ban.

As part of the HERU study, a model of the overall economic impact of a smoking ban in Scotland was constructed. The model was based on the evidence obtained on the various types of impact resulting from the smoking ban, as set out above. For each type of impact, for which a monetary value could be established the study projected the future value of costs and benefits in each year over a 30 year appraisal period. Future values of costs or benefits were then discounted to give net present values (NPVs).

An economic value was placed on the following impacts of the smoking bill (NPV (£m) of central estimate in brackets):

1. **Health Benefits**
   - The Economic Value of Lives Saved: a) as a result of reduced exposure to ETS (1024) and; b) as a result of reduced levels of active smoking (1216)
   - Savings in the human cost of ill health (morbidity savings) as a result of reduced exposure to ETS (144). (Savings in the human cost of ill health, aka morbidity savings, as a result of reduced levels of active smoking were not valued)

2. **Resource Savings**
   - Reduced NHS Treatment Costs: a) as a result of reduced exposure to ETS (60) and; b) as a result of reduced levels of active smoking (31)
   - Reduced Sickness Absence Savings: a) as a result of reduced exposure to ETS (46) and; b) as a result of reduced levels of active smoking (9)
   - Productivity gains as a result of reduced smoking breaks (1403)
   - Cost savings from reduced fire hazards (94)
   - Reduced cleaning and decorating costs (222)

3. Hospitality Sector Impacts

- Impact on the hospitality sector (369)

The robustness of the study results was extensively tested by HERU. In addition to the central estimate, 'low' and 'high' scenarios were tested based on much less, and much more, advantageous outcomes of a smoking ban.

The total NPV for the central estimate is +£4,620m. This suggests that the introduction of the smoking ban might be expected to have a significant positive impact in Scotland over a 30 year period. The total NPV for the 'low' and 'high' scenarios were +£55m and +£7,395m.

The HERU report concluded that a negative NPV would only be found "under an unlikely combination of circumstances" and that "under reasonable assumptions the NPV will be positive."

All evidence reports referred to in this section can be accessed at www.clearingtheairscotland.com

Appendix

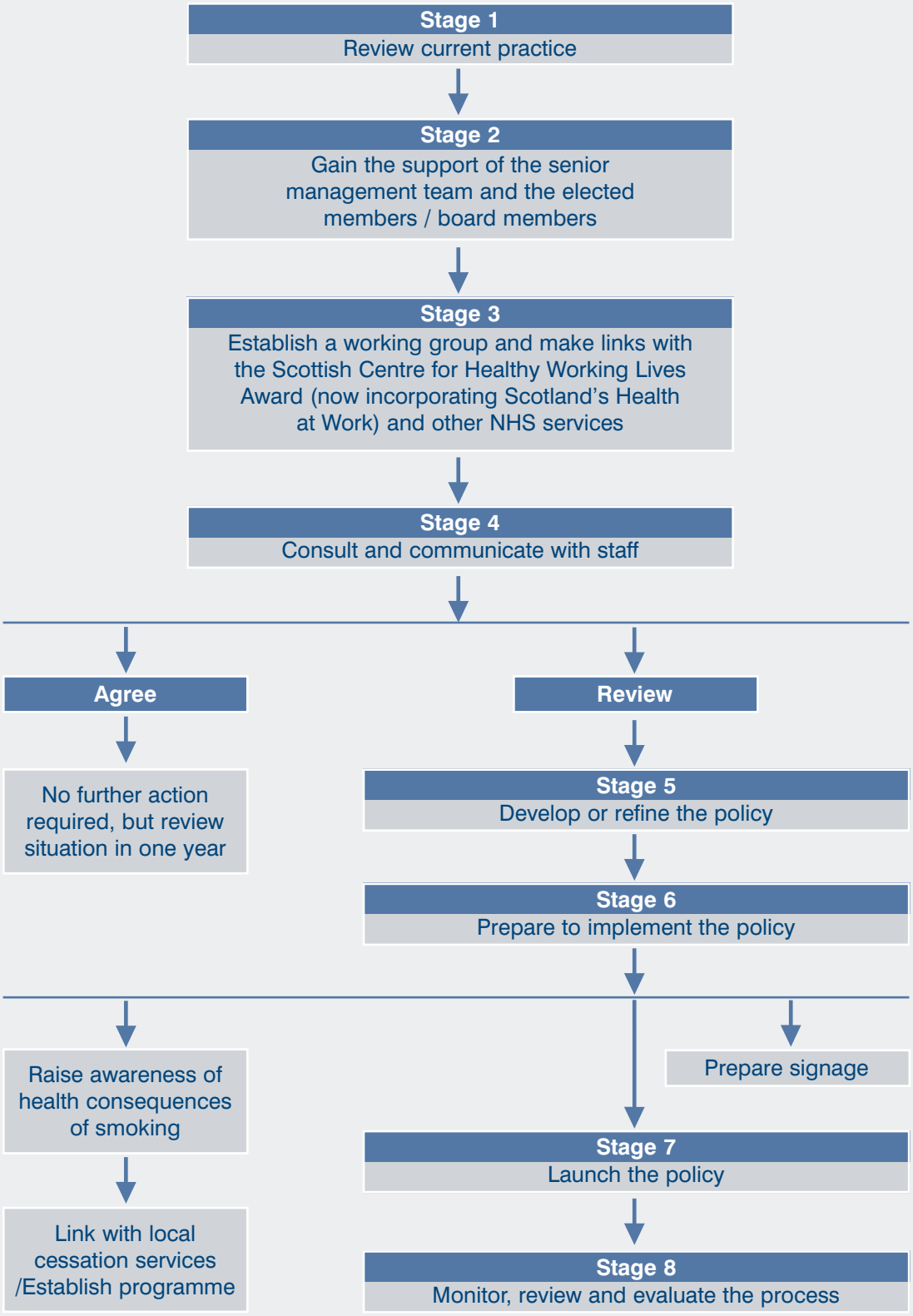
3 Practical guidance on preparing to become smoke-free

