Public Health Interventions Advisory Committee (PHIAC)

PHIAC 11: Minutes of meeting 9th February, 2007

Workplace Smoking

Attendees	*Members* Catherine Law (Chair), Dale Robinson, Ruth Hall, Mike Owen, Ann Hoskins, David Jones, Michael Bury, Muriel James, KK Cheng, Dagmar Zeuner, David Sloan, Mike Rayner, Philip Cutler, Jane Putsey, Susan Michie, Matt Kearney, Richard Cookson *NICE* Mike Kelly (MK), Tricia Younger (TY), Karen Holden (KH), Alastair Fischer (AF), Lesley Owen (LO), Hugo Crombie (HC), Patti White (PW), Emma Stewart (ES) *Contractors* Matthew Taylor (MT)(York Health Economics Consortium) *Co-optees and experts* Andrew Hayes (AH)(Regional Tobacco Policy Manager – London and smoking cessation PDG member), Nick Adkin (NA) (Department of Health programme Head - Tobacco) *Observer* Alasdair Hogarth (AH), Howard Gilfillan (HG), Sue Jelley (NICE),
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Audience	Members of PHIAC, co-optees/experts, York Health Economics Consortium, Smoking cessation Programme Development Group members, Department of Health, NICE publishing team.

Agenda Item	Minutes	Action
1 Welcome and introductions (Chair) **2 Apologies (All)**	The Chair welcomed Members to the eleventh PHIAC meeting. • Richard Cookson, Howard Gilfillan and Alasdair Hogarth, new committee members, introduced themselves and were welcomed to their first PHIAC meeting. • Karen Holden, new project manager at NICE, was also welcomed to her first meeting. • All attendees introduced themselves Apologies were received from Amanda Hoey, Andrew Hopkin (who will be absent for 6 – 8 weeks), Klim McPherson, Brian Ferguson, Simon Capewell, Joyce Rothschild (newly appointed member), Keith Malcolm (newly appointed member), Mark Sculpher, Cheryll Adams, Sue Atkinson	
3 Declaration of Interest (All)	Declarations of conflicts of interest in relation to Workplace Smoking: Mike Kelly had been a co-author on one of the studies considered (Hanlon et al) The following individuals indicated that they may benefit in the future from research funding on workplace smoking: Susan Michie, David Jones, KK Cheng The following individuals indicated that they may receive a service payment for implementing some of the interventions that the Committee may recommend: Matt Kearney, Mike Owen	
4a Presentation of new evidence (LO)	**Summary of additional evidence (Lesley Owen)** Three additional pieces of work were undertaken: 1. A review of evidence submitted during consultation. 3 commercial stakeholders were invited to submit evidence for consideration (Allen Carr, G-Nostics and New Ways Clinic); 2. A review of the evidence on workplace health assessments and smoking cessation support combined with occupational health and safety issues; 3. A reconsideration of the grades applied to effectiveness studies on gender and ethnic minorities. Conclusions reached by the review team were: • There was mixed evidence from the workplace health assessments – the committee should consider how to use this evidence. • Occupational health studies – were not about effectiveness – they were more a line of argument	

	than evidence. • Allen Carr and G-Nostics were the only commercial stakeholders to respond. • Allen Carr submitted two 2- studies. Results showed good smoking cessation rates, but further research would be required to determine a more accurate understanding of effectiveness because of methodological weaknesses in the two studies. • G-Nostics described the nature of the intervention rather than effectiveness. • Grading of gender and ethnic minority studies still to be completed. Comments from the committee: • Sorensen (2001) study is not referenced. • In relation to gender in Evidence Statement 5 in the updated review (ES3 in the previous version.) It was thought that the team were going to re-consider the evidence statement to include the grading of the relevant studies and the broad conclusions reached. **NICE team to look at the interpretation of this evidence further and return to the committee in 2 weeks.** • It was pointed out that, of the three studies considered in Evidence Statement 3 in the updated review (Gomel, Hanlon and Prior), the Gomel study was of a higher quality as it involved bio-chemical and not just self report markers of smoking status. **Employers Survey Report (Lesley Owen)** • 81% of those surveyed employed fewer than 50 people and were considered to be small or medium enterprises (SMEs) • Just over half were aware of the NHS stop smoking services • Only 10% intend to offer smoking support to staff The committee could consider if a recommendation is required for workers NOT working in a workplace (ie if the workplace is a vehicle.) • There is a job to be done to let employers know of NHS services (both awareness and how to contact) • The resource most required by employers was written information of what could be provided by the NHS. Comments from the committee: • Concern was raised about the sampling frame used for survey. • The need to have an idea of what % of SMEs make up the national workforce. • The need to consider how to reach hard to reach groups. • Narrative will be required in the guidance which explains in exactly what way providing smoking	**NICE team** **NICE team**

