Public Health Interventions Advisory Committee (PHIAC)

PHIAC 9: Minutes of meeting 5th December, 2006

Workplace smoking, Sexual Health and Implementation

Attendees	*Members* Catherine Law (Chair), Ruth Hall, Klim McPherson, Ann Hoskins, David Jones, Michael Bury, Sharon McAteer, Mike Owen, Muriel James, KK Cheng (morning only), Andrew Hopkin, Dale Robinson, Dagmar Zeuner, Brian Ferguson, Valerie King, David Sloan, Mike Rayner (morning only), Philip Cutler, Jane Putsey, Cheryll Adams *NICE* Mike Kelly (MK), Yvette Johnson (YJ), Gisela Abbam (GA), Tania Eiberg (TE), Emma Stewart (ES), Sue Jelley (SJ), *NICE Afternoon only:* Amanda Killoran (AK), Bhash Naidoo (BN), Antony Morgan (AM), Geraldine McCormick (GM), Gillian Leng (GL), Linda Sheppard (LS) *NICE Morning only:* Lesley Owen (LO), Tricia Younger (TY), Patti White (PW), Alastair Fischer (AF), Andrew Dillon (AD) *Contractors* Penny Cook (PC) (Liverpool JMU), Kevin Corbett (KC)(Liverpool JMU), Paul Trueman (PT)(York Health Economics Consortium (YHEC)) *Co-optees and experts* Paul Hooper (Smoking Cessation PDG), Kate Quail (STI Interventions)
Author	Emma Stewart
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Audience	Members of PHIAC, co-optees/experts, NICE Substance Misuse Intervention and STI prevention teams, LJM and Matrix, NICE publishing and implementation teams

Agenda Item	Minutes	Action
1 Welcome and introductions (Chair) **2 Apologies**	The Chair welcomed Members to the ninth PHIAC meeting. • All attendees introduced themselves • The Chair declared the meeting Quorate Apologies received from Sue Atkinson, Amanda Hoey, Mark Sculpher, Susan Michie, Simon Capewell, Richard Cookson, Matt Kearney, Richard Ma (Co-optee), Helen Ward (Co-Optee), Angela Robinson (Co-optee) Sarah Flack (YHEC) The Chair welcomed Dr Mike Owen, a general practitioner who has been newly been appointed to PHIAC.	
3 Declaration of Interest (All)	Declarations of conflicts of interest in relation to Workplace Smoking and STI's were requested. The following individuals indicated that they may benefit in the future from research funding on these topics: These were: KK Cheng, David Jones, Alastair Fischer, Lesley Owen Paul Hooper declared that The Tobacco Control centre is part funded by pharmaceutical companies with an interest in the topic under consideration.	
4a Economic analysis (AF and YHEC) **4b Workplace Smoking – review of recommendations (PHIAC)**	Workplace smoking – economic analysis was presented Alastair Fischer made the following observations: • A conservative approach to loss of days statistics has been used • Time taken off within the working day could not be taken into consideration Discussion by the group: • Other cancers (other than lung) should be taken into account in analysis • Labels in the tables need to match the labels in the figures. • It was agreed that sensitivity analysis was required. This should also include 'a group that will never quit.' • It was agreed that trying to consider gender differences was beyond the realm of the data available • It should be made explicit that the 'absenteeism' figure is conservative • It was noted that the background quit rate may change once the smoking ban comes into effect. • It was considered that some extra modelling that indicated the number of attempts to quit in a year would be useful	**YHEC** **YHEC** **YHEC** **YHEC** **YHEC**

	• It was also suggested that the figures should try to indicate the cost to employer – and in particular Small and Medium sized Enterprises (SMEs) who will find the changes harder to implement. • It was suggested that it may be useful to undertake a comparison with countries that have already had a workplace smoking ban enforced. The background cessation rate may change. It was agreed that, despite the above suggestions, it was likely that the suggested interventions were cost-effective. The group agreed that it was now important to consider how to help with implementation in line with the 1st July workplace smoking ban.	**YHEC** **YHEC**
4c Drafting Recommendations – Introduction (LO)	Presentation of the draft recommendations by Lesley Owen Issues discussed by PHIAC: • The need to be explicit about the type of evidence that was used to make a recommendation. • It was acknowledged that there is little evidence of effectiveness explicitly in relation to the **workplace** however the evidence could still be used to make recommendations as long as the context is always considered. • The evidence was also considered potentially problematic as the context will change dramatically when the workplace smoking ban takes affect. • The recommendations should be directed to a wide audience – not just the NHS. • Many of the recommendations circulated were considered to be context statements. • Cost-effectiveness based on health costs – it was considered that it might be useful to model where the break-even point would be for employers to release workers and when this would be cost-effective. This would make the recommendations more relevant to a wider audience. • Long term and short term life gains were considered important. Employers might be expected to be more influenced by short-term gains. • The importance of considering employees' preferences – bottom up approaches considered more effective for uptake. This would need either fieldwork or People and Public Involvement Programme to be involved – so with time constraints in this fast-tracked guidance it may be difficult. • It was agreed that the recipients of the guidance would be implementers of the workplace smoking ban NOT employees. • It was considered important to direct the	