The smoothest, most straightforward and sustainable way to capture the opportunities and potential of the legislation (both at the organisational and individual level) is to be proactive and to plan ahead.

This section describes eight stages, with policy development at the heart of these, which can be taken now to make the move to full compliance and the creation of a health enhancing environment as straightforward and problem free as possible. The diagram shows these stages in schematic form, with a more detailed explanation following.

The latter part of the section considers issues specific to the types of organisation for whom this guidance has been written.

The major stages in the development of a comprehensive approach to tobacco



Adapted from 'Tobacco at work – guidelines for local authorities. Achieving the best outcomes'[3]

Stage 1 Review the current situation

Many NHS organisations, local authorities and care service providers will already have well established approaches to tobacco in place. Some, but perhaps not all, will have moved the organisation to smoke-free or almost smoke-free status. For these organisations there is no need to reinvent the wheel, rather review and evaluate how close the current position is to the approach that needs to be in place in order to comply fully with the legislation, identify any gaps and then put in place measures to close the gaps e.g. ensuring that signage is of the appropriate size and in the correct position.

For those organisations that have yet to formally tackle the issue of tobacco at work, it is still important to review the current situation, as it is common for such organisations to have an informal approach in place. The problem with this is that while it may seem to work well enough on a day to day basis, when a problem occurs, or when external requirements change, as is happening with the implementation of the law, the starting position is unclear. Reviewing what has been done informally, and then using the strong elements of that as a foundation, on which to build a comprehensive formal approach, centred on a clear and robust policy, is by far the best solution.

Stage 2 Gain the support of the senior management team and the elected members / board members

This step is an essential prerequisite for all workplace health and wellbeing processes. Employees need to know that the organisation they work for is fully committed to their health, safety and wellbeing. This is reinforced by the public or open support of the senior management team, which in turn gives added significance to the actions of the working group. Ideally a member of the senior management team should be asked to monitor the development and implementation of the policy. Meetings of the senior management team should receive regular reports on the developmental process.

For many public and private sector organisations the most senior decision making body is the Board (NHS and private sector organisations) or the elected members (local authorities). These groups also have a vitally important role to play in the development of a comprehensive approach to tobacco. All those who serve on one of these groups should be briefed at the outset and those with an interest in the organisation's HR function should be invited to be active participants in the review and consultation procedures. Once the process of development has been completed, members of these senior decision-making bodies should be asked to affirm their support for the measures being introduced, when the approach is implemented.

Stage 3 Establish a working group and make links with the Scottish Centre for Healthy Working Lives (now incorporating Scotland's Health at Work) and other NHS services

Setting up a working group, to take forward the development and implementation of a comprehensive approach to tobacco, has a number of advantages over giving this responsibility to just one person. These advantages include:

- It is an indicator of the organisation's commitment to the process, especially so if the working group reports to the senior management team
- It provides a forum in which a variety of professional viewpoints can be shared and discussed
- By including smokers and non smokers in the working group the needs of smokers can be easily identified, smokers will have more confidence in the process and having a smokers perspective in the working group can shorten the time of the developmental process.

- The group can become an advocacy body within the organisation, raising awareness of the need for a comprehensive approach and the measures that will be implemented
- Different members of the group can be tasked with different actions, thus speeding up the process (as opposed to one person doing them all).

