Public Health Interventions Advisory Committee (PHIAC)

PHIAC 8: Minutes of meeting 20 November 2006

Workplace Smoking,
Draft Scope: older people& mental health.

Attendees	*Members* Catherine Law (Chair), Sue Atkinson, Mike Bury, KK Cheng, Philip Cutler, Ann Hoskins, Ruth Hall; Muriel James, David Jones, Matthew Kearney, Susan Michie, Klim McPherson, Mike Rayner, Mark Sculpher, David Sloan *NICE* Mike Kelly (MK), Tricia Younger (TY), Lesley Owen (LO), Patti White (PW) Clare Wohlgemuth (CW)(afternoon only), Linda Sheppard (LS) (afternoon only) *Contractors* Kirsten Bell (KB)(British Columbia Centre of Excellence for Women's Health), Paul Trueman (PT) (York Health Economics Consortium),Sarah Flack (SF) (YHEC), Ann McNeill (AM) (University of Nottingham), Adam Crosier (AC). *Co-optees and experts from the Smoking Cessation PDG* Deborah Arnott (DA) Action on Smoking and Health, Ian Gray (IG) (Chartered Institute of Environmental Health), Andrew Hayes (AH) London Regional Tobacco Policy Manager, Paul Hooper (PH) (West Midlands RTPM)
Observers	Sue Jelley, Alison Lake, Sue Latchem, (NICE)
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File Ref	PHIAC 8 – 20.11.06 Minutes
Version	14.12.06
Audience	Members of PHIAC, PDG co-optees/experts, NICE workplace smoking and older people and mental health teams, BCCEWH, YHEC, University of Nottingham, NICE publishing and implementation teams

Agenda Item	Minutes	Action
1 Welcome and introductions (Chair) **2 Apologies**	Ruth Hall as Acting Chair, welcomed Members to the eighth PHIAC meeting. • All attendees introduced themselves • The Acting Chair informed the members that the Chair had been delayed but would join the meeting as soon as possible. • The Chair noted that the committee was not quorate, but would be later in the day when the Chair and other members caught up in transport problems arrived. It was agreed that if any decisions were reached before those members arrived, these would be re-visited when the committee should be quorate. Apologies received from Amanda Hoey, Cheryll Adams, Brian Ferguson, Andrew Hopkins; Dale Robinson, Simon Capewell, Sharon McAteer, Dagmar Zeuner, Alexander Macara (PDG co-optee), Hugo Crombie (NICE)	
3 Declaration of Interest (All)	Declarations of conflicts of interest in relation to workplace smoking were requested. Ian Gray and Paul Hooper (co-optees) stated that they may have a conflict of interests as they are currently contracted by the Department of Health to deliver the national smoke-free legislation training programme.	
4. Freedom of information (MK)	Mike Kelly notified members that the emails that are sent between meetings are subject to Freedom of Information legislation and therefore potentially available for external scrutiny.	
5 a-e. Workplace Smoking; consideration of the evidence	Kirsten Bell of BCCEWH presented the findings of the review on the effectiveness of interventions for smoking cessation in the workplace. This included a consideration of a recent Cochrane review and consistent evidence that interventions that are effective elsewhere are also effective in the workplace. However the evidence of effectiveness of interventions in jurisdictions where smokefree legislation had been introduced was limited and there was a general lack of UK based research. *Economic Evidence* Paul Trueman of YHEC presented the economic review on the workplace smoking cessation interventions. The economic evaluation will be presented at the next meeting on 5th December. There was little evidence but all the available studies suggest that workplace smoking cessation	

	interventions are cost effective. However most studies looked at costs and benefits over a one year or five year time span rather than a lifetime. *Current practice and the impact of the legislation* Ann McNeill of the University of Nottingham and Adam Crosier noted that most of the stop smoking services would like to increase capacity to expand their workplace-based activities. In Ireland and Scotland there had been an increased demand for smoking cessation driven by media campaigns before the legislation came into force. At this point the Acting Chair handed over to the Chair. The meeting was now quorate. The co-opted members gave their comments on the reviews and the presentations. These included: • New local delivery plans have already been agreed on the basis of 4 week quits. Funding for the services has been determined for the next 2 years but it is not secure. Services are funded locally and have to meet local targets. It is not clear who pays for Nicotine Replacement Therapy (NRT). • Health Care Commission Improvement review of the services has reported. • The implications of the ban for services will mean an increase in demand which the services are not currently resourced to meet. Small and medium enterprises, without their own occupational health services can be expected to increase demands on the services. • In small and medium enterprises (SMEs) temporary or casual staff are not easy to engage • The media campaign in England should increase uptake of smoking cessation services. • Services need to support SMEs but this is probably not feasible for the services and may be costly for them. A telephone backup service is needed. Online quit packages may be needed too. • Large employers may be encouraged to provide and fund services themselves. • Information may be needed on the use of NRT to help manage cravings. Other members of the committee made comments as follows:- *Comments on the reviews* • <u>Evidence statement 3: T</u>he study on women may equally apply to men. There may be a self-reporting bias in that men may say they are more able to quit.	