	cessation support is cost effective to employers. • **NICE team should provide more information about the response rate and sample. Once provided, the committee will decide how to use the evidence.** **Stakeholder comments (Lesley Owen)** • Comments were themed into 8 categories • See PHIAC 11.7 for details. • No research recommendations have been suggested so far. The committee should consider this further. Comments from the committee: • Comments from trade unions had been received. **NICE team were asked to consider whether union representatives could be used for expert opinion to get a broader view.** • The issue of resourcing was considered an important element of this guidance • Concern over how to implement the ban for community workers. Concern was raised over some of the other possible negative outcomes of enforcing the ban in community work settings. • The need to make the economics as robust as possible.	**NICE team/ PHIAC** **NICE team**
4b. Presentation of the draft economic model (MT and AF)	**Economic model presented (Matthew Taylor)** **2 scenarios considered:** • Both scenarios compared smokers with non-smokers. • Interventions were considered against non-interventions. • The model excluded those over 65 • 6 and 12 month quits were considered • Costs to employer considered • 11 different interventions were looked at. • A 2% baseline quit rate was assumed. • Net financial benefit considered. • Second scenario also considered smoking breaks, assuming five 5 minute breaks per day • All considered the 'average employer' • Short and long term results varied. Comments from the committee: • The 5 minute break assumption was explained to have been drawn from a West Midlands study. This would need to be referenced. • The conclusion slides were considered helpful. These could be drawn upon in the guidance. • The exclusion of costs to the NHS caused some concern due to resourcing issues. • The results from the model were based on an	**YHEC/ NICE team**

	'average employer' but it was not possible to find the data to model the effects on different types of employer. • Concern was raised over assuming that smoking breaks constituted more of a break than a coffee break. **Commentary on economic analysis (Alastair Fischer)** • From the NHS perspective all interventions for smoking cessation are cost effective and worth doing. From an employer perspective it is important to know if the intervention will be cost saving. • Where employers pay all the costs themselves, an average employer should recoup their outlay in two years in terms of reduced absenteeism, not including time off. • When the NHS pays some or all of the costs, the average employer breaks even sooner. • Further economic analysis considered some of the assumptions the economic model made and how these could be presented in the guidance. • Caution was raised over the use of incentives to encourage people to stop smoking. Some people may use this as an opportunity to start smoking. • Economic modelling that considered other variables (other than lost productivity) was difficult due to the lack of data.	
4c. Expert Testimony (NA and AH)	**Expert Testimony on the implications of the smoke free legislation. (Nick Adkin)** • The Health Act, which will come into effect on 1st July, will probably include 5 exemptions. These are to be debated by parliament. They include: o Long stay residential care (1 further year to implement) o Off shore installations o Adult Hospices o Prisons (in cells only) o Research associated with smoking o As part of a smoking cessation intervention, for example: rapid aversive smoking. • 23rd March – Guidance packs to be ready for distribution. • 7000 'needy businesses' contacted to consider their needs. • Mass Media campaign to be launched in March. • The focus of the campaign will be on compliance. A secondary message to businesses is that people will use the legislation as an opportunity to quit. • When the NICE guidance is ready it can be distributed via the smoke free England initiative and website. The legislation refers to smoking in any enclosed or substantially enclosed public place.	