Stage 4 Consult and communicate with staff

Consultation and communication are essential features in the development of a sustainable approach to tobacco at work. A number of methods can be used to both consult with and communicate with staff.

In terms of consultation any of the following tools might be used:

- Team briefings / meetings – issues can be raised and feedback invited. It is important that, if employees put forward views and opinions, they receive feedback on why or why not their views were acted on, once decisions have been taken.
- Staff meetings – the traditional way of communicating a message, but care needs to be taken to ensure that one or two employees don't derail the process. Contentious issues can often be better dealt with in smaller groups.

In terms of communication, in addition to the above (with the exception of self-completion questionnaires) the intranet, the organisations staff newsletter, notice boards and leaflets / posters can all be used to convey information about the new approach to tobacco.

Stage 5 Develop or refine the policy

The question might be asked, 'Why bother with a policy when the law is so clear in its requirements?' The answer is that a formal policy provides a number of benefits to the organisation. These include;

- It is a clear, unambiguous written statement to which all can refer, and which leads to a consistent approach across the organisation – equally important for small as well as large organisations
- It legitimises action being taken on the broader range of issues associated with a comprehensive approach
- It enables managers and others with responsibility for ensuring that the policy is adhered to, to clearly know what is required of them
- As Section 7 demonstrated, the use of tobacco has significant negative effects for the user and for the organisations in which they work. A comprehensive tobacco policy will address issues such as support for those who are trying to stop smoking, and it is in encouraging and helping smokers to quit the habit that the real health and organisational benefits will be seen.

A note on 'comprehensive' policies

The term 'comprehensive policy' has been used several times already in this guidance, but what does the term mean?

A comprehensive tobacco policy is one that tackles in a positive way the wide range of issues associated with tobacco at work. It is not confined to a narrow focus on where people can and cannot smoke and what will happen to them if they do. Rather it provides information on a wide range of workplace related tobacco issues, including, for example, the provision of support to those trying to stop smoking, the creation of links with the local providers of NHS cessation advice and support, the taking, or not taking, of breaks away from the building which employees

can use to smoke a cigarette, and the way in which managers and others are expected to enforce the policy. For organisations who provide domiciliary visits, the policy should also address the issue of client smoking.

A typical workplace tobacco policy should be clearly and succinctly written and would consist of the following elements:

- **Rationale** - The reasons behind the approach being adopted
- **Statement of Intent** - A clear statement setting out the organisation's parameters, rules and procedures for dealing with the issue of tobacco
- **Background Information** - Key data and facts about the company / organisation's previous position on tobacco, the legal obligations it is now under, plus information on the dangers of smoking
- **The Objectives** (of the Policy) e.g.
  - To comply with The Smoking, Health and Social Care (Scotland) Act 2005
  - To ensure that there is minimal exposure of employees to tobacco smoke whilst on the organisation's premises or while engaged in the organisation's business
  - To ensure that the health and wellbeing of employees is protected and enhanced
  - To provide a consistent approach to break entitlements for smokers and non-smokers
- **Application of the policy** - Clearly state that the policy applies to all employees, sub-contractors, residents, clients and visitors
- **Smoking Provision** - Clearly indicate precisely where (if at all) smoking will be permitted on the organisation's site(s). This should only be for long stay patients / clients and then only in designated smoking areas.
- **Exemptions to smoke-free areas** - Outline where these will be established, who can use them (patients / residents, not staff and visitors), how they will be separated from the rest of the building and how tobacco smoke will be prevented from reaching the rest of the building
- **Employee welfare** / **Cessation support** - Outline how cessation support will be available to staff – either internally or externally, and how this can be accessed
- **Failure to Comply** - Indicate the process for dealing with staff who breach the policy
- **Effective date, monitoring and review** - To be legally binding a policy must have a date of implementation. Formal reviews of the policy should take place at least every two years, although for a new policy, an initial review after twelve months is recommended.

If your organisation is tackling the issue of policy development for the first time, then the following sources of advice and information may be helpful:

The ASH Scotland website:
http://www.ashscotland.org.uk

Tobacco Information Scotland:
http://www.tobaccoinscotland.org.uk

The Scottish Centre for Healthy Working Lives:
http://www.healthyworkinglives.com

The Advisory, Conciliation and Arbitration Service Advisory booklet –
Health and Employment (2001) http://www.acas.org.uk

Stage 6 Prepare to implement the policy / approach

Once the policy / approach has been finalised and given corporate approval, steps need to be taken to ensure that everyone associated with the organisation is familiar with it and the requirements it places on them.