	• Evidence Statement 5: white males tend to smoke in larger numbers and tend to smoke earlier in the day and may be more dependent but it is a leap too far to suggest that white males may benefit more than others from motivational enhancements. Better to say that disadvantaged groups may benefit from greater motivational support for quitting. • Query on the statement that a multi-component approach to behaviour change may be more effective, no supporting data in the evidence table. • Query on ES5: the statement that combining occupational health with health promotion and other activities is not supported by the data in the evidence table KB agreed to look at these evidence statements again and revise accordingly.	BCCEWH team
6 & 7 Drafting recommendations	The discussion focussed on the following areas: *General focus of the guidance* • Consider standards for smoking cessation services that all providers should follow. • Guidance should focus on: the NHS services; the employers; voluntary sector and other providers eg QUIT, regulators eg Chartered Institute of Environmental Health and Health and Safety Executive • There may be leverage and influence through regional public health groups, government offices, regional development agencies etc • Interventions need to be: o on site and off site o before the implementation of the ban and longer term o vary according to the type or size of the employer/business • It might be useful to consider evidence on the added value of providing onsite interventions and evidence on the effectiveness of recruiting onsite to other external or off site services. There may be useful evidence from health promotion interventions other than smoking cessation. • Potentially the impending ban could lead to a marked increase in quit attempts so the guidance needs to focus on before the ban as well as after it. *NHS services* • What services should be delivered on site and how to attract people to off-site services. • What should the NHS Stop Smoking Services do to prepare for the ban. What is their role? Do they provide NRT?	

	• Guidance should focus on the NHS as an employer and as a provider of services. • Services do not have the capacity to cope with the increase in demand so must use limited resources to target the most disadvantaged • A package of interventions appears to work best *The needs of employers and SMEs* • Consider the effectiveness of added incentives to going down smoking cessation route • Employers should give employees time off to attend NHS SSS • Self help guides may be more important for some staff- but it is important to be clear that it is effective • Many SMEs do not have a concept of occupational health and general guidance won't tackle those SMEs where there is a strong peer norm and peer pressure to keep on smoking. • Guidance needs to be simple and easy to follow and low cost as there will be limited capacity in small businesses to implement the guidance. • Local authorities will be providing resources but it will be time limited *Cost effectiveness* • Cost effectiveness needs to be considered from the perspective of the employer and from the perspective of the NHS. Cost per QALY is important as is cost per quitter. • A two-pronged approach should not conflate the NHS perspective and the net costs to the employer. • The evidence that it is financially worthwhile for the employer to invest in smoking cessation may be lacking. Quick and easy interventions may be required. It may also be possible to use NHS resources to subsidise employee support. • If SME interventions do not make financial sense for them then it will be necessary to consider the cost effectiveness of NHS support to workplaces. It will be useful to know how much the NHS can spend on promotion and provision of smoking cessation and still be cost effective? • Incentives for employers are needed as their goals are profit maximisation not health gain • Let us assume that all smoking cessation interventions are cost-effective, it may not be necessary to demonstrate cost effectiveness from the employers perspective - unless we want employers to pick up the cost of the services. • It is unclear if going into workplaces to train advisers is cost effective. Training costs have been omitted from the cost effectiveness reviews.	

Many members commented on the need for thinking differently about implementation and made some helpful and practical suggestions.

MK suggested that CDC Atlanta were reviewing the literature on workplace health promotion and that some of these studies may be able to provide additional useful evidence, particularly on referral of staff by employers to offsite services. AH suggested that the European Network for Workplace Health Promotion might be another useful resource.

LO proposed the following grid:

Interventions*	Cost per QALY	Net benefit and costs (to employers)
Self help materials		
Brief advice		
Brief advice + NRT		
1to1 counselling		
Group counselling		

MK suggested the following plan:

Guidance should capture the following points:

1. Summarise evidence of effectiveness
2. Identify resource implications for interventions of choice
3. Context and time dimension
   - Anticipating implementation
   - Implementation
   - Post-implementation
4. Recommendations
5. Needs of:NHS as an employer,
   public sector employers,
   large private sector employers
   small and medium enterprises
6. Consider the unintended consequences of the ban and whether it will impact on services e.g. managing litter; people congregating around entrances to buildings; noise pollution, etc.

8. Next steps – process and timeline to consultation (TY)

TY outlined as follows:

- NICE project team to circulate draft recommendations to PHIAC on 30 November
- Next meeting to consider economic model and draft recommendations on 5 December
- Draft evidence synopsis released for consultation 28 November to 28 December
- draft guidance released for consultation 22 December to 26 January

	Members of the committee expressed some concern that the guidance was not due to be published until May 2007. MK agreed to convey this message to the senior management team to see if it can be brought forward.	
Close	The meeting closed at 4.45pm	