	Expert Testimony (Andrew Hayes) • A plea was made for integration between the PDG and PHIAC and also between outside agencies. • Practical and not just theoretical guidance needs to be made. • Surveys in Scotland, Wales and Ireland have shown that half of businesses employ between 1 and 5 employees. Therefore focus on SMEs is justified. • Due to a lack of evidence about the impacts of the legislation, examples of current good practice are being gathered and proactive work with some organisations to encourage them to go beyond the legislation where appropriate. Committee discussion • Consider the importance of trying to track exemplar organisations from Scotland, Wales and Ireland to use as examples of good practice. • How to channel information to the right organisations will be important for implementation. • It could be beneficial to learn from the ways companies have implemented other policies such as those on sustainability. **Summary (Catherine Law)** • The need to be focussed on who the guidance is primarily for (scope states that this is everyone directly or indirectly involved in the implementation of workplace smoking policies and the provision of smoking cessation support.) • How to use the economic analysis – is it the committee's responsibility to say who should pay for smoking cessation support? • To remember that the committee is tasked with making recommendations not their implementation. • To consider whether the committee should be making recommendations and then prioritising where they should be implemented. (The scope does not make particular reference to reducing health inequalities.)	
5a Discussion (PHIAC)	A general discussion on the data included the following points: **Economic model** • The importance of strengthening the economic analysis so that private sector organisations pay attention. Greater sensitivity analysis required. • The bi-modal distribution of the days lost per year figure (0.9 and 7 days) should be reconsidered. At present an average of these figures is used, but both figures should be modelled, as well as modelling short term sickness absence and long	**YHEC**

	term sickness absence. • Concern that Quit Rate data is based on highly motivated people, and therefore the model might be over-exaggerating effectiveness. • Who is the brief advice given by? Brief advice from a GP is likely to be more effective than from a work colleague • Fixed overhead costs of the interventions have not been included in the model, only the variable costs. Fixed costs will be of particular relevant to small organisations. • **It was agreed that data from the Department for Work and Pensions should be used to help strengthen this analysis. Any other data that could help with this figure should also be drawn upon.** • An issue was raised about considering life-time savings i.e. the economic costs of having people live longer. • Further modelling could be done to consider the effect of differing retirement ages and pension costs. **General discussion** • Concern was raised about the possibility of increasing health inequalities. Is there a case for government subsidies for stop smoking services if it is not cost effective for employers to help their employees to quit smoking? • It was suggested that more weight should be given to the public health case for this intervention with supporting arguments relating to the employers perspective i.e. to concentrate on cost effectiveness rather than cost saving. There is also a need to acknowledge that the legislation will require that employers have to change practice. Supporting employees to quit smoking will help employers to comply with the legislation. • This also makes penalty fines for non compliance less likely and contributes to the business case for employers. • The importance of good economic analysis for arguing the case to employers for supporting quitting in the workplace. Some concern was raised about the extent to which the NHS could support stop smoking services. • The need to consider the other drivers that may influence whether a recommendation is implemented – it may not just be financial considerations. **Summary (Catherine Law)** • The economic model was discussed with suggestions as to how it could be improved.	**NICE team**

	• Recommendations should be made in the context of employers having to comply with legislation. • It is not appropriate to try and consider all policies and regulations – but the guidance should acknowledge they exist. • A consensus was reached on the need to prioritise the public health impact, as in previous guidance. • The committee will consider prioritising certain workplaces if it is felt that without support they may lead to a widening of the inequalities gap. • To keep in mind that the role of the committee is to consider what **should** be done. • Implementation issues may affect the chance of compliance/ non-compliance, but this was not for the committee to comment on.	
5a. Revising recommendations	**Introduction** Preamble about cost-effectiveness to be included therefore some changes to recommendation one will have to be made. • Do not single out NHS stop smoking services (SSS) as there may be other services that are effective. • The introductory paragraph should list interventions that are deemed effective. • It was agreed to change 'GPs and Nurses' to 'other health professionals.' • The need to more explicitly link the evidence to the recommendations was considered important. • It was agreed that 'trained individuals' should be used instead of listing all of the professions. • The following three points should be drawn out: o There is a set of legal requirements and these recommendations are aimed at helping to implement them o There are a range of public health interventions which are cost effective both to society and the NHS o There are economic benefits – especially to large employers. **Recommendation 1** • Concern was raised about the tone of the recommendation. Some felt it was too didactic whereas others felt that directive language was necessary. • Much attention was placed on the importance of consultation by employers. There was a lack of evidence on this and so it would have to be contextualised. • Many considered it a good idea to change the language from could to should. • The evidence should be explicit and accessible to the (sometimes reluctant) audience it is aimed at.	