All staff should be informed of the new policy / approach – this includes those who may work at a distance from the centre of the organisation, as well as those who work during the evenings and nights. Ideally they will be given something in writing, which explains the new situation, as well as receiving an oral briefing from a manager. Information about the new approach should, as a matter of course, be included on the organisations web site etc. Managers should understand their duties in relation to enforcing the policy among clients / members of the public as well as staff.

All existing clients and patients should be informed of the new situation by receiving something in writing and a clear oral explanation from someone from the organisation who is known to them.

All prospective patients and clients should receive a letter indicating the organisation's approach to tobacco several weeks in advance of their admittance – receiving it only a short time before does not enable them to amend their own smoking behaviour, in the light of the information they will have received.

Any materials / correspondence with patients and clients must contain information on the importance of smoking cessation for them; how they can access smoking cessation and support, both prior to and during their stay in the establishment and where they can receive follow up support should they return to their own homes.

Each of the above actions is enhanced when the organisation is able to publicise its new approach. Good PR can be obtained when organisations show to the general public the actions they are taking to promote the health and wellbeing of their staff, client and patient and user groups. For those organisations who are able to, the issuing of a press release creates a positive level of background awareness and reduces, to some extent, the likelihood of a person being surprised when they arrive, either as a client / patient or visitor, that they can no longer smoke while on the premises.

Other means of raising awareness include the use of signs and posters. Signs are a very important tool to indicate to people where they cannot smoke and are required as part of the legislation. Large signs at the entrance to sites, which are branded with the organisation's logo (always a good thing regardless of the size of the sign), establish very quickly that the organisation is committed to the process of going smoke-free. The important thing about signs is that they should be clear, readable and appropriately placed i.e. within people's line of sight. The mandatory requirements for signage in the smoke-free legislation are outlined in Section 2.

In the lead up to the day of the launch of the new policy posters can be a useful way of keeping the issue in the forefront of people's minds. Count down posters, posters with important health and wellbeing messages can positively reinforce the message that this organisation is taking a big step forward, in terms of health and wellbeing, and that people should be prepared for it.

Of key importance is the inclusion on such posters of information on where help and support to quit smoking can be obtained. This is a period of time when many staff will be actively considering this option. Helping them to take action is an important means of improving their health and over the longer term the health of the organisation. To be effective however, posters need to be widely – not sparingly – used. One poster hidden among many will not be effective. Posters which are changed frequently and which are prominently positioned in many locations will contribute to a raised level of awareness.

Stage 7 Launch the policy / approach

Once the approach / policy has been developed and agreed it needs to be launched. The date of the launch should be known in advance and as the previous section has indicated, measures put in place to ensure that everyone, who should know, does know that from the specified date the organisation will be adhering to the new position. Mandatory requirements must be implemented on or by 26th March 2006.

Having a clear launch date, often accompanied by some activities to support it – health fair, competitions etc. gets things off to a positive start. The alternative is to have a low key implementation with little awareness raising and associated activities. The risk associated with this approach is that the opportunity to promote the organisation's positive stance on health and wellbeing is lost, and that the opportunity for people to change their behaviour, so far as tobacco is concerned, might also be significantly diminished. Levels of resentment might also increase, as staff could feel that the new approach has been surreptitiously introduced.

Stage 8 Monitor, review and evaluate the process

An essential element of any organisational activity which focuses on staff health and wellbeing, and which also involves patients, visitors and clients, is the assessment of the short and long term outcomes, e.g. the impact on staff, resistance to the approach, the ease with which managers are able to enforce the approach and so on.

Responsibility for monitoring, reviewing and evaluating the process can be left with the working group, or it could be taken over by others, such as representatives of the human resources department. The key issue is that regardless of who is ultimately responsible for it, the process actively engages with the groups who are affected.

Key issues that need to be addressed include:

- How well is the approach working?
- Are there are any problem areas – frequent breaches of the policy / approach, issues of poor or inconsistent enforcement, poor communication with staff, patients or service users etc.? If there are problem areas what can be done to improve the situation?
- How do staff feel about the approach, do the staff continue to support it, if not why not?
- How do other stakeholder groups feel about the approach?
- Are there any elements of the approach that need to be amended in some way?

Once the evidence has been collected and reviewed, measures can be put in place to strengthen those areas that have been revealed to be weak. Under no circumstances does this mean moving away from a strong position on tobacco use and the need to be smoke-free, rather it may be that key groups need to be reminded of the rationale for the approach, managers might need to be trained, so that they are better able to enforce the approach etc.

While review should be a constant process, the commonly held position is that a formal review should be undertaken within twelve months of the approach being implemented and thereafter at two yearly intervals.