	recommendations to employers, specifically – perhaps occupational health or Human Resources. • It was considered that a quality framework for smoking cessation programmes would be useful but was beyond the scope of this guidance.	
4d Drafting Recommendations	**Agreed actions for revision of recommendations** • The tabled document contained a lot of information of relevance, some of which would be used to form recommendations. The remainder would form other aspects of the guidance document. • It must be highlighted that we work in a context based in legislation; and that the evidence base that has been drawn on has to be applied to a different setting (ie when the smoking ban comes into effect). • It was considered that recommendations should focus on how to expose people to the recommended interventions. • Epidemiological evidence to be added to identify recommendations based on evidence and on expert opinion.	**NICE**
Agreed Workplace Smoking Timeline	Agreed Timeline: 11th December – Draft recommendations finalised and sent to PHIAC 18th December – Comments back from PHIAC 22nd December – Recommendations out for public consultation 19th January – Public Consultation closes	
5 Update from Andrew Dillon	Andrew Dillon joined the meeting and provided an update on current issues facing NICE. • The importance of transparency in the decision making process was highlighted – if this is done then evidence can come from a wider variety of sources. • It is being considered whether committees in the future should be held in public – it is a difficult decision which is being thoroughly considered. NICE do not want to undermine the quality of the decision making process. • The importance of implementation – it now represents £2million out of a £30 million budget.	
7 Sexual Health Guidance **7a Introduction (MK)**	Mike Kelly presented paper 9.4 outlining how fieldwork can be used to help focus recommendations.	
7b Presentation of Fieldwork and stakeholder comments (GM	Presentation of fieldwork findings and stakeholder consultation: • An overwhelmingly positive response was received from fieldwork – reinforcing modernisation and	

and AK)	current practice. • There is much commonality in response across respondents. • Against this backdrop there were some issues raised that were felt might deter from universal delivery • The recommendations have been adapted to be less clinically based – so they can be delivered across a broad spectrum of services, and also with the awareness that they will have to be adapted further at the local level to be locally relevant.	
7c Discussion *	Discussion • It was considered very important that the pathways presented are conveyed clearly as being just one aspect of the guidance – as a way of clarifying the recommendations and making it clear who they are aimed at. The guidance must still reflect the wider context. • Due to time constraints 'users' haven't been represented in the fieldwork. The focus has also been on delivery of interventions rather than users. However lay perspectives were considered important. • Future methodology should consider whether fieldwork is appropriate or whether other mechanisms should be considered.	
7d Redrafting Recommendations	**When redrafting the recommendations it is important that terminology is consistent throughout.** **Recommendation one** • It was agreed that 'high risk groups' should be re-worded to 'high risk behaviours' – but it was also suggested that some indication of how to identify these behaviours would be required. • As a tool is not available to identify 'high risk behaviour' groups it was suggested that a research recommendation would be to develop such a tool. • Some groups have been missed out – looked after children and schools. However, it was agreed that the list couldn't be comprehensive so the wording should be more general to reflect this 'people such as...' • Concern was raised over whether pharmacists would actually have the skills to deliver some of the proposed recommendations. • There was some discussion as to the extent that recommendations should be changed according to stakeholder comments. It was agreed that fit with the evidence was of prime importance. • There was some concern over the meaning of the word 'counselling.' The need to clarify the meaning	**NICE**

	from the RESPECT trial and give a clear explanation was emphasised. • 'Focus on condom use' was not mentioned but was identified in the evidence. **Recommendation two** • The term 'voluntary sector' or 'the third sector' was discussed. • It was agreed that, despite some concerns from the fieldwork, and a recognition of some of the constraints of quantifying 15-20 mins of counselling, the research does show this is necessary. It was agreed that it should be re-worded to 'ideally 15 – 20 minutes'. • It was identified that the recommendations could prove problematic for capacity planning as 'risky behaviour' groups were difficult to define but the mismatch between evidence and practice meant that the committee couldn't be more specific. • The role of pharmacies in recommendations 1 and 2 was discussed and it was noted that not all pharmacies would be in a position to undertake this work. **Recommendation three** • There was some discussion over which terms should be used – client vs patient and partner vs contact. It was agreed that when finalising guidance it was important to be consistent with terminology throughout and to use language most appropriate to the audience – ie professionals giving sexual health advice. • It was agreed that a glossary should be developed to identify the preferred word used in the recommendations but also which highlights other terminology that could be in use. • It was agreed that there was a need for consistency in terminology throughout, and also to use terminology that is relevant to the audience. • It was agreed to remove 'medication for the partner' – given the limited evidence and concerns about legality in the UK context. **Recommendation four** • Problem of not including contraception or abortion services was acknowledged. • The idea that there was a need to establish the place of Human Papilloma Virus immunisation in interventions in future sexual health guidance was considered. It was noted that PHIAC was constrained by scope and evidence. However it was agreed this be put forward for future topic and it should also be mentioned in 'updates.'	**Topic Selection**