	The economic model should be available in summary. **Recommendation 2** • The need to clarify the term TOIL • The word 'incentive' should be changed to 'support' • There was some debate as to whether the recommendation should only be aimed at those 'who are ready and want to quit' or whether the opportunistic approach which targets all is the correct way to proceed. • The committee agreed that only those interventions where there is evidence of effectiveness should be recommended. • There was agreement that employers should support employees' access to effective interventions during working hours. • The need to clarify 'to quit' – does it mean to quit smoking or to quit work? • Change the wording to 'support smokers who wish to quit.' • There should be a level of support for people to go to effective stop smoking services in work hours without loss of pay. • There is no need to quantify (i.e. only employees smoking for a year) in this revised way. • There is a need to identify and consider the types of financial incentives used in the evidence. • The need to capture the evidence that incentives may not have a direct impact on quitting but do encourage more people to try to quit. **Recommendation 3** It was agreed that this should be deleted. However, the implementation team should consider this further. **Recommendation 4** • Concern that this recommendation is based on poor evidence. • It was agreed that there were two central themes to this recommendation: o Strong leadership o Having an enriched environment. • The committee agreed that the leadership element was important to capture, but not as a recommendation. The idea that 'it will be more effective if strong leadership is shown' should be captured as a consideration. • The 'enriched environment' should be re-checked against the evidence. **Recommendation 5** • There was some debate over whether to include	Implementation NICE team

	this recommendation and whether it added any value. • There is a need to make clear the difference between NHS and other smoking cessation services. • The NICE team were asked to look back at the evidence and clearly spell out interventions that are effective. This may not form a separate recommendation. • If it is decided that a separate recommendation is required for SSS, it must be evidence based. **Recommendations 6 & 7** • There was concern over whether it was the job of the committee to make a commissioning recommendation. • Concern was raised in case services might be directed away from the unemployed and therefore widen the inequalities gap. • The committee agreed that it was necessary to comment that if there were not enough resources to go around, priority should be given to certain groups. • The idea that this was likely to be a time-limited resourcing issue should be included, possibly quoting evidence of this from other countries. • Some implementation issues were raised – for example that PCTs are aimed at residents whilst business may be non-resident, whether it is the job of the NHS to proactively seek out people in need of SSS. These issues were beyond the remit of the committee. • Spearheads to be changed to 'disadvantaged' so not tied to Government targets. **Summary** • **It was suggested that smoking cessation interventions should be delivered by those who have received training which complies with the Health Development Agency standard on smoking cessation.** **General comment** • The need to have the primary studies available to help with the rewording of recommendations – not just for this guidance, but for all others in the future. • Concern was raised over the lack of consideration of the employee as this was a large part of the scope, for example, the need to consider the role of the employer if the employee does not comply with guidelines. NICE team to consider further.	NICE team
6 Research Recommendation	The committee suggested a number of possible research recommendations and it was suggested that these should	

s	be taken into consideration in the further development of the draft guidance.	NICE team
8 Agreed Timeline for the workplace smoking cessation guidance (TY)	• The date of publication of the guidance is 25th April 2007 • The timeline, PHIAC 11.11 was agreed. • Issues raised in the meeting today to be considered over the forthcoming weeks.	
9 Minutes of the meeting of PHIAC (All)	• The minutes were approved by the committee with no changes	
Close	The meeting closed at 16.30	