A note on enforcing the new policy

If the situation that has occurred in other countries that have gone smoke-free is repeated in Scotland, then the encouraging point to note at the outset is that enforcement should not be a major issue. This is especially so where there is a high level of public support for the measures, which research indicates that there is in Scotland [22]

Nevertheless people affected by the policy / approach need to be aware that it is underpinned by enforcement measures. Despite this it would be remarkable if these were not called into use at some time.

Within an organisation enforcement of a policy usually lies with managers. It is vitally important that if this is the case then they are aware of the implications of the policy themselves and are trained and / or supported as they seek to perform their enforcement role. Managers and staff need to be reminded of the terms of the smoke-free legislation and that it is a criminal offence to fail to comply.

Key steps in this process are:

a. Prior to the launch of the policy –

- Clear links should be established between the tobacco policy and other HR policies such as the Disciplinary Policy and the Health and Safety Policy
- All managers are briefed on the policy and have an opportunity to discuss the issue of enforcement and their role
- All managers receive training on the specifics of enforcement – how to raise the issue with a member of staff suspected of breaching the policy; collecting evidence; making a record of the discussions with the individuals concerned etc.
- All staff is made aware of their responsibilities and of the consequences of being in breach of the policy.

b. Around the launch of the policy

- While all the positive messages about the improvement to the working / living environment and people's health and wellbeing are promoted widely and positively, reference should still be made to enforcement measures i.e. the issue remains alive.
- Anyone found to be smoking in breach of the policy at this time should be warned about their future action and the workforce as a whole might be made aware (in an anonomised form) that x people have been warned and more significant action will follow for anyone found in breach of the policy from a predetermined date.

c. Collecting evidence of a breach and the Human Rights Act

- The European Convention for the Protection of Human Rights and Fundamental Freedoms contains a number of Articles, which have implications for employment practice. The Human Rights Act states that: "it is unlawful for a public authority, including a court or tribunal to act in a way that is incompatible with a Convention Right."
- An employer would have to be mindful of how evidence was collected to verify that a breach of a workplace smoking policy was taking place. If, for example, the employer installed a video camera to monitor a designated non-smoking area, in which employees were smoking, and dismissed an employee on the grounds that he / she had been videotaped smoking in the non-smoking area, an Employment Tribunal would have to decide if the evidence had been collected in a way that was compatible with the employee's Human Rights.

d. Cessation support

- Someone found to be in repeated breach of the smoke-free policy is likely to end up passing through the full measure of the disciplinary process. The process could, however, be put on hold, pending their successful completion of a smoking cessation course.

  It might therefore be advantageous to have established links with local providers of NHS cessation services, prior to the policy being implemented, and also to have in place a mechanism that enables the employer to contact the cessation service, in order to verify that a) the individual has participated in the course and b) completed it successfully.

  The employee should be informed when the cessation option is proposed that this information will be sought.

Appendix

4 References and further resources / information

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Further resources / information

If your organisation is tackling the issue of policy development for the first time, then the following sources of advice and information may prove to be helpful:

i. The ASH Scotland website: http://www.ashscotland.org.uk

ii. The ASH website: http://www.ash.org.uk

iii. ACAS. *Health and employment*. London: ACAS, 2005. [online] Available from: http://www.acas.org.uk/index.aspx?articleid=693 [Accessed 28 November 2005]

iv. The Scottish Centre for Healthy Working Lives (now incorporating Scotland's Health at Work) http://www.healthyworkinglives.com

v. A Simple Guide to smoking policies in the workplace – NHS Health Scotland http://www.healthscotland.com

If you need information on smoking cessation / cessation support – posters, leaflets, No Smoking Day etc. then go to:

i. Your local NHS Board

ii. Smokeline – 0800 84 84 84

iii. No Smoking Day organisation: http://www.nosmokingday.org.uk/

If you work in the NHS and require information about the Partnership Information Network Guideline on managing health at work go to:

http://www.scotland.gov.uk/Resource/Doc/47032/0013906.pdf).

Information on a range of issues connected with smoking in public places and work places, including the health and economic impacts of tobacco in Scotland, can be found at:

http://www.clearingtheairscotland.com/research/consultation-reports.html

Tobacco Information Scotland (TIS) is a new initiative from the ASH Scotland Information Service. TIS was developed to provide the best possible gateway to tobacco-related information in Scotland, providing access to key policy documents and guidelines, statistics, and health promotion materials.

http://www.tobaccoinscotland.org.uk

This legislation offers an historic opportunity to improve levels of public health in Scotland and to reduce health inequalities, both now and for future generations.