7e Next steps **Agreed STI Timeline**	**Recommendation five** • The need to emphasise 'appropriate' settings – advice cannot be given in any setting – it must be appropriate. • The need to link in with wider services – it was agreed this could be covered in the considerations section. • It was agreed that emergency contraception did not reduce unplanned under 18 conceptions and should not be recommended. • It was agreed that the background discussion should consider advice to both men and women. • It was agreed that the phrase 'one to one sexual health advice' was too vague and needed a fuller interpretation as per recommendation 2. Whilst the emphasis in this recommendation is different, there is some commonality between them. **Recommendation six** • It was discussed that the term 'regularly' could be defined differently on a local basis. It would be useful to re-visit the evidence to check whether the recommendation could be more specific. • There was a need to be clear about how to address the idea of life-chance – how returning to work may help reduce repeat pregnancies. The need to have 5 rather than 7 research recommendations was raised – the committee was asked to either re-word the current recommendations so they are condensed into 5. Or alternatively, the committee will need to vote on which ones they would like to proceed with. This is to be done by email. There was some concern that the current recommendations were too lengthy. The need to keep the detail was considered very important for implementation – although there was also concern to present clear, easily understood messages. It was agreed that the recommendations would be kept detailed, but subject to some editing to keep them as concise as possible. Agreed Timeline: 18th December – Re-drafted recommendations to be circulated to PHIAC 9th January – Comments back from PHIAC 23rd January – Guidance to be signed off by Guidance Executive End February – Publication of guidance	**PHIAC**
9 The Implementation Directorate (GL)	Key issues for public health implementation are: • Number of different audiences • How to implement outside the NHS and embed into the system. Some of the methods adopted to help with public health	

	implementation: • Meeting with the audit commission – document to be published in the New Year. • Consideration being given about why the NHS is possibly 'parking' public health guidance. • Meetings with improvement and development agency – with a joint statement to be published next year. • Secondary publications: Pulse – publish all NICE recommendations six months after publication and BMJ – from March all NICE guidance to be published as a one page summary. • Public Health website to be launched through BMJ • Health Services Journal also committed to publishing guidance. • Engaging with National partnerships • Practical tools – slide-sets, commissioning guides (practical guides NOT re-writing the guidance, much positive feedback.) • 2 on-line databases to be launched (a) shared learning from field and b) Guidelines. Two main models for implementation – • Appraisals (not much involvement) • Guidance Development Groups (A couple of people volunteer to be involved) Input was encouraged from PHIAC as to how they would like the implementation team to be involved. Andrew Hopkin and Dale Robinson to help Gillian Leng with information about cross-sectoral working – through regional assemblies and Local Area Agreement monitoring frameworks It was agreed that a future working model for PHIAC is to have people that are interested in a particular topic to be involved from scope right through to the implementation stage to follow it through it's journey at NICE.	**GL to contact AH and DR** **PHIAC**
10 Temporary Chair	It was agreed that a temporary deputy chairperson would be appointed to cover Chair duties on an ad hoc basis as required.	
11 Future Work Programme of PHIAC	A solution was sought to the increasing demands that PHIAC members will come under over the next few years. 2 options were presented: 1. To have two PHIACs (would decrease workload per committee but learning process would have to start over again.) 2. Enlarge this committee – so the burden is diluted. A third option was raised by the committee: 3. PHIAC membership could be increased, but then divided according to different topics that people are	

	interested in. For the final sign off the full PHIAC could reconvene. Some issues were raised over the concern of enlarging the committee – if the quorum remained a percentage and processes remained as they are, workloads wouldn't actually reduce. There was also some concern that certain topics would be more popular that others if option three was adopted. MK to draw up a position on the options presented – considering timing, workload, processes of the committee and terms of reference to take forward.	**MK**
12 Topic Selection	Possible future topics suggested were: • HPV (Human Papilloma Virus) immunisation • Accident Prevention (Klim McPherson to send an email to clarify in detail what is meant.)	Klim McPherson
13 AOB	• Inequalities in Health scope is currently being developed – comments can be sent to AM • Appendix items on agenda have not been forgotten but will be rolled forward to a future date. • Brian Ferguson has been involved in some work on economic appraisal of public health interventions through the Public Health Research Consortium. This will be presented in a future meeting. • Timelines were confirmed. • Mike Kelly confirmed that he had discussed the evidence on Chlamydia Screening (reviewed at previous meetings) as agreed with Sir Muir Gray and Catherine Peckham from the National Screening Committee.	
14 Close	The meeting closed at 17.00	